HEALTH EDUCATION IN NEW ZEALAND SCHOOLS: POLICY AND IMPLEMENTATION

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ABSTRACT This study was concerned with the implementation of health curriculum in schools and the effect of policy upon the implementation of the health education syllabus. The objectives of the study were to find out if schools had written health education policy; to investigate the impact of policy development on health education; and to identify any potential barriers which might impede the successful implementation of school health education programmes within the curriculum.

INTRODUCTION

In *The New Zealand Curriculum Framework* (Ministry of Education, 1993) health has been combined with physical education. Health educators had worked hard over the last decade to establish health education as a subject or area of the curriculum in its own right, but it seems that current curriculum planners consider it advisable to combine the two subjects. Certainly health and physical education share some common content, but health education goes beyond the "physical" aspect and embraces the social, mental and spiritual aspects of personal development. At this stage it is hard to say what the focus of the new curriculum guidelines will be. The social pressures confronting young people today suggest that health education deserves a place in its own right within the curriculum. It can help young people to recognise and cope with these social pressures. It can also play a part in the hidden curriculum in schools where, during lessons, the teacher can uncover, or be confronted with, other issues such as physical, social, emotional and sexual abuse indicators. If health's separate identity is lost, many teachers may not get the necessary grounding to deal effectively with health issues. They may then avoid health topics, particularly if they do not feel competent to deal with some of these situations.

A new health and physical well-being syllabus will not be implemented before 1996/7. In the meantime, schools are required to use the 1985 health syllabus, which became mandatory in all schools in 1989. This paper is concerned with the 1985 syllabus and its implementation into the school curriculum.

It is suggested that if schools are to be effective in implementing positive health education programmes then these programmes should be supported by health education policy. Policies should not only make a positive statement about the school's commitment to health education but also identify the perceived needs of the children in relation to health, and set the goals by which these will be attained. Policies should also establish a mechanism for monitoring and evaluation. To reach agreement on policy, consultation should occur with teachers, parents, caregivers, and the wider school community. It is suggested that effective health policy is a protective measure against any conflicts which

might arise (Ames et al. 1992), as well as for the handling of controversial health issues with which the teacher or school may have occasion to deal.

In summary, concern about health education in the curriculum led to a study of health policies in schools, and this paper reports some of the findings. Although this study is based in New Zealand, many comparisons have been made with international research. In particular, European research has been used because of the similarities in curriculum design.

METHODOLOGY

The aim of the study was to find out if schools had a written health policy, to investigate the impact of policy and to identify barriers to implementation. The study was conducted in three phases and used three different methods of data collection.

Phase one was conducted by means of a descriptive survey questionnaire to forty-six schools in a regional city, to which twenty-nine responded inclusive of primary, intermediate and secondary schools. Interviews with health coordinators as informants were the basis of *phase two* involving three groups of three schools divided into high, medium and low socio-economic enrolment areas The study concluded with *phase three*, a tape recorded group discussion forum with the staff of one of the nine schools from the preceding phase.

Key Issues

The key findings of the study are presented under four major research questions:

1. Do schools have written health education policy?
2. How does the policy affect the implementation of health education programmes in the school?
3. What types of programmes are classroom teachers implementing?
4. What are the barriers to health education programmes in schools?

DO SCHOOLS HAVE WRITTEN HEALTH EDUCATION POLICY?

This was the key question of the research study. A similar study in 1993 by Her Majesty's Inspectors of Schools (HMI) examined the provision of health education in Scottish schools and argued that a policy *was* necessary:

> As in any other curriculum area a clear and relevant policy is essential for designing detailed programmes of study, guiding practice and providing a basis for evaluation (HM Inspectors, 1993, p.9).

Results

The results showed that most of the respondent schools had some form of health policy, but they were not policies which necessarily guided health education on their own, or which might have provided the guidelines for health education programmes. Only four schools had a comprehensive health education policy

which clearly stated the particular school's philosophy about health education, curriculum and learning outcomes, teaching methodologies, implementation procedures, resource requirements, and suggestions for teacher development. From 1989 in New Zealand, the Ministry of Education required that every school prepare policy documents for all areas of the curriculum. The Education Review Office (ERO) was required to audit schools tri-annually to ensure that policies were in place and fully implemented. Examination of the ERO report of each of the nine schools involved in the latter two phases of the research, showed that only a passing reference was made to health education.

Key Issues

Three key issues emerged in relation to the question about whether schools had a written health education policy. First, it was found that there was no consistency in the types of policy for each school. Second, it was found that policy had been written as a consequence of several influencing factors, and third, there was a tendency for schools to develop single health issue policies. Each will be briefly discussed.

Types of Policy

Schools had a variety of health policy documents. Some of these did relate in some way to general health matters in the school and some were written specifically to address the issue of health and safety in the school environment. Other schools combined a general health policy with a series of single issue policies, while one school had a single health and safety policy.

Primary and intermediate schools were more likely than secondary schools to have health education policies. This concurs with a 1993 Scottish study which found that all the schools with separate written policies for health education were primary schools (HM Inspectors, 1993, p.10). In contrast, an English study in 1992 (Jamison, 1993) found that secondary schools were more likely to have a comprehensive health policy document. Comments made in the Scottish study suggested that it was easier for primary school teachers to find the time to include health education in their classroom programme. This was also found to be true in this study. The primary classroom teacher is the adult with whom a child spends most of the school day. The classroom teacher has the responsibility of providing the daily programme and nurturing the children in their growth and development, both through the curriculum and through the teacher-children relationships. Because of the primary school structure and organisation in which a teacher has the responsibility for a single group of children, the environment is probably more conducive to the development of health education as an on-going programme than in secondary schools which are organised differently. In his study of European schools, Williams (1987) also found that the environment in primary schools is more receptive to health education than in secondary schools. Williams (p.127) refers to the stable relationship between the teacher and child, the flexibility of the curriculum, and the child-centred teaching and learning approaches as being ideal for health education. These aspects of primary schools

are currently being furthered in the context of the new curriculum framework in New Zealand.

For secondary schools it was found that the major challenge regarding policy is the status of the subject. In some schools teachers recognised examinations as being the hallmark of status and academic accountability. Because health education was not an examinable subject, it was recognised only as a peripheral subject when it came to curriculum priority, and this was a reason that health education policy was not being prioritised by the schools. Similarly, Williams (1987) and HM Inspectors (1993), in their respective studies, found that the priority given to examinations in secondary schools restricted the development of non-examinable subjects like health education. Williams (1987) found that non-examination of a subject led to lower status. Consequently, health education was more likely to be found only in the programmes of children who were identified as being slow learners.

This was not the case in these New Zealand schools. Increasingly, more of the secondary teachers were beginning to recognise that major societal health issues such as drugs and alcohol, infectious diseases and relationship education were becoming a very real concern for the schools, and that these would have to be addressed somewhere in the curriculum. Many of the health coordinators said that teachers were coming to realise the important contribution that health education could make, and as a consequence the idea of having policy to address these issues was making health education more viable in the secondary schools. Jamison (1993) found that where inservice training was provided to schools, as in drugs and alcohol programmes, policy development was likely to occur. Similarly, the 1993 study of Scottish schools found that the need for a healthy school ethos was beginning to be recognised in secondary schools, and this was raising the status of health education. This was evident in planning to include the development of activities which promoted healthy living, such as drug and alcohol avoidance.

Some of the schools with general health policies provided a simple statement and overview of what was expected in the school in terms of health education. The statements contained a rationale, purpose or objectives and a short list of guidelines. It could be expected that a more comprehensive implementation plan would accompany the statement, outlining how health education programmes were to be organised and monitored, taught, resourced, funded and evaluated. However, in most cases these details were omitted, so that for many teachers, health education programmes were lacking in direction and purpose. Similarly, Green (1994), in an English study to analyse policies for sex education, found that one in every four policies did not specify content.

In the present study most policies made only vague reference to what knowledge, skills, attitudes and values should be included. Very few policies gave any specific detail and fewer still had a full implementation plan. If management is to be effective, the aims and policies should be clearly articulated to the staff (Deans et al., 1987). In this present study, one of the problems that was identified was that management in a school had failed to convey the importance and direction of health education. One of the reasons for this may well lie with the reality that more often than not, the responsibility for health education had been given to a junior member of the staff, who, without the same authority of

those in senior positions, had been unable to promote the subject effectively and achieve implementation. This was more likely to have occurred in the primary rather than the intermediate or secondary schools. As a consequence, policy was more likely to have been written to fulfil Ministry of Education regulations, and implementation plans had not followed. Lewis (1993, p.168) aptly summarised this situation:

> The organisation of health education in the curriculum is in practice crucial to the status it will hold in school and the function it will be seen to fulfil. Organisation and management have long been the Achilles heel of health education and it is probably no coincidence that the subject prospers best in schools with active and dynamic teachers designated to coordinate and manage health education.

Major Influences on Policy

The major factors influencing policy development in the schools were: first, the requirements of the Ministry and the national curriculum; second, the regulations set down in the 1992 Health and Safety in Employment Act; and third, the national trends in health issues such as HIV/AIDS, drugs and alcohol, and child abuse statistics. Programmes such as *DARE* and *ALAC* (both drug and alcohol programmes), and *KOS* (child safety) had a requirement that schools develop and implement policy to support the programmes carried out with children. Jamison (1993), HM Inspectors (1993) and Devine (1992) all found that similar factors had influenced the writing of policy in schools.

Five years ago the major factor influencing policy direction may well have been the national curriculum directives alone. Currently, drugs, substance and alcohol abuse, HIV/AIDS, hepatitis, conflict management, bullying, child abuse, suicide and eating disorders such as anorexia and bulimia, are but a few of the major issues which schools are being asked to address by way of programmes.

One of the principles of the 1985 health syllabus was recognition of the value of a school's community and parents, and the richness that they might bring to the development of school programmes. Given this goal, it might be expected that schools would have consulted parents and the wider school community, so that their concerns might influence policy. It was found, however, that only a few schools mentioned that they were influenced in this way. In a comparable study carried out in Belgium, Geirnaert (1987) concluded that schools should cooperate with their parents. and gave two major reasons: first, informed parents would more than likely support what was taking place in the school, and second, it would give parents the chance to support their children through complementary activities in the home. In a Scottish study, Eales and Watson (1994, p.86) found that there was growing support for the "need to liaise with parents to ensure cooperation and support for and reinforcement of health education teaching".

In the present study, primary and intermediate schools were more likely to involve parents and community in health education programmes and initial policy consultations than the secondary schools. This was mainly due, as might be expected, to difficulty in attracting parents to the secondary schools for any

type of meeting. The Scottish study by HM Inspectors (1993), also found that "consultation on policy had not extended beyond involving staff".

One of the major concerns for schools to address is that when policy is written to conform with legislation, it does not necessarily result in accompanying programmes. In the present study many teachers were left to their own devices in terms of implementation. Because of this, there was potential for health education to become marginalised in the curriculum. In some schools, there was a comprehensive policy document to which staff and parents had contributed, a sense of ownership had developed and a more effective programme had resulted.

Single Issue Policy

Most of the schools in this study indicated that they had a general health education policy covering curriculum programmes and the health and safety of the school environment. They also had a series of single issue policies covering specific health topics such as smoking, keeping safe, sun safety and cycle helmet safety. These single issue polices may or may not have resulted in classroom teaching units. For example, some of the primary schools had policy on the issue of HIV/AIDS, which covered safety measures and attitudes towards enrolled children with HIV rather than actual teaching programmes.

The twenty-nine respondent schools in this study had 157 written single issue policies, probably indicating that there is a move in the direction of single issue rather than comprehensive health education policy. The trend appears to be similar in England, Scotland and Wales (Tones et al. 1990; HM Inspectors, 1993). It seems that single issue policies have arisen from legislation on health following concerns identified in the community. Initiatives in New Zealand over the past five years were largely motivated by the *New Zealand Health Charter* (1989), which outlined the goals for health by the year 2000. Since the Charter's release, health agencies have become pro-active in promoting health strategies and preventative programmes. These have encouraged schools to provide programmes in drug and alcohol misuse, intervention programmes for smoking, child nutrition, child safety and cycle/helmet safety. For most of these programmes, it is a requirement that prior to implementation schools should have policy to support them, and hence the high number of single issue policies.

Research has not yet been carried out to evaluate the effectiveness of all the resulting programmes, although Briggs (1991) did study the *Keeping Ourselves Safe (KOS)* programme in Taranaki primary schools. Findings indicated that if *KOS* was taught carefully and continuously throughout the first three years of schooling, and alongside the 1985 health syllabus, children acquired preventative skills and a variety of strategies to help keep themselves safe. Similar research was carried out in England on comparative types of primary school programmes. One such study examined the effects of *Jimmy on the road to super health*, a preventative programme for smoking. Deans et al. (1987) suggested that the programme was effective in preventing the uptake of smoking, but did little to discourage those who already smoked. Bartlett (in Tones et al. 1990, p.91), said of the same programme:

> They were successful in increasing knowledge, somewhat successful in improving attitudes and infrequently successful in facilitating lifestyle.

Similarly, research in England by the School Health Curriculum Project team (Murray, 1982) on another smoking programme, the *My Body* project, found that the programme had been more successful with sons and fathers than with daughters and mothers. Findings of this kind suggest that health educators should consider whether single issue policies should take the place of the health syllabus with its developmental approach to addressing the same issues and emphasis on skills and strategies necessary for behaviour change.

However, Tones et al. (1990) discussed the possibility that having a variety of policies could have positive results for the implementation of successful health education. They found that too many single issue policies may be detrimental to the way in which health education is perceived in some schools. Where some issues were prioritised by policy, they had become the health education programme rather than issues relevant to the health needs of the children.

HOW DOES POLICY AFFECT THE IMPLEMENTATION OF HEALTH EDUCATION PROGRAMMES IN THE SCHOOL?

In this study it was found that there was no consistency between schools in the way their policies have affected the implementation of programmes. Devine, in the 1992 study of Scottish schools, found a similar pattern and concluded that it was the different structures of primary and secondary schools that determined how health education was delivered. The schools in New Zealand are also structurally different. The primary school classroom teacher is the one person with whom children spend the entire day. This teacher is responsible for the nurturing of the children, as well as guiding their physical and mental development. As a consequence, it is much easier for the primary teacher to plan for a classroom programme in health education, either on a formal basis, or informally, should the need arise. The primary teacher's approach to planning is more flexible than that of the secondary teacher, who is limited to teaching within a department, and to different groups throughout any day.

Jamison (1993) also found that in English primary and special schools, health education was more likely to be incorporated into the classroom programme, whereas in 84 per cent of the secondary schools, health education took place in Personal and Social Education (PSE) or other subject areas. In this study, secondary schools were more likely to teach health education through the physical education department, although in some of the schools, social studies took responsibility for drug and alcohol programmes. Closely related to the New Zealand situation was that in secondary schools in New South Wales, where Williams et al. (1992) found that 68 per cent of secondary school health education was administered by the physical education department.

Implementation

Although policy may give direction to the guiding philosophy of health education in a school, ideally this should be complemented with an implementation plan

that describes the details of the content to be covered over a designated time period. Many schools in this study considered that implementation plans were unnecessary because health education was integrated across the curriculum. However, many schools had also reported that difficulties in monitoring had made it impossible to know what was happening in individual classrooms. Lewis (1993, p.168), in commenting about health education in England, said that the integrated system was abandoned "because it proved haphazard, fragmented and lacking any coherent planning progression". Fragmentation and a haphazard approach were fears expressed by some of the respondents in this present study. Delivery of a mixture of isolated units was already evident in some schools rather than a developing programme across the age groups. Lewis also reported that some schools were developing a modular approach to health education. This was also found in two of the schools in this study, although the trend may have been wider, because most schools did this when setting aside specified units of time in which to teach programmes such as *Drug and Alcohol Resistance Education (DARE)* and *KOS*. A problem with the modular unit approach is the isolation of the unit from the rest of the health syllabus. Children actually refer to these units as "we're doing the drug programme" rather than "we're doing the drug programme in health education".

WHAT TYPES OF PROGRAMMES ARE CLASSROOM TEACHERS IMPLEMENTING?

In most schools in the study, health education programmes were being increasingly influenced by the packaged learning materials produced by outside agencies, as was the case in Scotland (HM Inspectors 1993).

Over the last two or three years, schools have been inundated with resource packages purporting to enhance children's health. Some were eagerly received by teachers, who, lacking the skills for health teaching, found the packaged materials to be ideal substitutes. Others were using the materials to introduce new health education programmes. According to a small scale, unpublished local study (Johnson, 1993), there was also a small number of teachers who were unsure of the value of some of the programmes. This would suggest that teachers need to assess materials carefully to ensure that the health messages they give are consistent with the individual school's philosophy and beliefs, and the children's needs. One respondent in this study commented that she went through every new resource which came into the school to ensure the appropriateness to the children and school situation.

In some of the schools in the current study, packaged programmes had become the health education programme, rather than complementing and being built into the regular health education programme. That packaged programmes should be integrated into an already existing health education programme is supported by Downie et al. (1990). The most prevalent programmes being used by the schools were *KOS, DARE, ALAC (drugs and alcohol), Life Education, Skills for Adolescence, Reaching Out, Peer Support, Be Smart - Don't Start, Sun Smart, Family Planning resource for secondary schools and Understanding Changes at Puberty*.

Research in elementary schools in the United States (Jones, 1987) found that "programmes were often fragmented and piecemeal in scope, bending to the

whims of the crisis of the moment". Although the research was carried out fourteen years ago, the situation has marked similarities to findings in this study. Jones found that many of the issues that resulted in programmes in the United States had been identified as the result of federal documents, such as Healthy People (1979), a paper written to draw attention to health issues of concern such as child abuse, nutrition, alcohol and drug misuse, teenage pregnancy, sexually transmitted disease, suicide and violence. So wide are the issues that there is a risk of curriculum fragmentation.

In this New Zealand study, most schools were implementing programmes as a result of pressure from educational or parental concerns. Examples were:

- *Kia Kaha*, a programme about bullying, because of the concern about increasing incidents of reported violence.
- *KOS*: because of the concern about the increasing incidence of child abuse.
- *Be Smart - Don't Start:* because of the concern over the incidence of smoking amongst school children.

Most of these kinds of programmes are well written and complement the health syllabus. There is a need, however, to evaluate the effect of such programmes on children's subsequent behaviour. In an English study, Deans et al. (1987) found that a smoking intervention programme for primary children may have deterred those children who had never smoked, but did little to persuade those who already smoked, to give up. Their conclusions were that there was a need for programmes specifically tailored towards children who already smoked, and that the programmes should continue into the secondary health education programme, so that adolescent smoking might be reduced. The New Zealand Programme *Be Smart - Don't Start,* was written to spiral upwards through all levels of schooling, but unfortunately, all schools were not doing this programme, so that children were not receiving the continuity suggested by Deans et al. (1987).

One of the major issues to emerge from the choice of programmes instituted in the classrooms was that teachers who were not familiar with methods for teaching health education were more likely to feel safe when teaching from packaged materials, where planning was already done and task sheets and learning activities provided. This was not necessarily a reflection on teachers' ability to teach health education, but rather, it was indicative of the time pressures placed on them and the lack of teacher development in health education. It may also show the enormous pressures teachers are facing to implement the new curriculum framework. Priorities for health education could be getting lost among other curriculum priorities, as teachers come to terms with new teaching methodologies and content across a range of curriculum subjects.

The points raised in the preceding discussion indicate that, first, there is a need for written health education policy which clearly outlines and guides the direction for health education in the school. To accompany the policy, there should be an implementation plan for the inclusion of health education programmes within the curriculum. Second, there is a need for pre-service and in-service education for classroom teachers, which among other things, would prepare teachers in implementation strategies and teaching methodologies.

WHAT ARE THE BARRIERS TO HEALTH EDUCATION PROGRAMMES IN SCHOOLS?

The major barriers to health education identified in the study were time, attitudes and values, and the continuity of programmes. Other factors included other demands and priorities of the new curriculum framework; lack of understanding by teachers of the importance of an on-going focus in health education; failure to write policy; lack of specific identity in an overall school programme; and difficulty, in some instances, to get senior management to take health education seriously.

Time

Time was a major barrier across all levels of schooling, which is consistent with findings by Eales and Watson (1994), and Williams et al. (1992).

Attitudes

This study showed that attitudes were a significant barrier for many teachers which affected their presentation of effective health education in the classroom. Some of the longer serving teachers had difficulty teaching about pubertal change in the intermediate schools. Some had a strong feeling that it was the home's responsibility. If they had to teach about pubertal change it should be a matter of teaching only the basic facts. Boys and girls should not be taught in the same class and young male teachers had no business teaching this material to young teenage girls. The fear of dealing with pubertal change, shown by some teachers, resulted in resentment towards the teaching of health education generally.

Devine (1992, p.5) also found that there were difficulties with attitudes and values and that "sensitive areas were being avoided by many schools for pupils at all stages". She concluded that although children may need to have the issues covered, teachers lacked confidence. Jamison (1993) found that many secondary schools brought in specialist teams to teach the sensitive topics of sex and drugs education because of lack of experience, skill or commitment of teachers. Looking at approaches to HIV/AIDS education in England, Hill (1993) found that some staff were unwilling and/or unable to deal with HIV and AIDS for personal, moral or religious reasons.

Values

The study found that many teachers had a genuine fear of becoming involved in a subject which reflected and explored individual values in the way that health education does. In health education there is no escaping values. Teachers are concerned with educating children in a way which means improvement or betterment. Teachers are, therefore, asking children to change their behaviour. However, it should be understood that in health education effective teaching methodologies encourage children to learn "how" to think rather than "what" to think.

Many teachers were worried about the potential conflict that health education might foster between the home and the school.

One teacher asked how to reconcile the facts that were being promoted among children about healthy eating when it was known that many of the children would return to homes where there was no possibility of healthy meals being served. Another asked how a teacher could convince children that what they were doing in class was the healthy way when they were constantly bombarded by contrary television and other media influences.

Continuity of Programmes

Continuity of programmes is another growing area of concern and is a real barrier to continuous and developmental progression in the health education curriculum. Wise (1987) identified the same difficulties in England, and noted that there was probably little liaison between primary and secondary schools.

The present study found that because there was a lack of close monitoring of health education in individual schools, it was unlikely that records of children's progress in health education would follow them as they progressed through the various levels of schooling, even though this is what had been envisaged in the structure of the 1985 health syllabus. As mentioned earlier, the reliance on packaged learning materials taught as isolated units, limits continuity. Wise (1987) was able to identify five areas of difficulty in the continuity of health education in his study, and they are very similar to the difficulties which have emerged in this study:

- lack of clarity and/or consensus as to what constitutes health education;
- relatively low status of health education in relation to more traditional subject areas;
- lack of teacher confidence and competence to teach health education;
- the view that health education is a by-product of the formal and informal curriculum and occurs, by implication, through the hidden curriculum; and
- lack of awareness of the opportunities to accommodate health education activities within existing curricular provision.

Because of these perceived difficulties some teachers have put up barriers to avoid teaching health education. There is no easy way around these barriers at the present, although it is to be hoped that the directions for health education in the new curriculum statement, currently being written, will recognise and take account of them. In the meantime there is a pressing need for more in-service teacher development.

While many of these findings draw attention to negative factors and barriers to health education, it should be pointed out that positive health education programmes are taking place in many schools. Many of the issues raised in this study have implications for the improvement of current educational practice in the delivery of health education in the schools. Several issues have a wider implication and may well result in recommendations to the policy and writing teams for the health and physical education learning areas in the new curriculum framework.

KEY FINDINGS

Policy

Many policies were being written because of the requirements of the national curriculum framework and the 1992 Health and Safety in Employment Act, rather than because of awareness of the real value of health education. The outcome of this was that many of the policies in the schools were written as "health policy" rather than "health education policy", and were more likely to result in policies to address safety measures around the school than health curriculum programmes within the school.

The fears of staff in relation to particular health issues, such as HIV/AIDS, for example, resulted in policy, but seldom resulted in teaching programmes in the classroom, particularly at the primary and intermediate level. Legislation and community awareness of the dangers of smoking resulted in smokefree policy in the school, but complementary programmes in the classroom were few. Policy was often written with regard to specific problems identified after they had occurred, but seldom were programmes implemented prior to the onset of the problem. It can be concluded that while societal health issues may have initiated policy, they did not always have a spin-off effect within the classroom programme.

Implementation

Except for major units, such as *KOS, Understanding Changes at Puberty*, or *DARE* , when specific blocks of time were set aside, teachers were frequently left to their own devices for the implementation of health education in the classroom. Except for a small number of schools with monitoring procedures for health education programmes, most could not give an accurate account of what was actually happening in each classroom. This had led to a fragmented, and often haphazard approach to health curriculum across all levels of schooling.

From this study it can be concluded that health education teaching had become topic-oriented. This may be attributed, in part, to the way in which the 1985 health syllabus had presented the nine themes for health education. The fault lay with the linear approach to listing themes separately in the syllabus and the way in which teachers had interpreted this to mean that each theme should be taught separately. This had resulted in many teachers becoming reliant on the packaged learning materials to teach the themes.

Although the 1985 health syllabus had identified the need for consultation beyond the school for policy formulation and programme implementation, very little evidence was found of this happening. In many schools, all responsibility for health education planning had been given to one staff member. Unless the teacher had the time, very little collaboration was sought from colleagues. Where there was a motivated health coordinator, awareness of the value of health was heightened and there was more collegial support and planning. Effective programming was the outcome.

Teacher Development

There was clearly a need for more promotional work in regard to health education in the schools, although the status of the subject had been raised as a result of its identification in the new curriculum framework. There was a need for pre-service and in-service teacher development to provide teachers with teaching methodologies, programming and implementation, and also to address the teacher concerns surrounding the values base associated with health education.

CONCLUSION

This study has demonstrated that there is a need for a more coordinated approach to health education in schools. International literature has suggested that school health education should build a foundation of basic health knowledge and skills rather than concentrate on established health problems. The schools in this study had a tendency to target the latter. It can be concluded that if young people are to be provided with a firm foundation of health knowledge and be provided with the necessary skills and strategies to allow for decision making about appropriate health behaviours which lead to a healthier lifestyle, then schools will need to have clear health education policy, comprehensive implementation plans, and well coordinated developmental health education programmes which are supported by teacher development, resources, funding and advisory services. Above all, "health education should be responsive to young people's expressed needs" (Tones et al. 1990, p.112).

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