Health Education in Tasmanian Government Schools Today

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Abstract
Health Education was introduced into the Tasmanian curriculum in 1987. This review considered aspects of system and school policy, resource management, curriculum, and student learning outcomes with the aim of recommending changes to policy and practice where these were indicated. A review of current literature provided a theoretical background. Multiple data gathering techniques were employed to provide a holistic evaluation of health education, with a focus on the middle school years. These included questionnaires, document examination, focus group discussions and case studies. The data was processed and analysed using database and spreadsheet facilities, and NUD*IST.
This paper reports on aspects of the data collection and some findings of the project.

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Introduction

Health education became part of the Tasmanian curriculum in 1987. All government schools are expected to provide health education in each year of schooling from kindergarten to year 12.

Theoretical models of health education

There are three main models of health education (Hawthorne, Garrard & Dunt, 1993):
The knowledge/attitudes model assumes that if students are given the facts about, for example, drug abuse, their attitudes will change and they will be more likely to reject unhealthy behaviour. Programs based on this model appear to improve students' knowledge, but do not change

attitudes or behaviour.
The values/decision making model assumes that unhealthy behaviour arises from poor self-esteem and lack of decision-making skills. Programs based on this model appear to improve students' knowledge, but do not affect students' values or behaviour.
The social competency model assumes that students need to practise social skills to reject the pressures to behave in unhealthy ways. These programs are more successful at changing behaviour than the previous two, but do not improve student knowledge.
The basis of the current Tasmanian health education program is a combination of the first two models. Its main purpose is 'to empower students to make their own decisions' and acknowledges that students should have experiences which 'will contribute to their feelings of

being valued individuals'(Education Department Tasmania 1987, p. 14) in keeping with the values/decision-making model. The content of the program also has a strong knowledge component, in keeping with the knowledge/attitudes model.
Background to the review
Community interest in health education has always been high in Tasmania. Many different organisations, some voluntary, provide health education, both in and out of schools. This community interest prompted this review.
The review was the first large scale evaluation of health education in Tasmania. Its purpose was to report on the implementation and operation of health education programs in schools with the aim of recommending changes to policy and practice where changes were indicated. The review considered the following aspects of health education:
System and school policy
Resource management
Curriculum
Student learning outcomes
The review focussed on health education in the middle years of schooling for the following reasons:
Several studies concerning the health of young adolescents have identified areas of concern, including teenage pregnancy, extreme weight loss and poor levels of fitness (Cumming, 1994).
Patterns of behaviour laid down in adolescence affect adulthood (Cormack, 1991).
There is some evidence that intervention to educate adolescents in social and decision making skills is better aimed at year 8 than older students (Cooney, 1994).
Methodology
The review was conducted in two phases. A variety of strategies was used to collect the data. Each strategy, together with the specific aspects of health education addressed, is described separately.
Questionnaires
Health education coordinators
Health education coordinators in all government schools received a

questionnaire about the implementation of health education in their schools. The format was mainly multiple-choice, to minimise response time and to facilitate data processing. Three questions were open-ended to allow for comment. The questionnaire responses provided baseline data about school health education. A total of 190 completed questionnaires was received, 79% (190/242) of the total number possible.

Members of the general community

A background paper and questionnaire were prepared for community consultation. The format was mainly open-ended, with some ranking questions. A five-point Lickert scale was used to measure attitudes towards different aspects of the curriculum. A total of 275 questionnaires was returned.

All schools received an information package about the review, that included both questionnaires, before the school year started so that the teachers involved could deal with this before students arrived. The general community questionnaire was also sent to members of the public who responded to advertisements in Tasmanian daily papers.

Both questionnaires covered all aspects of health education addressed by the review. Preliminary results from these questionnaires were used to develop the next phase of the review that used qualitative methods of data collection.

Document Examination

A group of nine teachers experienced in health education - from all school sectors - examined plans and policies for health education supplied by various schools. Criteria for examination of the documents were developed by the group. The nine teachers were divided into groups of three. Each group addressed one aspect of health education from school policy, resource management and curriculum. Data was collected in the form of notes from each group. These were transcribed and referred to the groups for approval before analysis.

The purpose of the document examination was to obtain a fuller picture about schools' policy development and implementation than could be obtained from the questionnaire alone. It also allowed comparisons to be made between school and state health education policies and programs.

Focus Group Discussions

While questionnaires and document examination could provide useful information about the system, they did not allow for the expression of feelings, opinions and attitudes. Focus group discussions allowed different stakeholders to share their experience of health education. The purpose was to collect a range of views and experiences from students, teachers and parents about health education. Students taking part in the focus groups were in years 5 to 8.

A computer randomly selected a district high (K-10) school and a high (7-10) school from schools in each of the seven Tasmanian education districts. Two associated primary schools were chosen to form a cluster with the high school. In this way fourteen centres were established for

focus group discussions. In each centre, a process of random sampling based on student birthdays selected nine students whose parents were invited to take part. Nine other students in years 5 to 8 were similarly selected to take part in the discussions. Nine teachers were also randomly chosen from staff lists supplied by the schools. If at least one health education coordinator was not included then a coordinator was chosen to make a tenth group member.

In each centre, three focus group discussions were arranged, one each for students, parents and teachers. Support staff attached to the schools involved, mostly guidance officers, facilitated these discussions. The facilitators were provided with a detailed protocol and kit of materials. To improve consistency in the data collection each facilitator received one full day of training and a debriefing session.

The discussions involved a total of 122 teachers, 86 students and 51 parents. The data were collected on large sheets of paper and transcribed for analysis. The focus groups particularly addressed the health education curriculum, student learning outcomes and resource management.

Case Studies

Researchers carried out case studies in five schools. The schools chosen were a district high (K-10) school, a small rural primary school, a large urban primary school in a low socio-economic area, a large suburban high (7-10) school with a significant number of rural students and a small suburban high (7-10) school.

The purpose of the case studies was to place the data collected from other sources into the context of a school's day-to-day operations. The researchers involved developed a protocol to provide a uniform framework for data collection and reporting. The case studies were carried out during five days spent in the school over a period of approximately two weeks. Each researcher held semi-structured interviews with the principal and health education coordinator, teacher volunteers, students selected by the school and other personnel as available, including the school nurse. Each researcher also examined health education policies, curriculum frameworks and other relevant documents supplied by the school and observed classes in health education.

Post Year 10 Study

This study was carried out by consultant project officers. They gathered the perceptions of young people about their school health education experience through a combination of questionnaires,

discussion groups and interviews. The groups involved were:

102 students in years 11 and 12 at two Tasmanian senior secondary colleges;

a group of ten unemployed young people;

53 pre-service teachers at the University of Tasmania (Launceston campus) who were taking health education units as part of their B.Ed. degree.

Data analysis

Data from the health education coordinator and the general community questionnaires were entered into a data base. This information was analysed using database and spreadsheet facilities. Data from open ended questions, the focus group discussions, case studies and the document examination group were analysed using the qualitative data analysis program Q.S.R. NUD*IST (Qualitative Solutions and Research, 1992).

Results

This paper reports findings of the review that relate to the context of health education in schools and to aspects of health education relating to resource management, the curriculum and student learning outcomes.

Context of health education in schools

Problems facing young people

Focus group facilitators asked each group to identify the problems facing young people today. Some interesting differences emerged. Students identified violence and bullying as the major problem facing them. This violence and bullying occurred both at school and at home - between peers, between adults and children, and between older and younger or less capable children. It was clear from the discussion reports that students wanted to acquire strategies enabling them to cope in these situations.

On the other hand, parents, particularly, and teachers saw peer pressure as the main problem. Teachers also mentioned the pressures on their students caused by family separation or divorce. Other comments mentioned the problems created when children are unsupervised or left to their own devices for long periods.

Students, parents and teachers all commented about the wide availability of drugs. Every student discussion group brought up this subject in some context, often related to peer pressure: 'You'd seem a dork if you didn't [try drugs]'. All groups felt that drug education needed to be a central topic for health education.

Schools and their local communities

Other factors also impinged on health education in schools. By far the biggest issue for teachers was the divergence of school and community opinions on matters relating to health education. As a consequence, teachers clearly felt unsupported by all sectors of the community in these matters. The wide range of community values and opinions added to the pressures felt by teachers. Parents acknowledged this difficulty. Students, too, recognised the divergence between what they were taught in school and what they saw in the wider community. In keeping with their age and experience, they commented, for example, on their parents' smoking or unhealthy food in their school canteen.

This provides the context in which health education takes place in Tasmanian schools today.

Resources

Outside organisations involved in school health education

Questionnaire responses indicated that overall 87% (166/190) of all schools responding used outside organisations for some part of their health education program. This initiative was strongly supported by the

general community with 94% (258/275) of respondents supporting the use of outside organisations in school health education. The organisations used are shown in table 1.

Table 1: Organisations involved in school health education

Both Family Planning Tasmania and Centacare provide student sex education programs. Nearly 70% (118/174 or 68%) of K-10 sector schools are using these organisations as part of their health education program. The 'life education van' provides a drug education program for primary students, and is used by nearly one-third of Tasmanian government primary schools. The Drug Education Network works only with teachers, mainly on policy development, rather than with students. Since these areas (sex and drugs) are those which attract comment, schools may be looking to outside organisations to provide expertise in these areas.

The health education curriculum

Content

The present health education curriculum in Tasmania comprises seven areas: personal relationships, care of the body (including hygiene and sexually transmitted diseases such as HIV\AIDS), nutrition, leisure, use and abuse of drugs, safety and accidents and community health and health services. These broad areas cover a number of specific topics. Figure 1 compares health education coordinators' indications of what topics are taught in their schools with the percentage of the general community agreeing or strongly agreeing with the presence of these topics in the curriculum.

There is broad general agreement with schools tending to be conservative in what they teach. It is likely that this conservatism in topics such as alcohol and illegal drugs reflects the views of schools about the appropriateness of the topic for different groups of students.

The general community response indicated very high levels of agreement with the inclusion of all topics, even those which might be regarded as controversial such as sexuality, HIV\AIDS or drugs. Comments received, however, did indicate some qualification of this support. There was concern about teacher training in sensitive areas and many respondents linked this to the need for some areas of health education to be delivered by outside professionals, who would be regarded as impartial and objective.

Delivery of the curriculum

At a school level, the major issue that emerged was whether health education should be taught separately or integrated with other learning areas. The mode of delivery of health education reported by health education coordinators is summarised in table 2.

Table 2: Responses to question - Is health education treated as a separate subject or as part of integrated units across the curriculum?

In practice, from case study and focus group reports, in most schools

of all types it is both integrated with other learning areas, and taught as a separate subject, depending on the topic and year level, as recommended in the Tasmanian policy.

Delivery of the curriculum in an integrated way requires teachers to be more intentional about their teaching. Teachers in the focus groups recognised this need. Many teachers expressed frustration at not having sufficient time to plan appropriately.

Emphasis on health education when taught as part of integrated units

Nearly three-quarters (124/174, or 72%) of K-10 sector schools stated that health education was made explicit to students when it was integrated with other learning areas or delivered as part of an integrated unit. Students, however, did not always appear to be aware that health education was being taught. Those in the focus groups and case study schools equated certain outside groups, such as Family Planning Tasmania, with health education but had difficulty in recognising when they were experiencing classroom health education unless the areas of the health education curriculum were pointed out to them. The apparent lack of opportunities for students to make connections between their classroom experience and health education

runs counter to current theories of learning and teaching. There are implications here for further research.

Students were particularly critical of current programs. They commented on the repetition from year to year, on teachers' lack of recognition of prior learning and the superficial nature of much of the information. Teachers also saw a need for curriculum guidelines to avoid both repetition and gaps. A framework for this could be provided by the national Statement and Profile for Health and Physical Education which is not yet being widely used in Tasmanian schools.

Learning Outcomes

Questionnaire and discussion group responses indicated that knowledge about topics such as hygiene, alcohol and other drugs was the most important outcome of health education. Sometimes this was seen as leading to informed decision making, in accord with the knowledge/attitudes theory of health education.

Whether students realise it or not, they are acquiring a knowledge base about good health. They can talk, for example, about the dangers of smoking, the need to use sunscreen or the components of a healthy diet. Much of what they are learning is reinforced by community campaigns. Many students will say, however, that having this knowledge has not caused them to change their behaviour in the short term, in keeping with evaluations of the knowledge/attitudes model. Some older students stated that they did draw on information gained from health education when making decisions. It is difficult, however, to judge the effectiveness of school health education programs over the long term as so many other factors play a part.

When groups were asked what were the outcomes of health education in reality, teachers and parents often mentioned programs that allow students to develop and practise social skills over time, such as

student mediation. Four main themes emerged from focus groups' responses:
health education has led to an awareness of healthy and unhealthy behaviour and its consequences;
adults described students as being 'more open' about sensitive issues, and better at resolving differences;
teachers were overtly teaching decision-making, conflict resolution and, sometimes, stress management;
school health education plays a role in educating the community.
It is interesting that the perceived outcomes of health education are different from those apparently desired by the community, which were mainly knowledge based.

Discussion

Bremberg (1991) concluded that health education programs succeed
when they are structured within a community context of cooperation;
where specific behaviours are targeted for intervention;
where more than thirty hours a years is given to teaching a particular topic;
and where teaching includes the provision of quality materials and methodologies appropriate to the needs of the group.
Many of the findings of this review are in accord with this conclusion.

Curriculum matters

While the current curriculum was widely supported by schools and the community, students were critical of its structure and manner of delivery. They clearly wanted to be more involved in choosing the content and the way in which it is delivered. This desire of students is in accordance with constructivist approaches to teaching and learning, and with Bremberg's (1991) findings about health education. Implementation of student-oriented programs could also incorporate some aspects of the social competency model of health education.

Outcomes of health education

While the outcomes that people reported as desirable were in keeping with the knowledge/attitudes theoretical model, the actual outcomes reported accorded more with the social competency model. Programs which require students to develop and practice skills, such as peer support, were seen as a successful outcome of health education. This is in keeping with both Bremberg's (1991) findings and with some evaluations of social competency models of drug education, which suggested that programs based on this model reduce experimental smoking.

Responsibility for teaching sensitive issues

Teachers in the focus group discussions said that the best person to deal with sensitive issues is the class teacher, whom the student knows well and feels comfortable with. Responses to health education coordinators' questionnaires, however, indicated that nearly three-quarters of all primary schools used outside organisations for the sex education component of their health education program. In one case study school teachers talked about the importance of the class

teacher in health education but a relief teacher was asked to teach a health education lesson about relationships. These contradictions were not apparently noticed by teachers who were very sincere in their belief about the best person to teach health education.

Conclusion

The review of health education gathered a variety of data about the implementation of health education programs in Tasmanian government schools. Issues arising from the review for the Tasmanian system include the inadequacy of many school policies, the professional development of teachers and the determination of suitable learning outcomes for students.

There are matters which have wider implications.

The difference between adults and students of the perceptions of the problems facing young people could lead to further research into appropriate ways to deal with bullying and peer pressure.

The inconsistency between what teachers believe and what they do was an unexpected finding of the review, and one that warrants further study.

The inability of students to recognise classroom health education when it was integrated with other subjects also requires further research.

Constructivist theories indicate that students build on prior knowledge, but how explicit does the necessary scaffolding need to be?

Finally, teaching methodologies that emphasise the development of social skills and allow students to practise these should be developed. Action research methods may be effective here.

This review revealed wide acceptance of and support for health education today. The challenge now is to make it more effective tomorrow.

References

Bremberg, S. 1991, Does school health education affect the health of students? in D. Nutbeam, P. Farley, & P. Tillgren, Youth Health Promotion, Forbes Publications, London.

Cooney, S. 1994, Predictors of cognitive motivations for marijuana use amongst adolescents, Unpublished report for Bachelor of Arts with Graduate Diploma in Psychology, University of Tasmania, Hobart.

Cormack, P. 1991, The nature of adolescence, Junior Secondary Review, Education Department of South Australia, Adelaide.

Cumming, J. 1994, Catering for the needs of all young adolescents: Towards an integrated approach, Unicorn, Vol.20, No.2.

Education Department Tasmania 1987, Health education in Tasmanian schools and colleges - a curriculum framework, Department of Education and the Arts, Hobart.

Hawthorne, G., Garrard, J. & Dunt, D. 1993, Primary school drug education: An evaluation of Life Education Victoria - Summary Report, NCHPE, Melbourne.

Qualitative Solutions and Research, (1992), Non-numerical Unstructured Data * Indexing Searching and Theorizing (NUD*IST) v3.0.4, [Computer program], LaTrobe University, Melbourne.