MID-WESTERN HEALTH BOARD

SOCIAL AND HEALTH EDUCATION IN PRIMARY AND POST-PRIMARY SCHOOLS

HEALTH EDUCATION UNIT

MARCH, 1989.

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FOREWORD

1. Health education in schools has always been central to the health services provided by the Mid-Western Health Board and has traditionally been catered for by the school medical service. In more recent times a new emphasis is required in response to changing needs. Greater importance is now being placed on health related behaviour and on individual responsibility for health. When allied to the growing concern about social issues, this has prompted the need for a more comprehensive approach to school health education.

2. This report outlines the origin, growth and development of this Board's response in the form of Social and Health Education projects at Primary and Post-Primary School levels in co-operation with the Departments of Health and Education. Structured programmes in social and health education are being developed for all school-going pupils, from Junior Infant to Leaving Certificate classes, comprising classroom materials, in-service training for teachers, parental support courses and supplementary classroom resources. In this report the origins, developments and current status of school based social and health education are traced since 1984, with recommendations for the future.

3. The direction of Health Care provision in this region must place particular emphasis on primary prevention and Health Promotion. It is in this context that these initiatives in school health education have been taken with the underlying belief that the seeds of healthy behaviour sown at this early stage will reap rich dividends in the health status of future generations. A gap has been identified in the continuum of children's needs and the experience and research of the programmes indicates that a great deficiency exists in the areas of teacher training and in curriculum content. As a result of these deficiencies, health related messages for school children have been inadequate and often non-existent.

4. Fundamental to the success of these initiatives is the need for the Department of Education to become more involved in the implementation of these projects through teacher training, at undergraduate and in-service level, and curriculum design. It is a matter for concern that, with the demise of the Curriculum and Examinations Board in 1987, the place of Social and Health Education in school curricula is now uncertain. The Curriculum and Examinations Board had placed Health Education at the core of the Junior cycle curriculum, and had given prominence to the importance of Personal and Social Education at Senior Cycle level. The current emphasis of its successor, the National Council for Curriculum and Assessment, is with the core curriculum for the Junior Certificate. It is hoped that the thinking which informed the Curriculum and Examinations Board with regard to Health Education will have had an influence on the National Council for Curriculum and Assessment in its future approach to the personal development of each individual child. It is important therefore that, in the future design of Primary and Secondary school curricula, Social and Health Education will have a central role in mainstream education.

5. Whereas the role of the Health Board to date has been in identifying the Social and Health Education needs of children and making responses towards satisfying these needs, it sees the formal education system as the future provider of Social and Health Education, with the Board in a supportive role in providing a "health" input to the system. Thus, the resources of the Board, currently employed in Health Education, could then be redirected towards identifying and responding to newly emerging areas of need.

6. In the development of the Board's programmes as described in this report, the contributions of many persons and organisations must be acknowledged. These include Health Board staffs, School Principals and their Associations, Teachers, Parents, representatives of the Churches, the former Health Education Bureau, the Departments of Health and Education, also interested individuals who participated as members of working parties, committees and support groups over the years. Particular acknowledgement must be given to Dr. R. Stokes, my predecessor, who initiated the programmes, and whose contribution to them has at all times been most supportive. The work of Mr. Liam Leland and Miss Eibhlin O'Sullivan, Health Education Officers, must be especially recognised for their industry and professionalism over the period under review.

M.J. DUFFY
PROGRAMME MANAGER

MARCH, 1989.

SUMMARY OF RECOMMENDATIONS

The main recommendations of this report are that:

1. Social and Health Education Curricula be established as formal core areas in Primary and Post-Primary schools. (Para 3.7)

2. Schools should formulate policies regarding the teaching of Social and Health Education. (Para 4.11) (Appendix 1: 3.2)

3. The role of parents as primary educators of their children be recognised and that parents be informed about and involved in the school programme of Social and Health Education. (Para 5.2)

4. Teachers receive the knowledge, skills and resources necessary to implement programmes of Social and Health Education during introductory and in-service courses. (Para 6.2)

5. Relevant pre-service training courses be provided for all trainee teachers at undergraduate level in the area of Social and Health Education. (Para 6.2)

6. A support network and courses in parenting skills be provided for parents. (Para 6.5)

7. A centralised resource centre with appropriate localised resource centres be established. (Para 7.1.6)

8. Research into further areas of need be initiated and projects be designed to meet these needs. (Para 7.2)

9. The Health Education Unit be staffed to a level sufficient to discharge the present and developing workload. (Para 7.3)

10. The important contribution of Social and Health Education to the overall development of the child be recognized and that closer links with the Department of Education be established in the development and implementation of projects in schools. (Para 7.5)

CHAPTER 1.

INTRODUCTION

1.1 "By health I mean..... I want to be all that I am capable of becoming." (1)

This quotation has excited a great deal of debate about the implicit definition of what a healthy person is. There are those, on the one hand, who would argue that it is a good and sound description while, on the other hand, it could be argued that such a state is Utopian in concept and is impossible for the ordinary individual to achieve. One thing, however, on which both sides would very probably agree, is that health is a good thing. Health is something we all want to achieve, maintain and enhance. Health, as a topic of conversation worldwide, as a greeting or as a toast, is a constant and present concern. Health, as manifested in the strength and athleticism of our young people, is something in which we take pride, something natural and basic to our everyday existence and, therefore, is something very often completely taken for granted. What are the indicators of the health and well-being of a nation? To what can we point to prove that we are a "healthy" nation and that we hold health in a high and positive regard? Do we merely pay lip-service to the concept of health?

1.2 We are reminded by Mr. B. Desmond, T.D., a former Minister for Health, in an address at the Conference "Health: Value for Effort" (1984) that:

> "If we consider the factors which determine people's health we can see that the health of the community is as much determined by its lifestyle and behaviour, the quality of the environment and the level of its material wealth as it is by its level of access to modern medicine. All are important determinants of the quality of a community's health". (2)

1.3 In an address to the Advisory Council on Health Promotion (1988) Dr. R.O'Hanlon, T.D., present Minister for Health stated:

> "The difficult issues confronting us in dealing with the health needs of the country leave us with no choice but to look at our basic policies and to question whether they are deficient. The most obvious shortcoming is that we have been concentrating on treating illness to the neglect of protecting and advancing health ....."
>
> "We have not done enough to remove the practices and features of our society which may be obstacles to good health and over which the individual has little or no control ...." (3)

1.4 Traditionally, health has been narrowly defined and often equated with the absence of illness rather than with the presence of wellness. It was customary to measure health in terms of the amount of sickness prevalent at any one time. For instance, life expectancy has been increasing here, especially since the turn of the century.

Life expectancy at birth has improved from 57 years for a man and 58 years for a woman in 1926 to 70.1 years and 75.6 years respectively today. But most of this improvement took place before the 1960's and compares poorly with other E.C. Countries today. However, little consideration is given by society to the quality of that longer life.

1.5 The Consultative Statement on Health Policy - "Health - the Wider Dimensions" (1987) (4) referred to:

> "Ireland's relatively high incidence of cardio-vascular disease and certain cancers as major causes of mortality. While rising living standards had been associated with a decline in mortality and morbidity from diseases which afflicted earlier generations, the lifestyle practices associated with the new affluence had brought new health problems in their wake" (p.7)

Indeed, improving our health status will not be achieved simply by investing more resources in buildings and technology;

> "Given the nature of contemporary health problems, a more broadly based approach is needed. Health education and individual responsibility have important roles to play" (p.17)

1.6 The foregoing point is clearly debated by Marc Lalonde in his book "A New Perspective on the Health of Canadians" (1974). (5) He remarks that:

> "At the same time as improvements have been made in health care, in the general standard of living, in public health protection and in medical science, ominous counter-forces constitute the dark side of economic progress. They include environmental pollution, city living, habits of indolence, the abuse of alcohol, tobacco and drugs, and eating habits which put the pleasing of the senses above the needs of the human body. For these environmental threats to health, the organised health care system can do little more than serve as a catchment net for the victims."

1.7 Positive action is therefore needed to promote health, together with a greater investment in people. This concept is becoming central to the underlying policies in relation to the provision of the health services nationally and is supported by such seminal documents as "Health the Wider Dimensions" (6) and "Promoting Health through Public Policy", Health Education Bureau, 1987 (7). A Californian study of some 7,000 people cited in the "Irish Medical Times", January 1989 (8) makes reference to seven easy-to-follow aspects of life-style which, if adopted, might result in an addition to life expectancy.

The seven were: eating breakfast,
exercising regularly,
maintaining normal weight,
not smoking cigarettes,
not drinking excessively,
sleeping eight hours each night,
not eating between meals.

1.8 While there is no doubt that reduced alcohol, cigarette and other drug abuse, cleaner air, better diet, higher levels of vaccination, fewer road accidents, more exercise, would all lead to substantial improvements in the nation's health, such steps presuppose that basic conditions of housing, standards of nutrition and education relating to well-being are available to the individual. The challenge for the health services, and indeed all other social and political services, is how to organise policies and services to enable these changes come about and thereby create a healthier society in which;

> "each citizen is partly responsible for the whole of it rather than wholly responsible for part of it". (9)

Such an approach is based on a respect for the dignity of the individual and aims at enabling him/her to take personal responsibility for his/her own health and that of the community and become an independent and vital member of society.

1.9 In formulating its response to these challenges, the Board is developing policies in all areas of its activities, and making the prevention of illness central to the promotion of health. It is also developing health education programmes at community level and in schools. By assisting schools, teachers and parents in their work with children, the Board believes that education for personal responsibility and primary prevention will enhance the future health of the nation. Reid (1984) (10) points out that National Health Service expenditure on schools is based on the assumption that more health education means better health, and that education of the young may bring life-long benefits. Evaluation studies suggest that school health education does indeed contribute to health and the findings of Jones (1980) (11) substantiates Reid's (12) claim that school health education, in particular, has also resulted in improved knowledge, increased self-esteem and better attitudes to school on the part of pupils.

1.10 This report sets out some strategies as to how health education can be beneficial to overall health by developing awareness and appreciation of positive attitudes at an early age which will be carried on into adulthood, while, at the same time, permeating the wider community. It describes initiatives taken to date in this Board's and a focus for the future.

The policies which will imbue the Board's services and activities in other areas will be dealt with in a report on Health Promotion currently being drafted.

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CHAPTER 2.

CONCEPTS IN HEALTH EDUCATION

2.1 Language as a medium of communication is effective only when an understanding of its terms is mutually accepted. Sutherland describes "Health" and "Education" as "Humpty Dumpty" words and goes on to state that:

> "whoever we are, we all think that we know what they mean, more or less, until we talk about them carefully; when that happens, we discover that agreement on their meaning, except in the most general and imprecise terms, is difficult." (1)

Before proceeding to deal with the programmes currently operating, and in the interests of clarity and understanding, it is important to offer an interpretation of some of the terms currently in use in health promotion/education, and in this report. These definitions differ in scope and degree of attention to detail, and though offering different perspectives, indicate a broad level of agreement on the understanding of the terms "health" and "education".

2.2 Health

A very acceptable definition of the concept of health is that adopted by the World Health Organisation in 1946:

> " Health is a state of complete physical, mental and social well-being, and not simply the absence of disease and infirmity." (2)

Admittedly, this is a broad definition and, as such, it poses a challenge to Health Boards and all those concerned with health.

2.3 Health Promotion:

The World Health Organisation views health promotion as:

> "the process of enabling people to increase control over, and to improve, their health". (3)

The Health Education Bureau considered health promotion to be:

> "A process which aims at improving the quality of life of the whole population no matter what a person's basic level of health." (4)

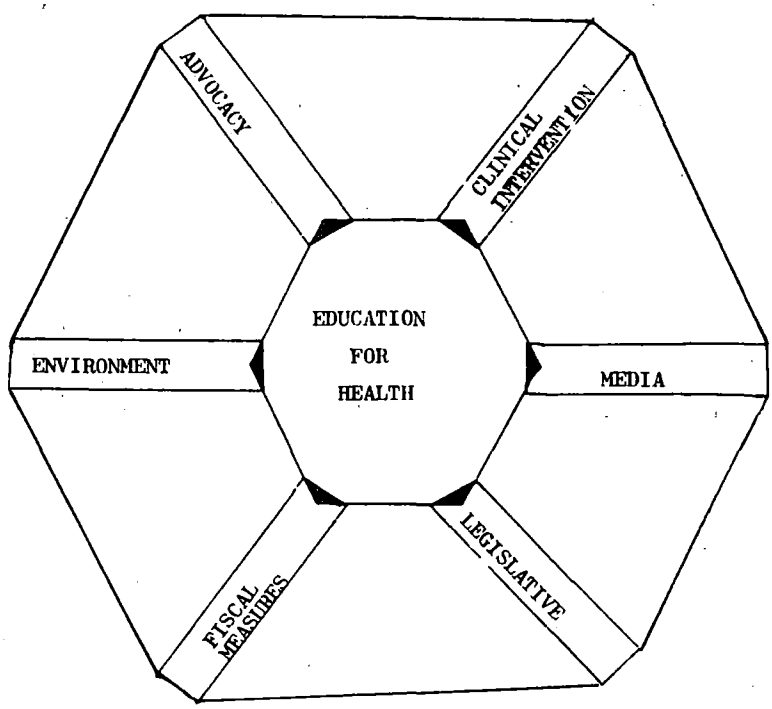
Ashton & Seymour, in a recent report, view health promotion as:

> "any combination of health education and political, economic and organisational activity designed to improve or protect health through its effect on the human environment and on behaviour" (5)

Tones offers a definition of health promotion as follows:

"Health promotion is - any measure which results in a healthy outcome..... (it) therefore incorporates health education, but also includes legal, fiscal, environmental or any social engineering measures designed to promote health." (6)

The inter-relationship between these various aspects is illustrated in the following diagram:



(7) **Health Promotion (After Lambert)**

Each segment represents an area of activity which has some effect on and interacts with each other area in the hexagon. All interact with the central unifying area, that is, education for health. As indicated in the previous definitions, health promotion encompasses all the areas of activity as shown by the enclosing box.

2.4. Health Education:

Although the Cohen Committee on Health Education in 1964 found that Health Education "means different things to different people," (8) there is a general acceptance among health care providers as to its centrality and importance. Health Education has been identified as one of the agencies of health promotion and as a vital and specific element of it. It has been described as a

> "process to persuade people to adopt and sustain healthful life practices, to use judiciously and wisely health services available to them and to take their own decisions, both individually and collectively, to improve their health status and environment." (9)

Lowry states:

> "the ultimate objective of health education is to help each person to make the best possible choice for his/her optimum health and total well-being. It must also seek to influence people to act on the advice and information given, and must seek to counteract pressures which are inimical to health".(10)

Thus, one may deem the business of health education to be a means by which educational opportunities are designed to encourage and enable people to live lives that are as healthy as possible for as long as possible. This entails consideration of the physical, emotional, spiritual and environmental health of individuals. Health education is concerned also with ensuring that conditions in society conducive to healthy living are developed and maintained; in other words, to help create an environment where healthy choices are better choices.

Opportunities to do this within the Board's area are many and include:

- co-operating with and co-ordinating national programmes and campaigns.
- developing specific programmes for community health.
- developing programmes for schools.
- supporting other statutory and voluntary agencies or groups.
- providing information, skills, training and resources to assist the realisation of the foregoing.

2.5 Primary Health Care

The Declaration of Alma-Ata describes primary health care as follows:

> "Primary health care is essentially health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford .... it forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

Primary Health care includes:

- education concerning prevailing health problems and the methods of preventing and controlling them;
- promotion of food supply and proper nutrition;
- an adequate supply of safe water and basic sanitation;
- maternal and child health care, including family planning;
- immunization against the major infectious diseases;
- appropriate treatment of common diseases and injuries;
- provision of essential drugs." (11)

Werner describes Primary Health Care as:

> "a comprehensive process whereby people work together to improve the total situation of their communities, and to deal with underlying causes of poor health." (12)

From this it is clear that primary health care entails

(a) resourcing and enabling people to deal with their own health problems;
(b) a whole series of activities of which health promotion and health education are vital parts.

Such an approach to the provision of health care and the enhancement of Community health must be pro-active in its application and should be indicative of the direction of the Board's policies in the future.

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HEALTH EDUCATION IN SCHOOLS.

3.1 The development of a Health Promotion Policy by the Mid-Western Health Board must be such as will influence existing and future health care provision in the region. A vital part of such a policy is the provision of comprehensive Social and Health Education through its Community Care services, especially at primary level, through the interaction of the school medical teams and with teachers, parents and pupils.

3.2 Traditionally, health education has been focused on disease prevention and has been largely information based. In recent years, the concept of Health Education has been broadened as it has become clear that the simple provision of information is not sufficient and it is the effect of this information on behaviour that is at least as important. For example, smoking and drugs education has traditionally been based on the transfer of knowledge, and especially on information on their negative aspects. While this is important, the social and environmental factors which influence smoking behaviour (such as low self-esteem, peer-group pressure (Bynner, 1969), (O'Connor/Daly, 1983) also need to be considered. (1) The more successful education projects about smoking have addressed these issues by helping young people develop their self-esteem and coping skills to resist peer pressure. Young people, as they grow, develop attitudes, values, behaviours and beliefs which will, for good or ill, affect their health and the environment in which they live.

3.3 "The truth of the matter is that young people do not come to school "tabula rasa" but come possessing knowledge, values, attitudes and behaviours closely and directly associated with health education". (2)

Research conducted by Jahoda and Crammond (3) and Campbell (4) confirms that attitudes to specific behaviour are being formed at an early age and are increasingly difficult to change as young people mature. Thus, health can be seen in terms of a career, in which each stage influences its successor through the development and shaping of attitudes, knowledge and behaviour.

3.4 It is important that young people are aware that their present health is related to their past behaviour and that their life-style now will affect their future health. One important aspect of the choices young people make is the consequence of such choice on their present and future health. Very many of the physical and mental illnesses that afflict our population today are due directly or indirectly to individual life-styles and so are, to a large extent, within our control. Of the factors involved in attitude formation in children, probably the most significant are the home, friendship or peer groups and the media, especially television. It is in these settings that children gain a great deal of their information. Williams makes the point, however, that:

"There are very few opportunities for children to be exposed to influences which can act as a counterweight to their informal social learning about health related behaviour". (5)

Further, H. and S. Kreitler suggest that:

> "when faced with a "knowledge gap", children will fill it with their own internally generated fantasy theory". (6)

3.5 There is a large body of evidence to support the view that schools are in a unique position to help children make rational decisions and choices about health matters, as established by the research findings of Milne et al. (1975) (7), Craft et al. (1981) (8), Wilcox et al (1978) (9) and Reid 1984 (10).
Evaluation of School programmes of Social and Health Education conducted in Ireland indicate that the outcomes are "positive and encouraging", having "a significant impact at a number of levels". (11)

It is the view of the Psychological Society of Ireland (12) that teachers should be supported in helping pupils to resolve societal conflicts:

> "in these difficult situations, whether by means of providing the necessary expertise or through development of new programmes that are appropriate to the perceived needs".

Similarly, support for this claim may be found in the Health Education Bureau's Report on School Health Education, presented to the Minister for Health in 1983 which stated that:

> "While the school should not be considered the only agency responsible for health education, it is clear that it has a special role to play within the community. At school, pupils have available professional expertise on a daily basis. At school, young people can be given opportunities to mediate the experiences of the community at large through discussion, analysis and simulation in the reflective atmosphere of the classroom and under the guidance of experienced teachers. In short, the school offers the best point of access to people at a time in their development when they are most responsive to health messages". (13)

In order to maximize the potential of the school in this regard, it is vital to involve teachers, and to provide them with the knowledge, skills and resources necessary for the effective implementation of education for healthy living.

3.6 The reality of our school system today is that the need for academic examination success is the over-riding purpose of our schools. With the possible exception of religious education programmes, careers education, and the haphazard provision of extra curricular activities in schools, there is, at present, little scope for personal growth and social development. The world facing to-day's teenagers may in some way be a more difficult one than that which faced their parents. The prospect of permanent unemployment and emigration is a real prospect for many. Society seems less cohesive and violence and vandalism seem to have increased.

Traditional values seem less accepted and traditional authorities less respected. With television in every home there is much more contact with other ways of life and much less public agreement on the meaning and value of life. Materialism and self-interest are rampant and are the basis of much of the advertising to which we are subjected. And even the world of nature and the life of the planet itself are threatened as pollution increases and the nuclear race continues. These are all social realities.

3.7 It is in this social and educational milieu that young people become who they are in the context of relations with other people, parents, friends, peers, etc. We live our lives in a complex social context and for this reason a health education programme which wishes to promote growth towards a mature and responsible attitude to health and living must involve not merely health education in its narrow sense but Social and Health Education in a broad sense. This is what the Health Board's programmes of Social and Health Education for Primary and Secondary schools as described below endeavour to do.

3.8 The Health Education Unit of the Board was set up in April, 1984. Prior to this, the Health Education Bureau had been developing teacher training programmes in Health Education for Second-level schools. The Board was becoming increasingly aware of the need for the development of its health education/promotion provision. At this time also Tipperary (N.R.) V.E.C., with the co-operation of the Board, was involved in piloting a Pastoral Care/Health Education project in a number of its schools and the Limerick Principals' Association was examining various possible approaches to dealing with aspects of student life not adequately covered by the current curriculum. The Health Education Bureau, the Board and the Limerick Principals' Association co-operated in developing a structure aimed at meeting their respective needs. This then led to the setting up of a committee which included Health Board Staff, Primary and Secondary School Principals and Community Representatives, to investigate various avenues of addressing the many problems common to their areas of work. These included:-

.concern about the misuse of drugs;
.an upsurge in vandalism and violence;
.low self-esteem;
.growing emphasis on academic achievement;
.absenteeism;
.lack of respect for authority and general indiscipline;
.poor diets of school children,
.an over-dependence on the State and particularly on the services of the Health Board.

It was felt that an attempt should be made to address these problems through the creation of a Health Education Unit in the Board. This Unit, by means of courses based on Primary prevention and aimed at schools and the wider community, would increase the health awareness of these groups in health matters and encourage them to take more responsibility for their own health.

Specifically, the Unit was charged with developing health education strategies in the areas of Primary Schools, Secondary Schools, the Community and in Industry. This work was supported by the then Health Education Bureau through a co-funding arrangement and provision of resources. This arrangement continued from its inception in 1984 to the demise of the Bureau in 1987.

3.9 Initially the Health Education Unit was staffed by a Health Education officer, a Secondary School teacher on secondment, with concentration on the development of a Secondary School Programme. With the subsequent development of the Primary School Programme, a second Health Education Officer who is a Primary School teacher, also on secondment, joined the staff in July, 1986.

Training of teachers in the methodology of Health Education is a main priority of the Unit together with the compilation of materials and the provision of classroom resources. Ancillary work includes:

(a) liaising with parent groups and resourcing them by providing speakers on topics of concern to them and co-ordinating courses for them.
(b) the provision of in-service courses on health education matters for both Principals and teachers, co-operating with schools in the designing and tailoring of programme materials on specific areas to suit their needs, for example, first aid, child abuse, drugs.
(c) resourcing the community care staff through the provision of in-service courses and providing access to resource materials from the Board's resource unit.

Chapters 4 and 5 to follow give details of the Programmes as developed for Primary and Secondary Schools.

3.10 To provide a sound footing for the development of social and health education in the area, a committee was established to examine the issues involved so as to enable it to put in place an acceptable Health Education programme in second level schools. The terms of reference of the committee enjoined it to make recommendations regarding:

The Health Education needs of second level schools.
The content of suitable Health Education programmes.
The role of Health Education generally in schools.

The Committee was composed of representatives of:

The Board,
The Department of Education,
Church Authorities,
Parent Bodies,
Limerick City and County V.E.C.'s, and
Limerick Principals' Association.

The work of the Committee included surveying the attitudes and wishes of schools and parents regarding the health education needs of children in second level schools in Limerick City and County. The committee published its report in November 1987 (14) and its main recommendations are included as appendix 1. The report is the main instrument which guides the Board in the development of health education both at Primary and at Secondary levels in its area.

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CHAPTER 4.

SOCIAL AND HEALTH EDUCATION IN THE PRIMARY SCHOOL

4.1 Introduction.

The social experiences of children and young people in their families and in the wider community provide a background against which new ideas, concepts and knowledge are placed. With little formal learning young children develop many attitudes, values, beliefs and behaviours directly or indirectly associated with their health. There is, as suggested by Trefor Williams (1), a body of evidence to support the view that children, even very young children, are already forming beliefs about health-related topics and that those are already beginning to be organised into attitudes. It has long been recognised that primary schools have an opportunity as well as an obligation to promote the health and well-being of the child. So too it is widely accepted that schools provide a receptive audience for a preventative health education programme. Although the early health education programmes were initially targeted at the teenager, recent research (2) has demonstrated clearly that children have opinions and attitudes about health related topics long before they become teenagers. This research shows that these attitudes of children are not fixed and inflexible but rather susceptible to influence. The Schools Council Health Education Project (5-13) makes the claim that:

> "Health Education in Primary Schools is now accepted by an increasing number of teachers as a small yet important and highly relevant part of the school curriculum. It is important because it is concerned with a vital aspect of our lives - our health and well being." (3)

4.2 It was therefore appropriate that a preventative health education programme be incorporated into the existing curriculum of the Primary school so that planned and relevant experiences be provided for children on subjects concerning their present and future health. Thus, the Health Education Unit of the Board initiated a Social and Health Education Programme for the Primary Schools in its catchment area in October, 1984. This initiative was given further impetus by the real concern of Principal teachers, who were involved in the implementation of a second-level programme, that students lacked basic knowledge of health related topics on entry to second-level schools. A necessary pre-requisite of the effective implementations of a programme of Social and Health Education at second level, it was claimed, must be the existence of such a programme at Primary level.

4.3 A working party was established and given a wide brief-viz: to research and develop a programme or syllabus in Social and Health Education suitable and pertinent to Primary School children in the Board's area. The early meetings of the working party were concerned with outlining objectives of the project, setting out definitions and determining working arrangements.

The working party consisted of the following:

. A Director of Community Care & Medical Officer of Health,
. The Health Education Officer,
. An Inspector of Primary Schools, representative of the Department of Education.
. A Principal Teacher, Primary Schools.
. A Vice-Principal Teacher, Primary Schools.
. An Assistant Teacher, Primary Schools.
. A lecturer in a College of Education.
. A Director of a Teachers' Centre.

At the outset of its work, the working party gave particular consideration to the contents and design of the Primary School Curriculum.

4.4.Purpose and planning.

One of the fundamental aims of education, as outlined in the Primary School Curriculum, is that of equipping the child with the knowledge, skills and attitudes which will:

> "enable the child to live a full life as a child and to equip him to avail himself of further education so that he may go on to live a full and useful life as an adult in society." (4)

The Curriculum handbooks of the Primary School Curriculum, 1 and 2, comprise a series of fourteen chapters which offer guidelines to teachers on the structure, organisation and content of the curriculum in the following subject areas: Religion; Gaeilge; English; Mathematics; Art and Craft Activities; Social and Environmental Studies; History; Civics; Geography; Music; Physical Education. Recommendations for the teaching of Health Education are located in the Physical Education chapter of the curriculum manual. The working party gave careful consideration to the adequacy of the existing curriculum guidelines in assisting schools to teach Social and Health Education. As a result it was decided that it would be unrealistic to bring about change as if the present system/syllabus did not exist. The team acted on the advice given by Skilbeck that a "situational-analysis" be first conducted to clarify and identify the internal and external constraints within the school setting. (5)

4.5 An extensive survey of the views of management and teachers on the place of the Social and Health education in Primary Schools was conducted in January, 1985. The questionnaire sought the opinions of teachers on the proposed aim of the programme. The questions included:

> Was the aim
> realistic/appropriate for schools?
> too idealistic or ambitious for schools?
>
> Could the aim be achieved given
> the workload of the Curriculum?
> the skills of the teachers?
>
> How much social and health education took place in schools

OBJECTIVES:

Health Education seeks:

(a) To establish and maintain a desire for healthy living in the child;

(b) To cultivate a sense of responsibility for personal and community health;

(c) To develop a capacity for effective social interaction;

(d) To promote a sense of identity and positive self-esteem as well as an ability to cope with change in themselves and their environment;

(e) To help the children to become aware of the extent to which they have control over their health and to realise that, as past decisions have influenced their present health, so current decisions and choices will influence future health.

4.7 HOW THE PROJECT WORKS.

MATERIALS.

A writing team set about compiling a syllabus/scheme/project which would cater for the needs of all classes in the Primary school and be organised within four units:

Junior and Senior Infant classes;
First and Second classes;
Third and Fourth classes;
Fifth and Sixth classes.

Themes, objectives, educational activities and resources were to be developed in relation to the following six units which were to comprise the Social and Health Education programme:

Nutrition;
Hygiene;
Safety;
Personal Awareness;
Media Studies;
Environmental Care.

This planning phase was completed by the end of 1985 and the subsequent development of the programme was envisaged in three phases as follows:

Phase 2: Development Phase, 1985-1986.
Phase 3: Pilot Phase, 1986-87.
Phase 4: Implementation Phase, 1988-1989.

The programme, however, has not progressed as planned since a change in the level of detail was required. Initial outlines and drafts of programme materials were replaced by extensively researched themes and lists of educational activities. The implementation stage is now targeted for late 1989.

4.8 The work targets set for the development phase of the programme's development were as follows:

(a) The working party examined, developed and, where necessary, adapted teaching aids and resources with a view to compiling a first draft of programme materials for dissemination in schools in the Board's catchment area. These materials related to each one of the six units which were to comprise the Social and Health Education Programme.

(b) The local Department of Education Inspectorate was consulted in relation to the choice of particular Primary Schools that might most effectively pilot any programme materials produced. Ten schools, representative of the range of Primary schools in the Board's area, (later to be increased to fourteen) were invited to participate in the piloting and assessment of various draft programmes over a three year period. Consultation between the Principal and Assistant teaching staff of these schools and the Health Education Officer took place and draft materials were distributed in April 1986, marking the beginning of the pilot phase of the programme.

(c) In light of teachers' responses to the questionnaire, the working party decided that an inter-disciplinary, cross curricular approach would be the most appropriate method of teaching Social and Health Education. It was also decided that specific guidelines for teachers should be provided in package form, comprising themes, objectives, educational activities, resources and children's workcards.

4.9. PILOTING.

Through a process of consultation between the working party and the staff of the fourteen participating schools, a continuous assessment of the first draft of materials has been undertaken by the Health Education Officer. Subsequently, a second draft of each programme unit (nutrition, hygiene, safety, environmental care, personal development and media education) has been compiled for each class level and approved by the Working Party.

Copies have been distributed to each of the 70 teachers of the 14 schools in question together with necessary resources. An evaluation of each programme unit is conducted on completion of its pilot phase in the schools and the effectiveness of materials and the extent to which they are pertinent to the primary schools in the Board's area are thereby assessed.

Such research indicates that there is widespread acceptance on the part of teachers, management and staff of the materials and the approach adopted by the Board to date. All criticisms, recommendations and adaptations suggested are given consideration by the working party when compiling the third and final draft of the materials. On-going liaison between the Health Education Officer for Primary schools together with annual in-service training provided for all

involved teachers ensures that a most effective implementation of the programme takes place.

4.10 Involvement of Health Professionals:

Materials in their first draft were forwarded to health professionals working with primary schools in each of the community care areas in August, 1986. The views of Doctors, Public Health Nurses, Dentists and Social Workers were sought. During the re-drafting of materials, the Health Education Officer consulted with representatives of the Community Care team and their expertise in certain areas has been called upon in the compilation of programme activities and in the provision of in-service education for the teachers concerned.

4.11 PARENTAL INVOLVEMENT:

A detailed enquiry in the form of a survey of parental attitudes to Social and Health Education in the primary school was conducted by the Health Education Officer in October, 1986.
The response to the survey indicated a very high level of interest in and support for all aspects of the existing programme materials. Parents also expressed an interest in the use schools made of them, together with the means by which they would be informed of and involved in their implementation.
The Board strongly recommends to the Principal and Assistant Teachers of the pilot schools the following matters relating to school policy:

(a) Each school, in developing and implementing its own policy on Social and Health Education, should give careful consideration to and have regard for the primary role of parents as educators of their children.

(b) Parents should be consulted at regular intervals on the content of the programme and on the progress made by teachers in the teaching of it.

(c) Parents should be encouraged to participate in and support the work of the school in this area.

The results of a survey to ascertain adult levels of approval,conducted by the Health Education Association (Great Britain) in connection with the Primary Schools project, for the inclusion in the curriculum of 43 listed health-education topics, show that the high levels of approval for the majority of the topics are a very strong affirmation of the belief by all three adult groups (Parents, Teachers, Health Care Representatives) that health education in its widest sense has a vital place in young peoples' school experience. (6)

4.12 Methodology:

Health education attempts to promote the skills and competencies required for healthy living. In the past, school

curricula, among them programmes of "Health and Hygiene" of the early 20th Century, have been organised in terms of content and information, and the child has been the passive recipient of such knowledge deemed appropriate by adults. In more recent times, this focus is broadening to encourage pupils to develop the skills, concepts and attitudes relating to their health and well-being under teacher guidance so that, in the long-term, they will make better and healthier choices. Based on this belief, and in line with the general methodology of the present Primary School Curriculum, the approach adopted has been child-centred;

in which planned experiences, relevant to the child's interest, readiness and stage of development are provided for the child,
in which the child is the active participant in the discovery of relevant health related messages,
in which ample opportunity is provided for the reinforcement and extension of the skills and concepts at opportune times during the schooling of the child and through home-school links.

Thus, different teaching strategies are applied to different learning situations and the teaching methods go beyond traditional, instructional and didactic means of presenting the material.

4.13 Training.

The experience of the working party and the Health Education Officer has been that comprehensive and on-going pre-service and in-service training courses for teachers in the area of Social and Health Education are pre-requisites to the effective implementation of the programme in schools. During such courses, the provision of background knowledge and imparting of skills can take place; assistance in encouraging and maintaining home-school links is offered; the formulation by each school of its own policy with regard to Social and Health education can be aided; resource materials can be reviewed; teachers can have first hand experience of organising schemes of work using the most effective inter-disciplinary, cross-curricular approaches.

Indeed, such in-service education is vital if teachers are to be made aware of the wide scope of the programme and appreciate the abundance of themes and activities designed for each class. The success of the programme at ground level depends on the careful selection by individual teachers of the ideas and approaches most appropriate to the children they teach. As pointed out by Holt (1983), the challenge of devising an appropriate curriculum is one thing but it is:

"quite another to put it into practice and keep it going."(7)

4.14.STRUCTURE.

In September, 1987, a Steering Committee and a Representative Consultative Committee were established to assist in the development and implementation of the Primary School Programme, representative of:-

Steering Committee:
Health Board.
Department of Health.
Department of Education.

Consultative Committee:
Health Board.
Department of Education.
Department of Health.
The Churches.
Irish National Teachers' Organisation.
Primary School Management Associations.
Parent Bodies.
Principal and Assistant Teachers.
The Working Party.
Limerick Teachers' Centre.
Curriculum Development Unit, Mary Immaculate College of Education.

The Steering Committee oversees developments in the programme, while the Consultative Committee monitors the developments of the project, represents the project to interested parties and makes recommendations on matters relating to the project.

4.15. DISSEMINATION OF THE PROJECT:

It is envisaged that programme materials will be available in published form for primary schools in the Board's catchment area in late 1989. To date, the implementation of the project has been addressed by the working party and Steering Committee. Based on the experiences of the writing team and the Health Education Officer in implementing programme materials, it is believed that in-service education is vital for all teachers who undertake the teaching of the area. Thus, the Board plans to make the published materials available only to those teachers who have successfully completed an introductory course.

Reference.

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3. Schools Council Health Education Project (5-13) Nelson, 1983.

4. Curaclam na Bunscoile, Lamhleabhar an Oide, Cuid 1, An Roinn Oideachais, Baile Atha Cliath, (1971).

5. M. Skilbeck, "School-based Curriculum Development", Harper and Row, London, (1976), p. 15.

6. Wetton, N., Moon, A., "Health Education in Primary Schools", Health Education in Schools London, Harper & Row, (1987).

7. Holt M., Curriculum Workshop: an introduction to whole curriculum planning, London, Routledge and Kegan Paul, 1983. p.1.

CHAPTER 5.

SOCIAL & HEALTH EDUCATION AT POST-PRIMARY LEVEL.

5.1 INTRODUCTION

Following on the meetings between the Board and Primary and Secondary School Principals in April 1984, the Board arranged that 12 teachers, nominated by the Secondary School Principals, would participate in the training programme of the Cork Social & Health Education project, as the basis of developing a programme in this area. This initiative was taken by the Limerick Principals' Association and the Schools involved, together with the Health Board and with the co-operation of the Health Education Bureau. Up to this time, the Board was also co-operating with the Tipperary (N.R.) V.E.C. in developing materials for use in Junior Cycle Health Education Classes. The new move was in response to the needs of schools in relation to the senior cycle. Further, the emphasis now is on training of teachers in the methods and range of options available in Social and Health Education.

5.2 PURPOSE:

The second level project endeavours to assist in the promotion of the healthy growth and development of the individual into mature responsibility. It seeks to do this within the context of his/her environment, respecting and cherishing the values of home, school, Church and society within which the individual functions.

The project recognizes that education for responsible behaviour begins in the home. It acknowledges the primary position of the parents as educators and seeks to co-operate with the schools, churches and community in general. It is the aim of the project to build on this foundation by helping the schools to better support and strengthen young people as they grow to an understanding and acceptance of each other and to take more responsibility for the way they live their lives.

In seeking to promote the healthy growth and development of the individual, the project views health in terms of living life more fully, productively, abundantly and not just in the sense of an absence of illness. It aims at being a formal education of the self, recognizing that such concepts of growth and health are complex and composed of many aspects. It helps young people to be more aware and respecting of themselves and others and to be prepared to live life more fully and responsibly.

Adolescence is a difficult time, at the best of times. In contemporary society, with its rapid changes, breakdown of traditional consensus on values, the sense of a lack of permanence, conflicts between individuals, peoples and religions, the threat of nuclear war, the reality of unemployment, the pressures of examinations, the need to succeed in a society where people are valued in relation to their material success, it is even more difficult for young people to cope.

> "It is in the adolescent years that the shift must begin to occur from control by others to self-control, from living by the values of others to making one's own basic options and value decisions" (1)

In seeking to help adolescents, the project has two main elements,

(a) personal growth and development and
(b) primary prevention,

each complementary to and interlinked with the other.

The element of personal development concerns itself with the individual and his or her view of him/herself and of the world. It endeavours to help the student to get a better understanding of, and to encourage positive attitudes towards, him/herself. It does so on the understanding that developing a sense of self-worth in young people is the basis for self-respect and personal responsibility, as well as respect for others. Likewise, a person who respects himself/herself is more likely to make health promoting choices and resist peer, social and media pressure, than one who has little respect for himself/herself.

The element of primary prevention seeks to develop the health promoting skills and competencies which young people need so as to grow into mature adults and to live their lives in a healthy and respectful way, avoiding physical and mental ill-health. Such skills and competencies include effective communication, decision-making skills, managing conflict and coping constructively with feelings.

5.3 AIMS AND OBJECTIVES:

Aim of the programme:
To assist young people to grow in their ability to cope responsibly with the difficult choices confronting them and to take more responsibility for how they live their lives.

Objectives:

1. To develop young peoples' sense of self-esteem and self-confidence, so as to help them value the different aspects of themselves.
2. To develop skills in relating to other people so that their relationships are respectful of the needs of all concerned.
3. To help young people to be aware of their feelings and to deal with the many pressures, especially peer-pressure, that arise in their lives.
4. To help young people make responsible decisions based on a critical examination of their own needs, attitudes, values and relevant information.
5. To help young people develop the skills of listening and communication.

5.4 HOW THE PROJECT WORKS:

The project works mainly with teachers, who will in turn work with young people in second-level schools. Normally, these young people will be in Senior Cycle, that is, post Intermediate and Group Certificate students, aged 15 to 18. It currently provides a training programme for the volunteer teachers and is beginning to develop materials for use in the classroom.

5.4.1 TRAINING.

The training programme is a long one and demands a large commitment from the teacher, both personally and professionally. The introduction programme consists of weekly sessions and residential workshops, totalling approximately 150 hours in all. It involves the teachers going through the same kind of group experience they will eventually be providing for young people. Therefore it involves personal growth and development, the acquisition of practical group-facilitation skills and skills in designing classroom material. This basic course will be followed by a series of optional refresher courses on topics and areas in which the project and teachers express interests or needs. The teacher's progress in the classroom is monitored by regular meetings with the staff of the project. This ensures ongoing support for each individual teacher, where problems, difficulties and materials can be shared and addressed and where it can be ensured that teachers are adhering to the principles and values underlying the programme.

The teachers are selected in co-operation with the principals of the school in which they teach and, on the Principals' recommendations, are invited to meet with the staff and others in the project to discuss and clarify the commitment demanded in becoming involved in the project. When this is concluded satisfactorily they are invited to participate. Currently, the project works with 15 schools and 60 teachers.

5.4.2 MATERIALS.

As indicated at the outset, the project is beginning to develop materials for use in the classroom, by adopting materials used in other programmes, by developing its own materials and by identifying other suitable resources. All of these will eventually go to make up the "handbook" of Social and Health Education. However, the handbook and its contents are seen only as a resource to be used at the discretion of the teacher and in the light of the teacher's interpretation of the needs and concerns of the young people with whom he or she is dealing. The objective is not to produce a common syllabus for use in all schools, but rather a manual of resources and support complemented by a teacher training programme which will allow each school to develop its own.

5.4.3.CONTENT AREAS.

The project does not have a programme of exercises for sequential transmission in the classroom. This means that the teachers, helped by the school health education policy, will

design a course or curriculum, suitable and pertinent to his or her own group, having discussed with the group their issues and concerns and with regard to the issues and concerns relating to social and health education in the context of the school/parental ethos. The long training should enable the teacher to respond with skill and sensitivity to the concerns of the people in the group.

The content areas which form the core of such school based designs are determined by the aims of the project, its experience to date and the expressed needs of teachers and students. It has been possible therefore, to decide on content areas which are fundamental in the provision of a relevant Social and Health Education programme.

The Content Areas are :

Self-Esteem;	**Self-Awareness;**	**Responsibility;**
Communication;	**Decision Making;**	**Healthy Lifestyles;**
Drugs;	**Stress;**	**Exercise;**
Nutrition;	**Relaxation;**	**Relationships;**
Peer Pressure;	**Assertiveness.**	

5.4.4 METHOD:

Even in subject areas where the goal is simply the transmission of a body of knowledge, straightforward information giving or lecturing is not the only, or, on its own, the most effective method of teaching. Experience of practical education makes teachers

> "only too well aware that human beings are not simple rational beings who will change their behaviour when presented with the facts." (2)

The imparting of information can be fruitfully combined with various discussion methods which involve the learner more. Such methods, sometimes referred to as "informal teaching methods" are based on the quality of the relationship between pupil and teacher,

> "being the result of a reduced emphasis on hierarchical authority plus a desire to make the learning process a genuinely shared experience".(3)

> "These methods actively seek to tap the knowledge and experience of individual pupils, and then to encourage a training of those insights." (4)

This is even more true in the area of health education where the goal is not merely the transmission of knowledge but helping students to take more responsibility for their lives and health. The information component needs to be pertinent and up-to-date, but even more important is that it be included in what may be called an experiential learning programme. This involves teachers creating opportunities for participants to grow in self-awareness by reflecting on various aspects of their own experience - their feelings, choices, actions, judgements, decisions - usually in a group setting to allow them opportunities to learn from others. The key elements are discovery learning and group discussion. The person is involved in his or her own learning and is an active participant and not a passive recipient of information.
A fundamental aspect of group work is respect for the participant and their position in relation to the issues being considered. This respect can be shown by a supportive, sensitive and accepting attitude on the part of group members, allowing participants to develop and change at their own pace or not change at all if so desired.

Guided and enabled by a skilful and sensitive tutor, this way of working promotes greater knowledge and respect for oneself and others and the ability to make decisions on matters affecting personal behaviour.

Social and health education is not and cannot be a total approach to personal development and primary prevention. It is limited in terms of personnel, material and timetable usually having just one period a week. It can, however, assist in that development by making a contribution which complements and strengthens the work of other educators.

5.5 Structure:

During its earlier years, the project was administered by an ad hoc group of Health Board personnel including some of the group trained under the Cork Project mentioned above. Arising from the Report on Health Education in Second-level schools (November, 1987) (5) (See appendix 1 for recommendations), the structure of the Project is now as follows:

MID-WESTERN HEALTH BOARD

↓

SOCIAL & HEALTH EDUCATION PROJECT COMMITTEE
REPRESENTATIVE OF:
- Health Board
- Department of Education
- Parents
- Churches
- Principals
- Teachers

↓

STAFF (HEALTH EDUCATION UNIT) & VOLUNTEER TUTORS

↓

TEACHER TRAINING PROGRAMMES

↓

SCHOOLS

5.6 THE "LEARNING FOR LIFE "PROGRAMME.

In the late 1970's, Tipperary (N.R.) V.E.C. introduced a pilot programme of Pastoral Care into its schools.

> "to ensure that our schools concentrate on the overall development of the individual student" (6)

This programme, called "Education for living-Pastoral Care Programme", developed over the years into a major resource spanning the initial 3 years of post-primary education in the area of health education. It was published in September 1986 under the title "Learning for Life", (7) and comprised 3 student workbooks (one per year) and a teacher's manual.

The Board became involved in the programme in the early 1980's along with the Health Education Bureau. The Board provided part-funding for the project and was represented on the various committees together with the V.E.C. and the Health Education Bureau.

The funding arrangement ceased with the publication of the resource materials. The project has gone on to begin developing materials for senior cycle students. The materials produced are used in many of the schools in the Board's area, and indeed in many parts of the country.

Reference

1. Dorr, F., Health Education: Responsibility and Objective Values. Cork Social and Health Education Project. (1988)

2. Thompson, I., "Personal Rights and Public Policy" - Seminar Paper (1984).

3. Rice, B., "Informal Methods in Social and Health Education, TACADE (1981), Manchester.

4. Ibid.

5. Report on Health Education in Second level Schools, Mid-Western Health Board (1987).

6. Policy Document, Co. Tipperary (N.R.) V.E.C., Nenagh (1979), "Post -Primary Education 1985 - 2000 and its relevance to the Economy".

7. Moore, E., "Learning for Life", A Health Education/Education for Life Project (1986), Gill and McMillan, Dublin.

CHAPTER 6.

Focus on the Future.

6.1 The World Health Organisation "Targets for Health for all" (1) has placed special emphasis on:

- Primary Health Care as the most important single element in the re-orientation of the health care system which require very strong support.
- encouragement of a new climate conducive to health.
- encouragement of individuals preserving their own health.

The Health Board sees the development and continuing maintenance of the Social and Health Education projects in schools as part if its contribution to achieving these targets. The long-term aim with regard to these projects is to establish them firmly as part of the permanent educational provision in the Mid-West. Immediate objectives focus on specific aspects of the development and realisation of the courses concerned.

Specific Objectives

6.2 The provision of resource material.

A major concern of the projects will be the provision of relevant material for use by the teacher in the classroom. This primarily means written material and also includes audio-visual and other teaching aids. Such provision means researching suitable sources and designing specific class sessions on the topics involved in each programme. It is important here to repeat that the emphasis in these courses is on the provision of a range of materials from which a selection is made by individual teachers on the basis of what is deemed to be appropriate for their classes.

Further, this material needs on-going monitoring to ensure its suitability and updating in order to maintain its relevance.

The effective use of the classroom materials produced by the Unit are currently in draft form. The use of these materials and the various strategies implicit in their use form part of the basic introductory training programmes. Experience indicates that this training is necessary. When the resource materials for each project are finalised in late 1989, they will only be made available for use to those teachers who have completed the basic introductory training programme, that is, their dissemination will be linked with training. The materials will, of course, be available to various legitimately interested bodies for examination on request.

6.3. To provide an appropriate level of in-service training.

As indicated in chapter 3, in-service education for teachers in health education projects is a pre-requisite for the implementation of the projects. This will continue to be a central need particularly in the context of:

(a) Introductory training,
(b) In-service support.

By introductory training is meant the courses which introduce the teachers to the concepts, contents and strategies of health education. These courses have an established position in both primary and secondary projects. As the projects develop, new schools and more teachers will become involved.

Therefore, the need to provide introductory education programmes will be a constant feature of the projects and the courses themselves will need to adapt to the changing demands of the children and the schools. It is germane to point out that the need for such training would be gradually diminished if adequate and relevant pre-service courses on Social and Health Education were provided for all trainee teachers at the undergraduate level. Consequently, more money and time must be made available for the development of new resources and the updating of old materials. By in-service support is meant those courses offered to teachers who have completed the introductory course and are involved with the projects in the classroom. In terms of refreshing teachers' skills and abilities, updating their information and developing a support network, it will be necessary to provide short courses, seminars, workshops etc. to those involved, on a continuous basis.

The need for the second level Health Education programme is now accepted and teachers and schools are demanding it. Principals acknowledge its importance. Pupils and parents are reacting positively to it and there is a growing acceptance by the Departments of Health and Education of the important contribution it has to make. There is no doubt that it meets a very obvious need in the educational system.

It is opportune therefore to remind ourselves that there is very little provision for Health Education in any of the undergraduate courses for teachers in third level training colleges in this country and, such provision as there is, is at the discretion of highly motivated and interested individuals. We believe that it is time that serious consideration was given to the provision of formal pre-service Health Education to all aspiring teachers.

6.4 To provide Social and Health Education Programmes for the entire school life of children in the Mid-West Region.

Currently our projects cover the primary school life of children and the senior cycle at second level. Various options are being examined to provide a similar programme at the Junior cycle of second level, and some materials have been piloted.

It is intended in the near future that the work being done in the primary school in this area will be linked with that of the second level, thus ensuring that each child will have the opportunity of acquiring the skills and competencies required for healthy living at each stage of his or her development.

6.5 To provide support for parents in the work of raising children.

As the projects developed, it became clear that parents see a great deal of value in this work with children and often feel unable to support the work outside of school because they lack the information or skills/competencies to do so. To date, we have attempted to meet this need through the provision of courses and lectures on topics of concern. For the future, the projects will:

(a) encourage schools to involve parents in the Social and Health Education projects in the school.

(b) provide a Social and Health Education type course for parents themselves.

(c) assist teachers to respond to other needs expressed by the parents.

The importance of health education for parents is further highlighted in the report "Cherished Equally - Educational and Behavioural Adjustment of Children" (2) which recommends, inter alia, the development of support networks and courses for parents in parenting skills and an understanding of the educational and emotional needs of their children. The Social and Health Education projects will continue to provide all the support they have available to the development of such networks and courses.

6.6 To assist schools create an environment conducive to healthy living.

In an environment which extols the work ethic, the unemployed person cannot be truly healthy; in an environment which undervalues the role of women in society, women cannot feel truly healthy. Similarly, in a school environment which does not support healthy living through the practical organisation of its elements, it is unlikely that anyone can be truly healthy.

In terms of the school environment, the concerns are hygiene, nutrition, safety and the relationship between staff and pupils and the hidden curriculum. It is the intention of the projects to continue to assist schools to develop policies which will ensure that the school environment will be one in which healthy choices will be more easily made choices and will exhibit a health conscious philosophy.

References.

1. World Health Organisation Targets for Health for all Denmark (1984).

2. J. O'Connor, H. Ruddle and M. O'Gallagher "Cherished Equally? Educational and Behavioural Adjustment of Children", a study of Primary Schools in the Mid-West region. Treaty Press, Limerick, (1989).

CHAPTER 7

THE FUTURE OF SOCIAL AND HEALTH EDUCATION WITHIN THE HEALTH BOARD:

7.1 This Health Board has clearly indicated its commitment to school health education through the initiation, development and maintenance of the programmes detailed earlier in this document. School health education is seen as an intrinsic part of the overall health promotion activity of the Board and the Board's investment in health education is an investment in the future health and well-being of the community. It is proposed as part of a Health Promotion Unit within the Board:

1. To co-ordinate regional development and implementation of projects in Health Education/Promotion.

2. To propose policy with regard to Health Education/Promotion for the consideration of the Board.

3. To decide on priorities with regard to specific projects.

4. To initiate research into areas of need and development of educational strategies.

5. To evaluate projects and strategies carried out in the region.

6. To develop a centralised resource centre with appropriate localised resource centres.

7. To allow for the professional development of the Board's personnel in the area of Health Education/Promotion.

8. To liaise with outside bodies on behalf of the Board in matters relating to Health Education/Promotion and to maintain an up-to-date knowledge of developments in Health Education outside of the Board's area of responsibility.

9. To provide a contact person to act on behalf of the Board in all matters relating to Health Education/Promotion.

7.2 The organisation of the Health Education Unit would be overseen by a Health Education Standing Committee. This would be appropriately representative of persons involved in the area of Health Promotion and Education.

The main functions of the Committee would be as follows:

1. To administer all aspects of Health Education/Promotion in the Mid-West Region.
2. To provide a forum for discussion of local area needs within the context of the region as a whole.
3. To monitor and assist in the co-ordination of regional projects.
4. To ensure that Health Education in the region is properly resourced, including the preparation of budgets for health education.
5. To indicate areas of research and assist in the development of projects consequent on such research.
6. To report and advise the Chief Executive Officer and the

Board on all aspects of Health Education/Promotion in the region.

7.3 Staff:

It is proposed that the Health Education Unit would be staffed to a level sufficient to discharge the present and developing workload.

7.4 THE FUTURE OF SOCIAL AND HEALTH EDUCATION IN SCHOOLS:

In view of the continuing economic strictures on schools, it is unlikely in the near future that educational provision will expand in terms of the necessary resources required. Generally speaking, at such times, given the academic bias in most schools and the requirements of the third-level sector which now dominate the second level curriculum and are also having an increasing influence on the primary school curriculum, those subjects that are not directly related to third-level placements or employment are those which are first sacrificed. Therefore, the position of Social and Health Education in the curriculum of many schools can be a tenuous one. However, the realities of society in which the children are growing are also unlikely to radically alter for the better in the near future, thus indicating the continuing need for supporting young people in adopting healthy lifestyles. A time of adversity can also be a time of opportunity, a time when one's commitment to a certain course of action can be tested and not found wanting. It is the belief of the Board that it is now even more important that Social and Health Education courses be provided for young people.

7.5 The Department of Education has supported the programmes by seconding two teachers to co-ordinate them, through official representation on the various committees concerned and through supporting the work of teachers in this region's schools. It is also involved in other aspects of school health education through the Curriculum Review Bodies. To date, however, the brunt of the financial and other support for these projects has been borne by the Board. In the forward planning of the Curriculum Examination Board, as published in: "Issues and structures in Education, a consultative document", (1984), (1) (See Appendix 3), Social and Health Education was seen as a core subject at Junior Cycle to be provided for all students in secondary schools. Provision was also made for similar courses at senior cycle. In its interim report, the Curriculum and Examinations Board recommended that the senior cycle curriculum should distinguish, inter alia,

> "the centrality of the personal and social development of each individual student...
>
> while at the suggested junior level, health education is a core element of the category entitled "Science and the New Technologies"".

With the change of emphasis and structure of this group in recent times into focusing on the junior cycle, there is a danger that this area would be neglected in the short term. It is therefore all the more important that the Health Board should continue to develop resources in the area of Social and Health Education. As outlined in a submission made to the Review Body of the Primary School Curriculum, closer links with the Department of Education in the developments of these projects would be welcomed. Not alone would this partnership give such projects a sounder footing and greater impetus, it would also serve to further legitimise such initiatives on the part of the Health Board in the eyes of Principals, teachers, parents and pupils. Further, such action by the Department of Education would formally acknowledge the importance of Social and Health Education programmes in the schools' curricula and the pioneering work of the Board in this field.

Such a liaison is advocated in a study of the educational and behavioural adjustment of children commissioned by the Mid-Western Health Board in 1988 (2). In this study it recommended that, in catering for the needs of pupils,:

> "a holistic, inter-disciplinary approach (be adopted) so that the child's problems are not dealt with in isolation but are assessed in the context of family, social and school circumstances where overlap and interconnections between different problems are recognised and taken into account."

7.6 The Board's initiatives at Primary and Post-Primary levels should be developed on a planned, incremental basis until such time as a "critical mass" of teachers and pupils are availing of Social and Health Education programmes as part of the recognized, formal educational process. The successful achievement of this target will depend on the early introduction at undergraduate teacher training level of Social and Health Education as a core training module. The parallel introduction into the school curricula of Social and Health Education together with inservice training of older teachers is also necessary. The Board has responded to the perceived and proven need for Social and Health Education programmes. The educational system must now take on stream the future response to these needs with the Health services in active support of their implementation.

Reference

1. Curriculum and Examinations Board, "Issues and structures in Education", A consultative document, (1984)

2. J. O'Connor, H. Ruddle and M. O'Gallagher "Cherished Equally? Educational and Behaviourial Adjustment of Children", a study of Primary Schools in the Mid-West region. Treaty Press, Limerick (1989).

APPENDIX 1.

RECOMMENDATIONS AND GUIDELINES - FROM REPORT ON HEALTH EDUCATION IN SECOND LEVEL SCHOOLS, NOVEMBER, 1987.

1. Objectives of Health Education:

   1.1 The provision of coping skills to face life situations.

   1.2 The responsible development of those areas which directly contribute to the students' health and well-being, and which otherwise would not be addressed in other subject areas.

   The focus therefore is on the acquisition of skills and skills training. Where individual students indicate serious personal difficulties, the role of the health educator is personal support and problem identification with a view to referral to the appropriate professional service. The training enables the teacher to use groups appropriately and avoid using individual private difficulties as material.

2. Content and legitimacy of a Health Education Programme:
   2.1 The role of the health educator must be one of respect and support for the religious, moral and cultural values of the home.

   2.2 Ongoing consultation with allied disciplines must be a feature of a health education programme as its scope from time to time will encroach on other, more established disciplines.

3. Formulation of a Health Education Programme within a school:

   3.1 Each school must be responsible for its own health education programme.

   3.2 Each school would be expected to annually co-ordinate such a programme for the school. This would involve the Principal, Vice-Principal, Parents Representatives, Health Educators, Religious Educators and Career Guidance Counsellors.

   3.3 The course outline is to be fully explained and made available to parents of the classes concerned. The materials to be used and the methodology applied is to be reviewed annually by this school based group.

   3.4 The accountability of Health Educators to the school and parents is the source of legitimacy for the health educator and his/her activities.

4. Methodology of Health Education:

   4.1 Man in isolation cannot come to the truth; he needs guidance. The mechanism to be used in health education should be through informed group discussion, guiding students to a living acceptance of and positive participation in the Christian truths.

4.2 Traditionally, schools concentrated on a primarily didactic approach. The Committee sees the experiential approach as one which has much to recommend it as it allows for a mix of didactic and other educational approaches with the guidance of a trained and skilled health education teacher.

4.3 While therapeutic techniques have a role in training of health educators, the Committee considers that they are not appropriate for the classroom.

4.4 Values clarification should be a form of reflection on the values taught, not temporary values. In this way, young people are more likely to accept what they are taught, through the process of active discussion, rather than passive reception of information. The radical values clarification approach is unacceptable.

4.5 At all levels of health education the Committee recommends that there should be a policy of openness and dialogue.

5. Overall Administration of Health Education Programme:

5.1 The Health Board employs a Health Education Officer to service and stimulate health education programmes in post-primary schools.

5.2 The programme should be administered by the Health Education Officer who would be accountable for programme operation at post-primary levels to a committee known as the Social and Health Education Committee, representative of:

1. Health Board
2. Educational
3. Parents, and
4. Church Authorities

5.3 The Social and Health Education Committee, as part of its function, will be responsible for the development of the programme generally and specifically for:

- writing of materials for use in classroom,
- selection of potential health educators,
- training programme for health educators,
- research into health education,
- conducting of surveys and evaluation,
- development of a support network,
- ongoing in-service training,
- other activities deemed appropriate by the Health Board.

5.4 The Health Education Officer will make periodic reports, as required, to the Social and Health Education Committee.

APPENDIX 2.

Themes of the Primary School Social and Health Education Programme.

Unit 1 - Nutrition.

Food promotes growth
Food gives energy
Kinds of food and drink
Variety in form and price of food
The food groups
Our main meals
Special or festive meals
The function and use of utensils
Manners, hygiene and posture at mealtimes
Choosing what we eat
Food and the media
Vitamins
Iron
Water
The digestion of food
The lifetime of a food
Eating throughout history
References to food in the Bible.

Unit 2 - Hygiene.

Caring for hands and feet
Taking care of our skin
Hair care
Caring for our eyes
Caring for our ears
Caring for the nose
Care of the mouth and teeth
Germs, bacteria, viruses and the body's defences

Unit 3 - Safety.

Safety in the home
Safety in the school
Play accidents
Keeping safe outside
Safe people and strangers
Dangerous materials and substances
Care at play
Plant safety
Bicycle safety
Being responsible for personal safety and that of others
Road safety - the Country Code/the Safe Cross Code/rules of the road/road signs
Knowing about electricity
Knowing about alcohol
Knowing about drugs
Knowing about smoking
Water Safety
Fire danger

Unit 4 - Media Education.

Messages and how we receive them:
- What are messages?
- Missing messages?
- How do we give messages to other people?
- Wordless messages
- Conflicting messages

The Printed Message
- Books
- Newspapers
- Comics
- Magazines
- Signs and Symbols

Video
Fact and Fiction
Pictures
Radio
Reporting
Television
- News programmes
- Advertisements
- Special effects
- Alternatives to television

Unit 5 - Self-Awareness

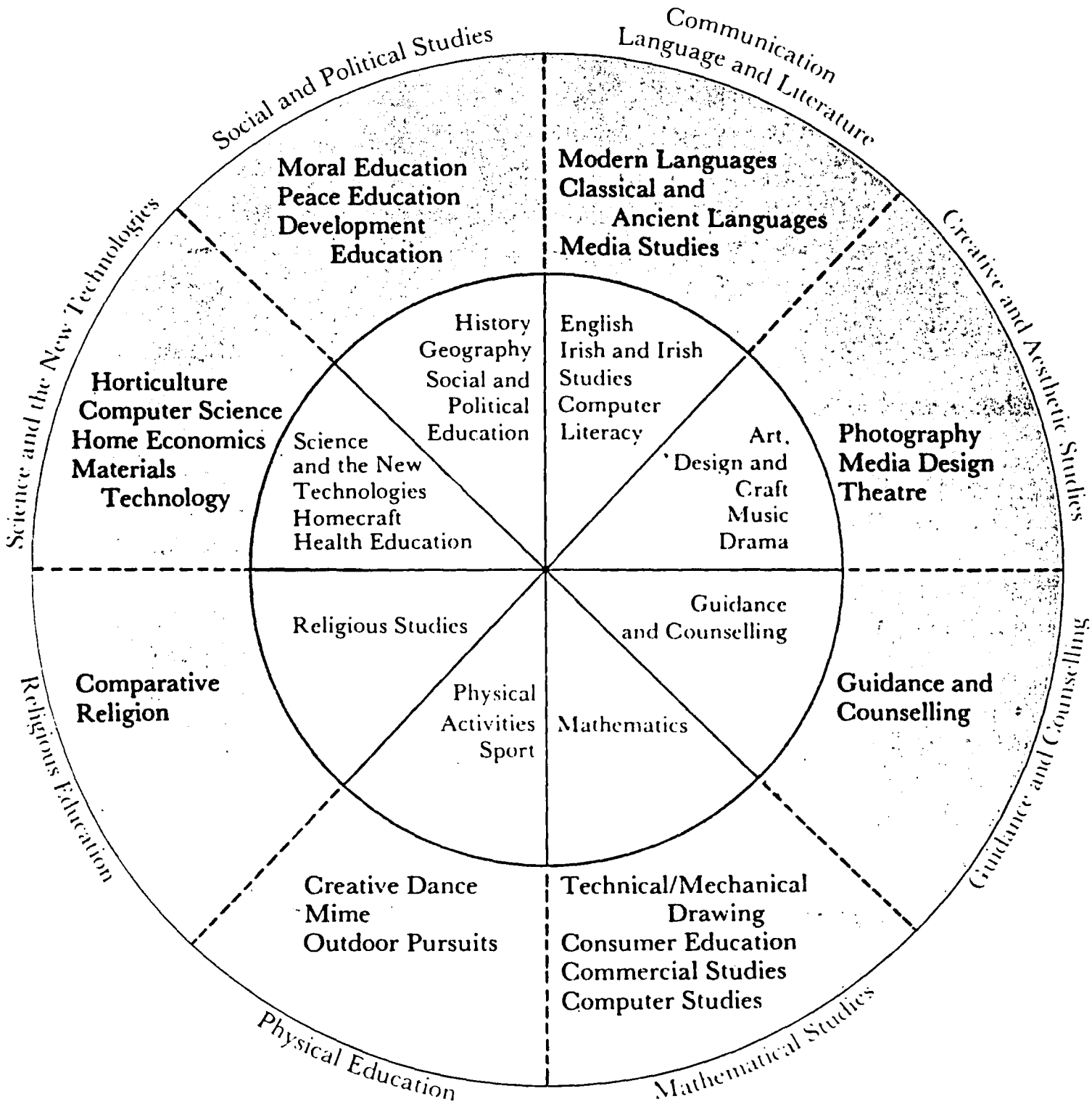
Self-concept
Family relationships
Getting along with others
Feelings and expressing feelings
Physical Development
Beginnings
Individual Differences
Responsibility
Expressing negative feelings
Making choices
People who are different
Sense of Irish identity
Friendship
Respect for others
Assertiveness
Separation
Coping skills
Goal setting
Problem solving

Unit 6 - Environmental Care

Personal tidiness
Tidiness indoors
Tidiness outdoors
Respect for property
- personal property
- school property
- property of others

Litter awareness

APPENDIX 3: PROPOSED CURRICULAR FRAMEWORK FOR JUNIOR CYCLE.



'ISSUES AND STRUCTURES IN EDUCATION', A CONSULTATIVE DOCUMENT. CURRICULUM AND EXAMINATIONS BOARD, SEPTEMBER, 1984.

APPENDIX 4
EXPENDITURE ON SOCIAL AND HEALTH EDUCATION BY THE MID-WESTERN HEALTH BOARD

1984	£23,500
1985	£30,000
1986	£40,000
1987	£47,000
1988	£49,000
1989	£55,000 Est.
1990	£60,000 Est.