HEALTH EDUCATION IN THE PRIMARY SCHOOL

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In contemporary society, the primary school is increasingly being allocated a major function in responding to an array of economic, social and cultural challenges. Schools are expected to educate children for the world of working and the world of living, and for European citizenship. They are also expected to broaden the primary school curriculum to include Science, technology and modern European languages and to foster the development of the health promoting school. Each of these areas demands the introduction of ambitious curriculum programmes which could eventually result in major curriculum overload at primary level. Rational curriculum planning is, therefore, essential if schools are to implement new educational and curriculum reforms all at once. For this reason it is highly important that teachers are involved in the planning process and in the delivery of new curriculum programmes. The CEC decided, in the light of recent developments in Health Education that the Education Committee should prepare a report on the question of Health Education for consideration by members. Its findings are contained in Part I of this report. The Central Executive Committee decided to invite two teachers who are currently on secondment to the Mid Western and North Western Health Boards, respectively, to present their views on the Health Education projects in their areas. Ms. Eibhlin O'Sullivan, M.Ed., is Health Education Officer with the Mid Western Health Board and together with Mr. Peadar Cremin, M. Ed., Lecturer in Social and Environmental Studies in Mary Immaculate College of Education in Limerick, they have compiled a report entitled Social and Health Education for Primary Schools. Ms. Ann McAteer, who is currently on secondment to the North Western Health Board area outlines the North Western Health Board's approach to Health Education in a paper entitled "Health Education in the Primary School". Their contributions are contained in Part II of this report.

The INTO wishes to record its thanks to Ms. O'Sullivan, Mr. Cremin and Ms. McAteer for their contribution to this report.

Senator Joe O'Toole
General Secretary
November 1992
HEALTH EDUCATION IN THE PRIMARY SCHOOL

PART I

SOCIAL, HEALTH AND SAFETY EDUCATION

INTRODUCTION

In recent years, a new approach to health care has been developing worldwide. There has been a gradual recognition that ill-health is often the result of individual lifestyles and there is a growing emphasis on people changing their lifestyles to improve their health. The resulting trend throughout the developed world is concerned with healthy diet, with regular exercise, with substance use and abuse and with the environment.

The realisation that prevention is better than cure, and also more cost effective, has led Governments of the industrialised nations to allocate more and more funds to preventative medicine while, at the same time, restricting overall health budgets. Research and practice has shown that the most effective form of preventative medicine is based on the development of Health Education programmes at every level in society with a view to promoting healthier lifestyles.

Health Education programmes tend to be nationally based, community based and school based. Nationally based Health Education relies heavily on the media to promulgate particular health related messages. Community based programmes tend to take the form of adult education classes or they may also be directed at the various people who attend Health Centres. While an international reduction in heart disease and similar 'Western style' illnesses is evidence of the effectiveness of these programmes, there is still a hit and miss element involved and a conception that it is too little, too late. The fact that virtually the entire population, at some time, is obliged to attend school for extended periods and that the habits and knowledge which are inculcated at an early age can have huge implications for the development of healthy lifestyles has led most countries to devote considerable attention to the development of school based Health Education programmes.

This report examines the implications of these international trends for Ireland and, in particular, for the primary education system. It presents an overview of the current curriculum in the context of changes which are likely to emerge in the near future. It examines the various approaches which are
being advocated for Health Education as either a single subject within the curriculum, as a cross curricular thematic subject or as a core subject within an integrated curriculum. It looks at the current provision of resources and examines the additional resources which will be required to implement this area of the curriculum. It also examines recent developments in the areas of sex education, child abuse, drug abuse, AIDS and the implications of these issues for teachers. It outlines some of the experiences and trends in other countries and projects new definitions for Health Education. The widening scope of Health Education has prompted the Education Committee to rename this whole area of the curriculum as Social, Health and Safety Education.
SECTION ONE

HEALTH EDUCATION IN THE PRIMARY SCHOOL CURRICULUM

1.1 THE PRIMARY SCHOOL CURRICULUM

Health Education is covered as part of the Physical Education curriculum in the Teachers' Handbook accompanying the primary school curriculum. It suggests that Health Education should be integrated with all other aspects of the curriculum and the following topics are suggested for the syllabus: Personal Hygiene, Nutrition, Safety, Lifestyle, Smoking, Alcohol and Drugs. Curáclam na Bunscoile also suggests that use should be made of the resources which are made available from time to time from various health authorities and voluntary agencies.

Social Education is covered in Chapter XI of Curáclam na Bunscoile under the title of Civics. The Teachers' Handbook suggests that "Civics is that part of school activity which helps the child to become a better member of society and to appreciate his rights and his obligations towards it." The concern of the Civics programme outlined in the Handbook is with the development of acceptable social and moral attitudes which take into account the rights of other members of society. It is suggested that Civics should not be formally taught from infants to fourth standard, but that it should form an integral part of Social and Environmental Studies and Religious Education programmes. The Civics programme should also cover areas such as caring, safety, good habits, local environment and moral behaviour. In fifth and sixth standards, formal Civics education was recommended under four headings: The Family, The School Community, The Local Community and The National Community. The informal social attributes of the earlier years are expected to be extended and formalised in the senior classes.

1.2 CURRICULUM IMPLEMENTATION

The extent to which Social and Health Education is implemented within the school curriculum is difficult to determine since the instruction is essentially informal in nature. Constraints of time within an overloaded curriculum and lack of resources have forced teachers to neglect some areas of these syllabi, especially in senior standards. In an Education Committee survey on the Curriculum conducted in 1975, teachers felt that the course in Physical Education was too wide ranging. The respondents to the survey demanded the provision of in-service courses. Health Education was not specifically
mentioned although it was implicit in the P.E. syllabus. There was a general feeling that Civics should be taught incidentally even in senior standards where lack of time appeared to be inhibiting formal teaching.

A report by the Inspectorate of the Department of Education (1979) on a review of the teaching of Physical Education does include a section on Health Education. The report stated that "the area of Health Education shows great need for improvement". It also noted that teachers lacked confidence in their ability to teach P.E.; that many regarded P.E. as an area of lesser importance within the school curriculum and that there was a lack of knowledge and understanding of P.E. amongst teachers. The report recommended an expansion of inservice courses and the provision of resource materials for teachers.

A report by Broderick (1985) suggests that about two thirds of primary schools have some form of Health Education programme. Topics tended to be covered informally and the depth of coverage was hard to gauge.

In the Report of the Education Committee entitled Primary Curriculum Survey (1986), presented to the 1987 INTO Education Conference, it is reported that over three quarters of the teachers surveyed taught P.E. once per week or more often. Games, free movement and Health Education, in that order, were the most common components of the programme. P.E. was reported as being integrated with Religion by 39% of the respondents. It can be assumed that some, if not a lot of this integration, relates to Health Education.

1.3 REVIEW BODY ON THE PRIMARY CURRICULUM

The Report of the Review Body on the Primary Curriculum (1990) states that Health Education is of sufficient importance to warrant inclusion on the primary school curriculum but that the addition of a new subject would tend to overload the curriculum. It, therefore, recommends that:-

- Health Education should be treated as a cross curricular theme in primary schools. This strategy will involve a precise identification of the aims, objectives and content and the pinpointing of various existing curricular areas in which these objectives would be catered for most appropriately.

- All curriculum developments in this area should be coordinated, supervised and monitored by Department of Education authorities.
While the Review Body does not have the opportunity to give adequate attention to such matters, we recommend an examination of issues relating to (i) sexuality and (ii) child abuse and their implications for the primary curriculum.

Parents should be given the opportunity to express opinions on the content of Health Education programmes and to influence their development.

The curriculum in Health Education should be particularly sensitive to the need to match materials with pupils' level of development.

There is a particular need for inservice programmes to make teachers aware of the range of informal methods that are appropriate for some of the learning objectives in this area.

In making decisions regarding these areas we recommend the broadest consultation should take place since Health Education involves moral, educational and health issues.

The section on Health Education warranted two pages in the chapter entitled "Other Curriculum Issues". Physical Education is included under the Arts in the Curriculum. There are no recommendations in relation to developing the health and fitness of children. Civics is not given the status of a subject but is described as an attitudinal rather than cognitive area. It is suggested that new ways of bringing about desired outcomes should be developed. The Report of the Review Body recommends:

- That, in the context of developing positive civic attitudes, including the concept of civic responsibilities, there should be opportunities for pupils to get involved in local projects in the community, and the school timetable should be flexible enough to accommodate this.

- That those State and semi-State agencies that are also concerned with civic attitudes should have an involvement in schools. There should be coordination of this involvement and provision for suitable training for the personnel involved.

- That attention should be given to children's understanding of the mass media and their influences.
The Green Paper on Education (1992) makes very little reference to specific areas of the curriculum. However, Physical Education warrants one complete section which proposes a radical new approach linked to diet and hygiene. The emphasis is on health-related fitness and the development of an interest in physical activity as an essential component of an active and healthy lifestyle. The following proposals on Health Education are contained in the Green Paper:-

- A syllabus which it will be possible to implement with limited facilities.

- A "holistic" approach, including addressing questions of diet, hygiene, posture, flexibility and a healthy lifestyle.

- A daily period of 30 minutes devoted to these activities.

- A balanced Physical Education programme based on motor skills and aerobic fitness.

- The availability of services of specialist teachers of Physical Education to provide guidance to primary teachers.

- Special attention to Physical Education during preservice training, together with in career training in Physical Education for teachers.

- Continuity in Physical Education provision between first and second level and continued emphasis at all levels on fitness as underpinning sports activities.

- Research to produce programmes and materials to suit the specific needs of Irish school children and continuous evaluation to ensure the effectiveness of the programmes.

The Green Paper also devotes a section to the promotion of health and well being amongst pupils. It suggests that health promotion within schools be categorised in terms of school climate, consultation and involvement of parents and the community. It proposes that school managements should examine the extent to which their schools:-

- Promote self-esteem in all students
Develop good relationships between staff and students

Encourage an exemplary role for staff in health related issues

Ensure that staff are enabled to identify students at risk of abuse in any form.

The Green Paper goes on to propose that schools should work closely with the community including:

- Consultation with parents on the development of school policy.

- In disadvantaged areas, the home/school liaison programme, which offers a means of enhancing parental involvement.

- Cooperation with voluntary agencies in initiatives relating to lifestyle influenced diseases such as cancer, heart disease and HIV/AIDS.

- Cooperation with agencies concerned with safety and the environment.

It further suggests that, with due regard to family and social circumstances, positive intervention would include:

- A Physical Education programme, beginning at the early stages of primary education, that would promote the physical well being of all students in a non competitive way and linked, where appropriate, to education on hygiene and diet.

- The provision of a systematic health screening programme, including the provision of medical and dental services to students, linked to support and advice for families of young people in need. This provision will be reviewed in collaboration with the Department of Health.

- Developing a school policy on personal and social education in consultation with staff and parents.

- The provision of a sexuality education programme, appropriate to all levels of students, beginning in the early stages of primary education.

- At the appropriate level, programmes relating to substance abuse and
Health Education in the Primary School

the promotion of a healthy lifestyle.

- Ensuring the appropriate allocation and training of teachers for work in this area.¹³

The Green Paper proposes the inclusion of Health Education in pre-service training for all teachers and in-career provision for teachers wishing to get more involved in health promotion.

Finally the Green Paper advocates the development by each school of a policy on standards of behaviour in consultation with parents and with reference to Department of Education guidelines on school discipline and behaviour in primary schools.¹⁴
SECTION TWO

CURRENT TRENDS IN HEALTH EDUCATION AND CURRICULUM DEVELOPMENTS

2.1 DEVELOPMENTS IN HEALTH EDUCATION

The promotion of health as both a positive and social dimension of lifestyle was fundamentally initiated in Geneva in May, 1977 by the World Health Organisation when it resolved that "the main social target of governments and the World Health Organisation in the coming decades should be the attainment by all citizens of the world by the year 2000 a level of health that will permit them to lead a socially and economically productive life". There is no doubt that, although achievements will fall well short of the goals set, considerable strides have been made in the promotion of positive health and, in the short term, some of the fruits of positive health have been observed. Certainly, in the developed world and amongst the more educated peoples, health issues have become an important aspect of both social and political life. The result for education systems has been an evolution of Health Education programmes especially at second level and more recently at primary level. The Primary Curriculum Review Body Report notes that new programmes of Health Education have been introduced in England, France, United States, West Germany and Denmark².

The WHO Regional Office for Europe has been promoting the concept of the healthy school since 1984³. The adoption in 1988 by the European Community Council of Education Ministers of a Resolution (CR 89/C3/01) concerning Health Education in schools added impetus to the movement to involve schools as promoters of good health (ECC, 1988)⁴. The key characteristic of the health promoting school is that it is not aimed purely at pupils' health or at the school curriculum, but that there is a reciprocal interaction between, on one hand teachers, pupils and parents and, on the other hand between the school, the community and the health service. In the Health Education of the future, the school is envisaged as playing the pivotal role in health promotion as well as in social, environmental and ecological dimensions of life. The development of appropriate curricula to promote health and to develop life skills and the statutory establishment of such curricula within education systems is the longterm goal of the promoters of the healthy school⁵.
2.2 **Health Education in England and Wales**

Since the Education Reform Act of 1988, there is "a statutory responsibility upon schools to provide a broad and balanced curriculum which:-

(a) promotes the spiritual, moral, cultural, mental and physical development of pupils at the school and of society;

(b) prepares pupils for the opportunities, responsibilities and experiences of adult life.\(^5\)

The National Curriculum Council (NCC) for England and Wales has outlined a framework for Health Education as a cross curricular theme from which schools can develop both a policy and a school curriculum. The underlying feature of the recommendations of the NCC is that Health Education should permeate the physical environment and the life of the school. The programme should be continuous and integrated with the rest of the curriculum and should reflect, the age, developmental stage, background, social pressures and interests and needs of the pupils. Nine components form the framework for a Health Education curriculum 5-16: substance use and misuse; sex education; family life education; safety; health related exercise; nutrition; personal hygiene; environmental aspects of Health Education and psychological aspects of Health Education\(^7\). The NCC outlines areas of study for each component at the various levels of development and gives advice on teaching methods and school implementation.

2.3 **Health and Social Education in Northern Ireland**

New developments in Health Education in Northern Ireland predate those in England and Wales and the Education Reform Act (N.I.) 1988. The Northern Ireland Council for Educational Development (NICED) issued guidelines to schools on Health and Social Education in 1983\(^8\). The incorporation of personal relationships into the already established parameters of Health Education added the social education aspect to the combined areas. The underlying aim of the guidelines is, in fact, more social than health orientated although all the typical health topics are included. The aim outlined by NICED suggests that pupils should be helped to achieve:

(a) full physical and emotional development;
(b) a positive self esteem;
(c) effective social communication;
(d) interests;
(e) a sense of responsibility\(^9\)
The Council outlined suggestions for establishing school policy, developing the school environment, teaching methods and materials and using outside agencies.

In 1989, NICED published revised guidelines entitled Health Education within the Curriculum. The revised guidelines incorporated sex education as an aid to the planned, coordinated and integrated development of Health Education in primary, secondary and special schools, further education colleges and the youth service. Within the primary school, the guidelines make suggestions for staff development, for the role of the principal and health education coordinator, for inservice training, for planning, implementing and evaluating a programme and for integrating Health Education within overall school policy. The guidelines outline six health themes: Myself; Lifestyle and Health; Safety; Myself and Others; Protecting our Health and Food and Health. There is a separate section on Sex Education but it is suggested that it be integrated within the overall Health Education programme. While most of the topics which are covered would have their corollaries in the guidelines for England and Wales, there is a noticeable difference in emphasis and in approach in Northern Ireland which is more humanistic than relativistic and it resembles more closely the approach in the Republic of Ireland.

2.4 HEALTH AND SOCIAL EDUCATION IN THE REPUBLIC OF IRELAND

2.4.1 The Health Boards

In the Republic of Ireland, Health Boards have become increasingly involved in school based Health Education programmes. They have begun to provide the kind of resources which the Department of Education has consistently failed to provide. The newly produced programmes develop the existing areas of Health Education, Civics and Personal Safety and Development. Their aims typically involve the development of personal identity and self-esteem, awareness and understanding of health matters, positive attitudes towards healthy lifestyles and personal responsibility. The newly developed programmes significantly involve pupil research, discussion and role playing. Team work and an emphasis on activities are crucial aspects of these programmes.

2.4.2 Western Health Board

The Western Health Board was the first Health Board to become involved in Health Education in primary schools. A pilot project was carried out in the
Athenry District Care Area by primary teachers between 1976 and 1981. The teachers used and adapted the "Good Health Series" from the United Kingdom and as a result of the pilot scheme, a booklet entitled "Health Education: Notes for Primary Schools" was produced. The approach was based on the methodology suggested in the 1971 Curriculum and it was child centred and based on the local environment and integrated with other areas of the curriculum. The aim was not to impart maximum knowledge but to form and develop good attitudes and behaviour. The topics covered in this resource book included: the human body; food and drink; hygiene; smoking and safety. A list of resources and suggestions for curriculum integration was also included.

The Western Health Board drew up Policy Guidelines for Hygiene Standards in Schools in 1990 and issued them to each Board of Management. Subsequently, local Environmental Health Officers undertook a survey of hygiene standards in schools in late 1990 involving 493 primary schools in Galway, Mayo and Roscommon. Almost 40% of the schools in Galway and Roscommon were considered to be overcrowded. Satisfactory levels of heating (72%), ventilation and classroom hygiene (93%), cleaning arrangements (78%) refuse and sewage disposal (87%) and provision of staff facilities (62%) were recorded for all counties except Roscommon where satisfactory heating was only in 47% of schools and provision of staff facilities was only adequate in 37% of schools. A total of 54% of schools had drinking water in the schools and only 30% had fluoridated water supplies. 15% of schools had only outdoor toilet facilities and only 2% had adequate facilities for handwashing. The results of the survey were furnished to each Board of Management and the concern of the WHB about the inadequate provision of basic facilities and the absence of routine hygiene procedures was expressed as a serious matter from a public health perspective.

2.4.3 Southern Health Board

In 1979, a Health Education programme based on the United Kingdom School Council Project "Thinkwell" was piloted in a number of Cork schools. In 1984, a programme was designed for use in an Irish context and was piloted over the following two years. In 1987, this programme was published under the title "Grow in Health". The aims of the programme are to develop understanding of one's body; to develop a sense of responsibility of one's own health; to develop self-concept; and to provide parents with the opportunity to become involved in Health Education. The content includes: the body, nutrition, leisure activities, safety, drugs, relationships, growth and development, feelings and personal responsibility. The programme is in use in approximately half the schools in Cork and Kerry. Inservice courses for teachers are provided each Summer.
2.4.4 **Mid Western Health Board**

In 1984, the Mid-Western Health Board embarked upon the development of a Health Education programme for schools. A working party of health professionals, teachers and the Inspectorate examined the perceived needs of schools in the Health Board area and devised a pilot project. The MWHB adopted the aim of "providing each child with a foundation for healthy living in all its aspects" and with the development of each child "as an individual and as a member of society in the communal and global sense". The project set itself the following objectives:

(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 identify and positive self-esteem as well as an ability to cope with change in themselves and in their environment;

(e) to help 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 made will influence future health.

The ‘Bi Folláin’ programme which emanated from the working party was piloted in fourteen schools between 1987 and 1991 and was enhanced in the light of teacher evaluations. The programme was devised around the concept of child-centredness and six themes were developed for each class grouping: nutrition, hygiene, safety, environmental care, media education and personal and social development. The Health Board currently organises Summer courses for teachers in Health Education.

The MWBH intends to provide a two day school based inservice course to staffs of schools who wish to avail of the ‘Bi Follain’ programme. The programme is presented as a cross curricular theme based Health and Social Education programme and it is recommended that it should be included in the curriculum within the current timetable and within the time taken for both Physical Education and Social and Environmental Studies. The programme is now available for senior standards and it will eventually be extended downwards to the rest of the primary school.
2.4.5 The South Eastern Health Board

The South Eastern Health Board adopted a report in 1988 of its Regional Health Education Committee on the priorities, objectives and organisation of Health Education in the South East. In each year since, the Board has held Summer courses on Health Education in the primary school. The SHB primary school programme "Grow in Health" was made available to participants. The SEHB intends to liaise with Parents Councils, Boards of Management and school staffs to develop a Health Education programme for the primary school. A Health Education Officer was appointed in 1991 and the programme is in the initial stages of development.

2.4.6 North Western Health Board

A working party on Health Education in Primary Schools was established in 1989 by the North Western Health Board with representatives from the NWHB, the Department of Education, management, teachers and parents. The report of the working party was adopted by the NWHB in late 1989. The report defined Health Education in primary schools as "the development in pupils of the knowledge, skills and attitudes that will enable them to promote, as a resource for everyday living, their own health and that of the community". The aim of the Health Education programme is to enable pupils to take more responsibility for their health through self awareness and developing personal skills. The programme has since been developed and the topics include: self esteem; relationships; nutrition; hygiene; leisure; drugs; the environment, safety and growth and development; each topic appropriate to the four primary school groupings. The report recommends that Health Education should be formally timetabled on the school curriculum and incorporated into the School Plan. It also recommends that the managerial authorities, parents and the INTO should be informed about the introduction of a Health Education programme into schools. The NWHB is providing and developing inservice courses and teaching material for teachers for introducing the programme in infant and junior classes initially with subsequent extensions to middle and senior classes in the near future. The programme is entitled "Páistí Sláintíula".

2.4.7 Eastern Health Board

The Eastern Health Board has concentrated its Health Education services in the area of child abuse. A Child Abuse Prevention Programme for schools entitled "The Stay Safe Programme" which consists of a video for children, two separate curricula for junior and senior cycles at primary level and a training
course for teachers and additional information for parents was designed on the basis of consultation with teachers assigned to the project by the INTO. It aims to prevent child sexual abuse by equipping parents and teachers with the knowledge and skills necessary to protect the children in their care. Children are then taught safety skills in the normal classroom context and these skills are reinforced through discussion with their parents. This approach attempts to increase community awareness and make children less vulnerable to abuse of all kinds. The programme was introduced in the Easter Health Board region during the school year 1991/92. The programme has been extended to Health Boards on a nationwide basis for the school year 1992/93. In order to facilitate teacher training, a total of ten teachers and ten social workers are currently on secondment to the programme.

2.5 Child Abuse

Child abuse and, in particular, child sexual abuse has received increasing public discussion and coverage in recent years. It has been the subject of increased research, media reports and speculation and public concern. A number of motions to INTO Annual Congress have defined INTO policy in this area (c.f. Appendix A) and have led indirectly to the Stay Safe Programme developed by the Eastern Health Board. The ISPCC has also produced material for teachers on child abuse and child sexual abuse. It has also established a free-phone for children entitled Childline. The free-phone service is designed to enable children to report or talk about abuse and for counselling purposes.

Following discussions between the INTO, the Department of Education, Managerial Authorities and the National Parents' Council, all schools in the Republic of Ireland were issued with the Department of Health Child Abuse Guidelines, Procedures for Dealing with Allegations or Suspicions of Child Abuse, a Child Abuse Checklist and the lists of Directors of Community Care in each of the Health Board areas.

In 1989, the Department of Health and Social Services in Northern Ireland published 'Cooperating to Protect Children' as a guide to Health and Social Service Boards on the management of child abuse. This publication stressed the necessity for effective inter agency cooperation in the field of child protection. In the same year, the Department of Education published Circular 1989/41 to advise the Education Sector on action to be taken when cases or suspected cases of child abuse are encountered in schools. Education and Library Boards and the Council for Catholic Maintained Schools have circulated guidelines to schools to ensure that children are protected from abuse, neglect and exploitation.
2.6 SEX EDUCATION

Traditionally, sex education has been limited to moral instruction through the Religious Education Programme in senior standards. Since the introduction of the 1971 primary school curriculum, schools have gradually been including varying amounts of sex education within their curriculum programmes. This has come about mainly at the request of parents.

A number of experts in this field have been available to talk to schools on the subject of sex education for a good number of years. The leading figure in the sex education movement has been Angela McNamara, who has spoken to parents, teachers and school children in the senior classes on a regular basis. She has written extensively on the subject and produced video tapes on most aspects of sex education. Veritas has produced a variety of books and tapes, both video and audio on sex education.

However, teachers are becoming more involved in sex education in their own schools. Two Dublin teachers, Herron and McGinley have written two books on sex education and have addressed many teacher and parent groups on the subject. In a paper read to the Ninth Annual Drumcondra Education Conference entitled “Sex Education - A Survival Guide for Teachers”, they argue convincingly for a holistic approach to sex education developed jointly by parents, teachers, church and state interests, as part of an overall Health and Social Education programme. The INTO “Guidelines on Sex Education” (1990), recommend that sex education should be part of a school's overall plan and that parents should be both informed and involved in drawing up a sex education programme (c.f. Appendix B). The National Parents' Council also advocate a sex education programme with the involvement of and support of parents. The policy of the Conference of Catholic Bishops confirms that sex education is adequately covered in the sixth class religion programme. The Department of Education appears to have no policy. However, the Green Paper on Education (1992) does propose a sexuality education programme for schools beginning in the early stages of primary education.

2.7 SAFETY EDUCATION

Ireland has one of the worse records in Europe in respect of the number of children killed or injured accidentally. A number of agencies are actively involved in the general area of safety promotion. The National Safety Council (NSC) was established to replace the National Road Safety Association, the Fire Safety Council and the Water Safety Council. It
produces a wide range of resources in these three areas including leaflets, posters, booklets and videos. The NSC has recently launched a new look Rules of the Road Booklet. It has also published and distributed to schools a Road Safety Awareness Programme for 6 - 8 year olds. The pack includes Teaching Notes, Workbooks and Wall Charts. The most recently produced video is entitled "The Kid, the Bike and the Helmet." The Irish Red Cross Society (IRCS) has also produced a Safety Pack for Schools which includes the results of a school accident survey, posters, worksheets and a teachers' manual and lesson notes for a minor injuries course. The IRCS also supports the establishment of School Safety Squads to promote safety within schools and it provides regular newsletters both for information and feedback between Safety Squad members around the country.

2.8 Substance Abuse

While substance abuse has been traditionally confined to smoking in the primary school years, there is increasing evidence that a certain amount of alcohol abuse, solvent abuse and drug abuse does exist amongst primary school children. Even where substance abuse does not exist amongst young school children, there remains the danger that they become exposed or partake in substance abuse in later life. As a result, substance abuse forms one topic in all Health and Social Education programmes. As well as information about the effects of substance abuse, programmes alert children about the advantage of a healthy lifestyle, self-esteem and dealing with peer pressure, all of which are established methods of deterring substance abuse. The Department of Health produces materials for schools on substance abuse through the Health Promotion Unit. The packs include posters, leaflets booklets, audio and visual aids. Health workers will visit schools to give talks to children or staffs. They also produce materials on healthy living and lifestyles.

The National Federation of Community Action on Drugs (CAD) is an umbrella organisation for parents, teachers and community leaders which has been formed to fight substance abuse at local level. CAD encourages parents to become involved with the school's Health Education programme and is primarily concerned with parents of teenagers.

2.9 AIDS

The Acquired Immunodeficiency Syndrome (AIDS) has been diagnosed in children in the primary age group. An additional number of children at risk
have been identified as HIV positive. There is a need, therefore, for schools to include a policy on AIDS in their overall health and safety policy and to include AIDS within their Social and Health Education programmes. AIDS education should be integrated with other areas of the Social and Health Education programmes including drug abuse, sex education, nutrition, hygiene, self esteem and relationships. Booklets, leaflets and posters on AIDS have been produced by the Health Promotion Unit of the Department of Health. The Eastern Health Board has devised a programme on AIDS education for 6th class pupils in primary schools. The programme is designed to seek the active involvement of parents, teachers and children in the process of AIDS education. The INTO has participated in a working party with medical and social personnel in the Eastern Health Board in an attempt to draw up guidelines for schools in dealing with infection control in schools. Draft guidelines are included in Appendix C.

2.10 Infectious Diseases

The Departments of Health and Education and the INTO have established a working party to prepare a pack for teachers on the question of infectious diseases and hygiene in schools. The pack is expected to include guidelines for infection control in schools, policy statement on safe practice in schools including items for inclusion in first aid kits, guidelines regarding the application of dressings in cases of lacerations and other bleeding lesions. The pack will also include a statement regarding the provision of hot and cold water in schools. Information will also be included on infestations, scabies, chicken pox, rubella and hepatitis infection. Asthma, Diabetics and Epilepsy. The pack is expected to be circulated prior to the school year 1993/94.
SECTION THREE

DISCUSSION AND RECOMMENDATIONS

3.1 WHAT IS HEALTH EDUCATION?

According to the World Health Organisation Charter 1947, "Health is a state of complete physical, mental and social well being and not merely the absence of disease or infirmity".

The aim of Health Education is to develop in the child a positive self-esteem, effective social communication, healthy interests and a sense of responsibility. Maximum knowledge is not the main aim. The thrust of Health Education is affective and the focus is on action and on making informed positive choices. Self-esteem is regarded as the fundamental determinant of good Health Education. Children who have a strong sense of their own worth are more likely to make decisions effecting their health. Making decisions is central to healthy living and so is the very heart of Health Education. The emphasis on decision making, however, should not be based solely on good or bad decisions but on making informed and considered decisions. Attitudes and values are formed at an early age and are influenced by religious, cultural and social pressures. Relationships with peer groups, parents and other adults and exposure to the media have a strong influence on the child's overall development. Since not all of these influences and attitudes are positive, Health Education becomes a way by which children can consider and discuss alternative courses of action with their own age group and with teachers. Each school needs to clarify its own understanding of Health Education and define its own aims. An individual school's programme for Health Education must take into account the social, cultural and religious background of the children. In implementing a programme of Health Education, the ethos of the school is as important as the content of the programme and any Health Education programme needs the full backing of teachers, parents and management. Health Education should be a special relationship between teacher and pupil, whereby the learning process becomes a shared experience. In this approach, the gaining of knowledge is encouraged but the main thrust is in the formation of attitudes, value clarification and in the development of decision making skills.

3.2 THE PRIMARY SCHOOL CURRICULUM

At present, Social, Health and Safety Education is fragmented through the primary school curriculum between Physical Education, Social and
Environmental Studies, Civics and Religious Education. The degree of implementation is hard to define but it is acknowledged to be reasonably high. The constraints on implementing Social, Health and Safety Education appear to be a lack of a structured syllabus, suitable teaching materials and curriculum overload in the more senior classes.

The Report of the Review Body on the Primary Curriculum recommended that Health Education should be treated as a cross curricular theme in primary schools. In its response to the Review Body Report, the INTO warned that "the implementation of such a proposal could become so diffuse that the coherence of an appropriate Health and Safety programme might be lost." Health Education features as one of the four compulsory educational themes in the Northern Ireland curriculum for primary schools. The Education Reform (Northern Ireland) Order 1989 empowers the Department of Education to set in place, by statutory order, the aims and objectives relating to Health Education. Objectives are specified for the cross curricular theme Health Education which are expected to be incorporated within other aspects of the curriculum. The objectives relate to health in the context of personal development, social development and the environment. (For information on Health Education objectives see Appendix D). In operating aims and objectives for Health Education, as a cross curricular theme, particularly in terms of content, there is always the temptation to include so many activities that curriculum overload inevitably occurs. Treating Health Education as a cross curricular theme may also result in less emphasis being placed on health related issues in the curriculum. This raises serious questions regarding the status of Health Education in the curriculum. Should Health Education be treated as a core subject area of the curriculum, involving content guidelines which may be integrated with other areas of the curriculum, particularly Science, Religion, Geography, Civics and other areas of Environment Studies or should it be treated as a cross curricular area as suggested by the Report of the Review Body on the Primary Curriculum? In adopting a cross curricular approach there is always the possibility that health messages may get neglected at the expense of either scientific enquiry, geographical data or religious dogma.

The Bi Follain programme which was developed by the Mid Western Health Board caters for children at four levels in the primary school. Each level comprises six units of information and materials. The Bi Follain programme adopts a cross curricular thematic approach in an attempt to ensure that teachers are not overburdened by additional work. The themes are expected to be incorporated into the day to day curriculum of the school. Yet the programme in Social and Health Education which has been designed for fifth and sixth classes and the accompanying materials runs into a total of 294
pages. Teachers are advised to implement one unit per term over a two year period.

The Paístí Slaintiúla project which has been developed by the North Western Health Board adopted a 'lifeskills teaching' approach to Health Education. The report of the project team recommended that a properly structured Health Education programme should be part of the curriculum in each school. The team also recommended that such a programme should be implemented by combining formal timetabling under Environmental Studies with an integrated approach through other subjects where appropriate. Initially the teachers' manual for infant classes ran into 400 pages but this was reduced to 180 pages following consultation with the teachers involved in the pilot project. Having set out originally to prepare content guidelines, the North Western Health project soon discovered that attempting to include all the Health Education in content guidelines is tantamount to introducing a new core subject area. The question of whether Health Education should be introduced as a core area of the curriculum with content guidelines, or whether it is more appropriately taught as a cross curricular theme is a matter which warrants considerable debate within the Organisation.

In contemporary society schools and teachers are readily being allotted a major role in contributing to the solution of an array of social and environmental issues, not least of which is the renewed emphasis on healthier living. The modern emphasis on healthy living has led to increasing pressures from various health authorities to involve the schools in targeted programmes designed to inculcate good 'healthy habits' in children. The modern trend towards 'healthy lifestyles' relies upon behaviour modification techniques which necessitate early intervention programmes if they are to be successful.

The Green Paper has reflected the international convergence on the new demands on schools, particularly primary schools. Chapter 4 suggests broadening the curriculum by introducing new curriculum programme most notably in areas such as Science and technology, modern European languages and in fostering the development of the health promoting school. Each of these demands alone implies ambitious programmes in preservice and in inservice teacher education and major reorganisation of learning and timetabling in schools. From the point of view of classroom teachers, what matters most is that they will be expected to promote these new programmes actively, and perhaps all at once. It is vital, therefore, that curriculum planners and, in particular, the National Council for Curriculum and Assessment take greater control over the array of curriculum development projects which are emerging from Environmental Groups, Health Board Authorities, Development Education Agencies, Safety Councils and private
companies anxious to create the appropriate climate for their individual product or service.

As a result of research and development, targeted programmes have been or are being developed by a number of Health Boards which will become a useful resource both for planning and for implementing syllabi in Social, Health and Safety Education. However, it must be noted that Health Boards are driven by different constraints and philosophies than those which apply to educational institutions. There are certain degrees of disparity also emerging between the content and the development of programmes by the various Health Boards which, while allowing for the influence of regional variations, display a divergence of opinion in relation to certain pedagogical strategies. For example, one programme is being developed from infants to senior standards, while another is developing from the other direction and a third was prepared as a complete entity. While most of the programmes which have already been produced, advocate a cross curricular thematic approach to Health Education, much of the information and materials which have been produced resemble content guidelines more closely. Perhaps this is in line with emerging curricular thinking which suggests that in order to integrate subjects, there must also be a core content. Integration is seen more as a pedagogic principle. From a classroom teacher's point of view there seems to be increasing pressures from a wide variety of sources vying for the inclusion of additional areas on the curriculum. Society will have to decide whether Health Education is of such importance that it warrants greater emphasis in curriculum implementation.

There is also a degree of input into SHSE programmes by external agencies and a great deal of materials and resources are being made available in particular topics by these agencies. However, it should be acknowledged that all of these agencies have vested interests in providing their own areas of expertise which may not always be compatible with the educational constraints of the schools concerned. The recommendations made by the various agencies and Health Boards in relation to the primary school curriculum have ranged from the formal timetabling of a Health Education programme and the informal integration of Health Education within the existing curriculum to the establishment of cross curricular themes which could be formally timetabled or informally implemented. There is merit in all these suggestions and they need to be examined in detail in the light of other curriculum developments at primary level.
3.3 **The Future Development of Health Education**

The Education Committee welcomes the recommendations of the Review Body on the Primary Curriculum in relation to coordination, supervision and monitoring of all curricular developments in the area of Health Education. The Committee also endorses the views that sexuality education and child abuse issues should be included within the area of Health Education; that parents should contribute to the development of Health Education programmes; that inservice training for teachers should be a priority and that the broadest consultations should take place with all the interests involved. However, the Committee notes the low level of attention given to this broad area in the *Report of the Review Body on the Primary Curriculum*.

The Green Paper on Education proposes a major redirection for Physical Education which emphasises physical fitness and a closer liaison between Physical Education and Social, Health and Safety Education. There has been some disquiet in recent years in the United Kingdom and other developed countries at the level of fitness, not only of the adult population, but also of the school going population. There is a need for research in Ireland into the levels of fitness of children. The Education Committee proposes, therefore, that the appropriate education agency undertake a comprehensive nationwide study on the question of fitness amongst young children.

The Green Paper proposes a holistic approach to teaching in these areas which is to be welcomed. However, the proposal to allocate thirty minutes per day to Physical Education has serious implications for timetabling, but more importantly, for the provision of physical resources and for curriculum development and implementation. The Education Committee endorses the proposal to avail of specialist teachers to provide guidance to primary teachers but only if such teachers are recruited and trained from within the primary teaching profession or if graduates of Colleges of Physical Education have completed a B.Ed. course as mature students in the Colleges of Education. The Committee deplores the lack of commitment in the Green Paper to the provision of adequate resources, both for the development and sustainable implementation of programmes in these general areas. The Education Committee, therefore, demands that primary teachers, with 'appropriate' experience in teaching Health Education at primary level, should be seconded to facilitate inservice education at school based level. Teachers must be facilitated to become active constructors of their own health curriculum knowledge, rather than being passive recipients of transmitted curriculum programmes. Teachers should not be expected to become active agents of change without appropriate inservice provision which must entail a radical
new approach to inservice education in Ireland. It cannot be stressed often enough that real curriculum development will only come about through teacher development. The Education Committee recommends that an agreed nationwide programme of inservice education should be established to coincide with the introduction of any new curriculum material on Health Education. A framework for multiplying the effectiveness of inservice should be established immediately in order to prepare a sufficient number of resource teachers to act as Health Education support teachers. These support teachers should be deployed on a nationwide basis to help schools to develop their own individual Health Education programmes based upon guidelines issued by the National Council for Curriculum and Assessment.

The Education Committee recommends that the National Council for Curriculum and Assessment (NCCA) which has the responsibility for planning the primary school curriculum, for supporting the implementation of the curriculum and for reviewing the effectiveness of the curriculum should take immediate responsibility for the development of a Social, Health and Safety Education syllabus for the primary school system. This would involve the NCCA in a process of consultation with all the interested parties and using, where appropriate, available materials and resources for the implementation of an appropriate Health Education programme. The Committee is opposed to the fragmented development of SHSE as it is currently evolving. The Committee is strongly of the opinion that no segments of an SHSE programme should be taken in isolation and that there should be appropriate guidelines from which schools may devise an SHSE programme suited to their particular policy and school plan. The NCCA is the most appropriate body to develop an SHSE curriculum for primary schools.

3.4 TEACHERS AND SOCIAL, HEALTH AND SAFETY EDUCATION

There are many implications for teachers in the development of Social, Health and Safety Education. In the first instance, teachers should have a major input into the development of Health Education programmes. As outlined earlier in this report, the new programmes should be developed under the auspices of the National Council for Curriculum and Assessment with an input from the various interests in Health Education. Any new programme of Health Education must be accompanied by adequate inservice facilities for teachers. Such inservice should be either school based or locally based involving day release for the teachers concerned. Health Education support teachers should be recruited for this purpose. The concept of self esteem has been established as the cornerstone of SHSE, yet the educational system has done little to bolster the self esteem of teachers in the past. A genuine reduction in class sizes and an improvement to the school environments are
essential elements in improving teachers' self esteem. Many classrooms do not have running water, toilet facilities in many schools leave a lot to be desired and proper hygiene facilities, both for teachers and pupils receive only minimal attention from school authorities\textsuperscript{14}. It is hoped that the Inter Department Working Party on Hygiene in Schools which includes INTO representation will produce a strong statement on the question of hygiene in schools and outline in detail the requirements of each Board of Management in the areas of school cleanliness and standards of hygiene.

There are health implications for teachers in the context of the health promoting school. High stress levels among teachers arise from various aspects of their conditions of work. Foremost among these are increased workload, large classes, a decrease in pupil motivation and behaviour, the lack of provision of adequate resources, insufficient opportunities for career development and inservice training\textsuperscript{15}. These are issues which must also be addressed when considering the question of the health promoting school.

3.5 Resources

The environment of the school must be exemplary if SHSE is to be successful. The Western Health Board Survey on the Standards of Hygiene in Primary Schools (1990) gives cause for the gravest concern\textsuperscript{16}. It is an appalling hypocrisy to promote grandiose schemes of SHSE while school environments continue to remain below the standards advocated in such programmes. The Education Committee recommends that SHSE should not be contemplated in schools unless the school environments are of sufficient standards to positively support such programmes.

The Committee also recommends that adequate teaching materials and technical resources should be made available for SHSE. This will include utilising the expertise of outside agencies but any input from such agencies should be in the context of agreed programmes and at the instigation of the NCCA or of the schools concerned. This would also include the provision of suitable accommodation and equipment for Physical Education and adequate changing and washing facilities. It is ironic that at a time when proposals are being made to increase the time allocated to Physical Education, the building section of the Department of Education is effectively reducing the number of general purpose rooms in schools. Increasingly, schools in Ireland are being forced to use their general purpose rooms for classroom purposes because the Department of Education refuses to provide the necessary resources to adequately grant aid the current school building programme. Primary education is underfunded to such an extent that areas like Physical Education and Health Education are being neglected due to a serious lack of
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resources. The vast majority of rural schools are small two, three of four teacher schools which have little amenities to undertake Physical Education programmes. All schools are dependent on outside agencies to provide the necessary resources to promote Health Education in Schools. For Health Education programmes to be successful at primary level, a major initiative must be undertaken by the Government to fund primary education. The funding of primary schools must be the Organisation's persistent demand during the forthcoming decade. If there is to be a commitment to healthier living, it must be reflected in the front line of SHSE - the primary school.

3.6 CONCLUSION

The issues raised in this paper relate not only to the teaching of SHSE and its place in the primary school curriculum, but also to the place of SHSE in a rapidly changing and increasingly health orientated society. It is impossible to come to legitimate conclusions by focussing merely within the schools. It is necessary, therefore, to examine and consider the wider context before embarking upon a major Health Education promotion at primary level.

Questions that need to be addressed in the broader context include:-

(a) What is the status of positive health in the Irish health system and the implications for positive health in a wider European context?

(b) What are the relative positions of the State, the Churches, the professional bodies, parental, community and sectional interests with regard to positive health?

(c) What are the relative positions of the various Government Departments in relation to this issue?

(d) What is the status of SHSE within the overall framework for the promotion of positive health?

(e) Will the resources to support positive health and, implicitly, SHSE be made available? If not, what are the consequences for Health Education?

(f) What are the implications for the whole of the education service of the considerations arising from the above questions?

Within the primary education system, questions which need to be considered include:
Who should devise a programme in SHSE for primary schools? What role should the NCCA adopt? Where do the Health Board's current initiatives fit into any new Health Education programme?

What input should the state, the churches, the teaching and other professional bodies, parental, community and sectional interests have in shaping an SHSE curriculum?

What status should SHSE be given within the primary school curriculum?

What approach should be adopted towards the implementation of a SHSE programme, in the context of a timetabled core subject, a timetabled semi-core, semi cross-curricular subject or a cross curricular subject within the current timetabling of curriculum?

What are the methodological and pedagogical implications involved in a SHSE programme to promote positive health?

What resources are necessary for the implementation of a SHSE programme in primary schools? Are all the agencies willing to invite contributions towards an overall programme of Health Education?

What issues arise for teachers, both from a professional and personal perspective from the development of a SHSE programme for the primary school?

What issues arise for the INTO from the considerations arising from all the questions.

These are some of the issues which need to be debated in order to determine the Organisation's position in relation to recent and future developments in Health Education. In all the emphasis on new curriculum reforms, neither the child nor the classroom teacher should be neglected. Schools cannot always be expected to solve the array of society's ills. Perhaps the time is opportune in the context of proposals to broaden the curriculum to reconsider the nature and function of schooling and more importantly, to give careful consideration to, not alone how young children think and learn, but to the amount of knowledge and skills which society is increasingly asking them to master. Society must also recognise that young children too have limitations regarding the amount of knowledge which they can legitimately be expected to comprehend.
APPENDIX A

RESOLUTIONS TO ANNUAL CONGRESS ON HEALTH RELATED ISSUES

1988 - CHILD ABUSE

Congress calls on the CEC:

(i) to consult with other relevant bodies with a view to drawing up:

  (a) guidelines for the early identification of the victims of child abuse, including sexual abuse;

  (b) procedures for referral of such cases to the relevant professional agencies;

  (c) recommendations for teachers dealing with these children.

(ii) to negotiate with the Department of Education to establish an inservice course on the topic of child abuse;

(iii) to issue guidelines to all primary schools advising on the school's role in the detection and referral of cases on child abuse.

1992 - CHILD ABUSE

Congress welcomes the development of the Child Abuse Prevention Programme in the EHB area and demands that the community care services be adequately resourced so that:-

(a) children who are victims of child abuse receive adequate support, counselling, therapy etc;

(b) the Child Abuse Prevention Programme be established on a nationwide basis with appropriate inservice training for teachers;

(c) all teachers be guaranteed sufficient support and advice from the community care services in this area of child care.

In order to ensure the effective implementation of the above programme,
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Congress demands that the CEC verify that there is no confidentiality for teachers in reporting suspicions of child sex abuse and that they meet with the appropriate bodies to seek to improve the situation in this regard.

1992 - AIDS Education

Congress demands that the Department of Education provide an appropriate AIDS Education Programme.
APPENDIX B

INTO GUIDELINES ON SEX EDUCATION

1. Education is concerned with the personal, social, emotional and moral development of young people as well as their academic attainment. Through the study of Health Education in many areas of the curriculum, children should learn about changes which will occur in their bodies as they grow older. During their school career, as they become more aware of their own sexuality, they require instruction and guidance in coming to terms with physical and emotional changes and how these affect their feelings towards, and relationships with other people.

2. Most parents see the need for their children to have knowledge of, and information about, sexual matters. Some undertake this responsibility in the home; some prefer to share it with the school and other appropriate agencies; others, however, are unable or reluctant to advise their children adequately. As a result, many children's knowledge of sexual matters is acquired in a distorted manner from their peers or other sources. In a society in which sexual conduct is presented openly in the media, children need both the guidance of sympathetic and well informed adults and the opportunity to learn about, discuss and reflect upon sexual development in a secure and understanding environment such as that provided by the family and the school.

3. Sex education should be part of the curriculum of all pupils. It should be imparted in a sensitive manner which is in conformity with the moral and religious principles held by parents and school management authorities. Sex education should take place within a caring moral context, stressing the importance of stable personal relationships, the responsibilities of both sexes in sexual matters, parental responsibilities and family life.

4. The teaching should put a proper emphasis upon what is positive and good in relationships between the sexes, especially in the treatment of those matters about which people have diverse and deeply held views. Schools should not ignore consideration of sexual practices which run counter to the accepted moral standards of society. The teaching and guidance which pupils
receive on such matters should help them to appreciate the value of such standards. In today's world discussion about many diverse aspects of sexuality and sexually transmitted diseases in the media and elsewhere is so common that pupils of all ages are aware of them. All questions about sexuality should be answered truthfully and in a manner suited to the maturity of the child.

5. As part of its overall curriculum plan each school should have a policy on sex education. The policy should set out the aims of sex education in the school and describe the topics to be taught, their sequencing and depth of treatment at each level, and teaching methods and materials to be employed. The policy should be formulated in consultation with the school Board of Management and parents. All teachers, whether or not they are centrally involved in teaching the programme should be aware of its details and their implications. Teachers who do not wish to implement the programme in sex education should be facilitated as far as possible. Every child should have an opportunity to experience the programme. The right of parents to refuse to allow their children to participate in such a programme must be respected, however.

6. Parents should be involved in, and informed about the school's programme on sex education and about its approaches to particularly sensitive issues. For example, in order that parents should know and understand the context in which certain teaching materials are used, they should be given opportunities to examine them and to discuss them with their children at home. What is done in, and by, the school should always reinforce and strengthen positive family relationships and the role of parents.

7. In translating these aims into classroom practice, the school should ensure that teaching is, at all times, appropriate to the maturity of the pupils concerned. As maturity is not always determined by chronological age, teachers have to be alert to the personal and emotional circumstances of the individual pupil. Some aspects of sex education can be taught in classes or groups, but there will be occasions when individual counselling is necessary. Close cooperation will be necessary between teachers and parents to ensure that such counselling is available when required.

8. Any structured and systematic sexual education programme may involve more than one teacher. It will certainly involve more than
one aspect of the curriculum. For example, the moral framework could be established in Religious Education classes, and other aspects of the programme dealt with under such topics as Social and Environmental Studies and Physical Education.

Within an overall programme the biological aspects of sexual behaviour can be presented in a straightforward and factual way. Irrespective of how the programme is taught, it should take account of the individual pupil's emotional and intellectual development. Subject to this limitation it should deal as comprehensively as possible with the ethical, moral and biological implications of the subject.

Sex education in the classroom is primarily a matter for the professional judgement of the staff. Care should, however, be taken in choosing and making use of commercially produced teaching materials, some of which may reflect assumptions and approaches which are not compatible with the policies of the school. In the choice of materials schools may wish to seek advice from the appropriate advisors of the Department of Education, the Health Education Officers of the Health Boards, the Religious Education Advisors of the various Roman Catholic or Protestant churches and other informed and responsible sources including voluntary organisations concerned with specific health related issues.
APPENDIX C

PAEDIATRIC GUIDELINES FOR INFECTION CONTROL OF HUMAN IMMUNODEFICIENCY VIRUS IN SCHOOLS AND NURSERIES.

The Acquired Immunodeficiency Syndrome (AIDS) has been diagnosed in 8 children aged under 13 years as of 30th September 1991. All of these cases have been transmitted from mother to child, ante or perinatally. Risk factors for maternal infection include intravenous drug abuse (6 of the 8 cases) and heterosexual contact (2 cases). An additional seventy children at risk have been identified as HIV positive. As an increasing number of HIV infected children reach school and play school age it is appropriate that guidelines be made available for those who have responsibility for children.

1.1 In formulating guidelines it must be constantly born in mind that HIV is not highly contagious and that transmission ordinarily requires repeated sexual contact or intravenous inoculation. Indeed those responsible for schools and nurseries should be aware that HIV infected children and other immunodeficient children are more at risk from the common infections that they may acquire from other children, such as measles and chicken-pox.

1.2 Because all infected children will not necessarily be known to school officials it is preferable to treat ALL children as potentially carrying infectious communicable by blood or blood contaminated fluids. Such a policy would also reduce the transmission of other more contagious diseases such as Hepatitis B.

1.3 Such policies and procedures should be based on the understanding that, even within an area of high prevalence, the risk of HIV infection resulting from a single exposure to blood from a school aged child or adolescent with unknown serological status is minute.

GUIDELINES FOR INFECTION CONTROL IN SCHOOLS

2.1 HIV infected children who are old enough to attend school can be admitted freely to all activities to the extent that their own health permits.
Lacerations and other bleeding lesions of all children should be managed in a manner that minimizes direct contact of the care giver with blood. Because of the minimal risk the only mandatory precautionary action where skin is exposed is to wash the exposed skin with soap and water. All schools should provide access to gloves so that individuals who wish to further reduce a minute risk may opt for their use. It is recommended that a pack of disposable gloves be kept available with the school first aid kit. Children, teachers and parents should be encouraged to cover cuts with plasters and children with oozing skin lesions should have them covered as recommended by the family doctor and/or paediatrician. (Non-oozing skin rashes such as psoriasis do not need to be covered.)

Under no circumstances should the urgent care of a bleeding child be delayed because gloves are not immediately available. In any case the care giver's hands should be washed promptly after caring for bloody lesions.

Hand washing should also promptly follow the handling of body fluids such as urine, stool, vomitus and oral and nasal secretions. It is important to realise that hand washing after changing nappies or helping young children to use the toilet also prevents the spread of viruses such as cytomegalovirus. There must be adequate handwashing facilities for staff. In nurseries washbasins should be located near to where nappies are changed and there should be proper arrangements for the disposal of used nappies. To avoid exchange of CMV through saliva the exchange of wet kisses or half eaten food should be discouraged.

**Body Fluids for which gloves are recommended:** Blood, Blood contaminated body fluids.

**Body fluids and procedures for which only hand washing is necessary:** Urine, Stool, Vomitus, Tears, Nasal, Secretions, Nappy changing

Soiled surfaces should be cleaned as soon as practical with disinfectants, such as household bleach (a 1 in 10 bleach to water freshly prepared solution). Disposable towels or tissues should be used whenever possible and properly discarded and mops should be rinsed in the disinfectant. Cleaning personnel should avoid the risk of having their mucous membranes or any open skin lesions exposed to blood or blood contaminated body fluids (by using disposable gloves for example).
2.6 Ideally, school staff should be so well informed of proper procedures as regards First Aid etc. that it should not be necessary for a staff to be informed when a child is diagnosed as HIV positive. It is important for such children and for others with an immunodeficient system e.g. leukemia, that illnesses such as measles and chicken pox be notified to all parents when they are in the school. In this way an illness that is potentially a killer for these children may be counter-acted. Where, because of special circumstances, it is necessary or desirable that a staff should be informed, this should be done with the help of a paediatrician so that all questions may be answered.

2.7 If the child's own family doctor is uncertain as to the efficacy or safety of placement within a group or school setting then consultation should be sought with paediatrician with expertise regarding HIV infection.
Health Education includes all those planned or incidental learning opportunities which can be used to develop behaviour which is conducive to good health. Responsible attitudes and the skills necessary to make informed decisions in matters relating to health are the intended outcomes of Health Education in the curriculum. The three main aspects of Health Education relate to:

- personal development;
- social development; and
- the environment

OBJECTIVES

OBJECTIVE 1: HEALTH IN CONTEXT OF PERSONAL DEVELOPMENT

Personal Development

Pupils should develop to their fullest potential. They should develop a positive self image and self confidence. They should understand the stages involved and the factors which govern physical and emotional growth.

Physical Fitness, Recreation and Relaxation

Pupils should achieve and maintain an appropriate level of physical fitness. They should understand the role of recreation and the value of relaxation.

Nutrition

Pupils should be able to make responsible decisions about their diet. They should know and understand the contribution of food to growth, energy and health.

Uses of and Problems Related to Drugs and Other Potentially Harmful Substances

Pupils should develop their knowledge and understanding of the use, misuse,
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risks and effects of drugs and other potentially harmful substances. They should develop a critical awareness of the relevant personal, social and economic implications.

**OBJECTIVE 2: HEALTH IN THE CONTEXT OF SOCIAL DEVELOPMENT**

**Relationships within the Family**

Pupils should be able to make a positive contribution to the life of the family unit, based on their knowledge and understanding of the concept of the family.

**Relationships with Peers**

Pupils should be able to manage relationships with peers in a variety of situations.

**Relationships with Others**

Pupils should understand the nature of relationships with others and, as they mature, be able to establish responsible relationships within a widening community.

**OBJECTIVE 3: HEALTH IN RELATION TO THE ENVIRONMENT**

**Personal Safety in the Environment**

Pupils should be able to cope safely and efficiently with their environment.

**A Healthy Environment**

Pupils should understand what is meant by a healthy environment and their responsibility for maintaining and improving it.

(Source: The Northern Ireland Curriculum, Educational (Cross Curricular) Themes - Objectives for Health Education, Department of Education, Northern Ireland).
APPENDIX E

USEFUL ADDRESSES

HEALTH BOARDS

Eastern Health Board,
1 James Street, Dublin 8
Tel. 01-537951

Midland Health Board,
Arden Road, Tullamore, Co. Offaly
Tel. 0506-21868

Mid Western Health Board,
Catherine Street, Limerick
Tel. 061-316655

North Eastern Health Board,
Navan Road, Kells, Co. Meath
046-40341

North Western Health Board,
Manorhamilton, Co. Leitrim
Tel. 072-55123

South Eastern Health Board
Lacken, Dublin Road, Kilkenny
Tel. 056-21702

Southern Health Board,
Cork Farm Centre, Dennehy Cross, Cork.
Tel. 021-545011

Western Health Board,
Merlin Park Regional Hospital, Galway
Tel. 091-51131
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Health Promotion Unit, Department of Health,
Hawkins House, Dublin 2.
Tel. 01-714711

Health Research Board
73 Lower Baggot Street, Dublin 2.
Tel. 01-761176

Irish Cancer Society,
5 Northumberland Road, Dublin 4.
Tel. 681855

Irish Heart Foundation,
4 Clyde Road, Dublin 4.
Tel. 01-685001

Irish Red Cross Society,
16 Merrion Square, Dublin 2.
Tel. 01-765135

Irish Society for the Prevention of Cruelty to Children,
20 Molesworth Street, Dublin 2.
Tel. 01-679 4944

National Council for Curriculum & Assessment,
Dublin Castle, Dublin 2.
Tel. 01-6796750

National Federation for Community Action on Drugs,
6 Exchequer Street, Dublin 2.
Tel. 01-679 2681

National Food Centre,
Teagasc, Dunsinéin, Castleknock, Dublin 15.
Tel. 01-383222

National Parents' Council - Primary,
Hogan House, Hogan Place, Dublin 2.
Tel. 01-613022

National Safety Council,
4 Northbrook Road, Dublin 6.
Tel. 01-963422
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Northern Ireland Council for Educational Development,
Stranmillis College, Belfast BT9 5DY
Tel. 084-666212

Social and Health Education Association,
Teachers' Centre, Drumcondra, Dublin 9.
Tel. 01-379799

Veritas Company Ltd.,
7 Lower Abbey Street, Dublin 1.
Tel. 788177
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HEALTH EDUCATION IN THE PRIMARY SCHOOL

PART II

INTRODUCTION

The CEC commissioned Ms. Eibhlin O'Sullivan who is currently on secondment as Education Officer to the Mid-Western Health Board to prepare a paper based upon her experience as a member of the Bi Folláin project team. Ms. O'Sullivan's report, which was compiled in conjunction with Mr. Peadar Cremin, lecturer in Social and Environmental Studies in Mary Immaculate College of Education in Limerick, outlines the historical foundations of Health Education, the current concepts of Health Education, approaches to Health Education in the primary school, models of Health Education, the role of parents in the Health Education process, existing curricular provision for Health Education, policy for Health Education and the Bi Folláin programme. The Bi Folláin programme advocates a cross curricular, multidisciplinary approach to the teaching of Health Education. This is in line with the proposals on Health Education outlined in the Report of the Review Body on the Primary Curriculum. Adopting a cross curricular thematic approach raises questions regarding content guidelines and whether Health Education should be treated as a core curriculum area and integrated with other aspects of the curriculum, particularly in History, Geography, Primary Science, Religion, Civics and Social Studies. It also raises the issue of whether Health Education might best be addressed using a cross curricular thematic approach.

Ms. Ann McAteer, who is currently on secondment as Education Officer with the North Western Health Board, was also commissioned to outline her experience of the 'Paisti Sláintíúla' project. The North Western Health Board advocated that a properly structured Health Education programme should form part of the curriculum in each primary school. The project team acknowledges that, because Health Education was dispersed throughout the other curriculum areas, it tends to get less prominence than it deserves. Accordingly, the team recommended that the programme should be implemented by combining formal timetabling under Environmental Studies with an integrated approach through other subjects where appropriate. The approach in the North Western Health Board area appears to differ from the
Bi Folláin programme. The Paistí Sláinteúla also differs from the B’Folláin approach in that the programme was initiated at infant level, whereas the Bi Folláin programme has been designed for senior classes. In view of the different approaches to Health Education which are emerging within Health Board areas, it is important to ascertain the views of two teachers who have experience in preparing Health Education curricula.
SOCIAL & HEALTH EDUCATION

by Peadar Cremin, M.Ed, B.A., NT., Lecturer in Social and Environmental Studies, Education Department, Mary Immaculate College of Education, Limerick and Eibhlin Sullivan, M.Ed., Health Education Officer, Mid-Western Health Board, Limerick

I. INTRODUCTION

This report presents an overview of Social and Health Education in the context of the curriculum of Irish Primary Schools. It documents historical and current trends in health education and argues for increased investment in, and commitment to, the area from both the health and education sectors. The report details the present status of health education in Irish primary schools and concludes that the school's contribution to the health and well-being of the child should stem from a systematic and comprehensive approach, taking cognisance of the varying influences over the child's health and development. The report adopts a definition of health education for the young child which places increasing emphasis on optimum health and fulfilment of life in all its aspects- social, emotional, physical, environmental and spiritual. It emphasises the direct correlation between the aims of education, as outlined in Curaclam na Bunscoile, and the general aims of health and social education. It recommends a holistic approach in the school setting, one which embraces all aspects of the child's development and learning, defying barriers to contain it within one structure or subject area. A cross-curricular, multidisciplinary approach to the teaching of health education is advocated in preference to a single subject approach. The report examines the implications of such an approach for the practising teacher and outlines the need for comprehensive in-service education so as to allow for the effective implementation of a curricular initiative. Further, the report argues for greater recognition of the influence of the school, its ethos and its curriculum, both overt and hidden, on the health career of the child. It calls for each school to formulate its own policy in relation to health education, in consultation with appropriate parties. The report also acknowledges the key role of the teacher as Health Educator, a partner in the continuum of the health education process.
2. **HISTORICAL FOUNDATIONS OF HEALTH EDUCATION**

"Measaim ná fuil aon seod is luachmhaire ná an óige agus an tsláinte." Peig Sayers1.

This quotation highlights the importance of health and youth throughout the decades. It underscores the view that health is a basic need and an essential tool for everyday living. Throughout our history, matters of health and education have been crucial to the lives and culture of the people and the provision of health and education services has always been a dominant concern.

In the mid-nineteenth century, attention was focussed on preventative health services in Ireland. The seeds of health education and health promotion were sown with the recognition of the role of environmental factors in the causation of infectious diseases. This, together with advancements in medical technology, resulted in vast improvements in mortality and life expectancy rates in developed countries. In the last century, a model of health education emerged which focussed on problems of personal hygiene, the spread of infectious diseases, poor and inadequate nutrition and unacceptable standards of housing and living conditions. At school level, presentations of information on these topics were usually accompanied by an inordinate concentration on drill and physical fitness. Although increasingly recognised as obsolete, this older model persists, regularly re-emerging to frustrate efforts at introducing a more holistic and comprehensive approach. Current school health education, broadly based and endeavouring to take into account the total life experience of the individual, aims at fostering knowledge, skills and attitudes to health which are conducive to the attainment of individual, group or community health2.

2.1 Recent Developments in Health Education

Motives for health education and the nature of health services have changed in recent years as increased emphasis has been placed on promoting good health and enhancing the individual's well-being, through proactive intervention. The care crisis has led to the growing perception that curative medicine cannot effectively deal with the contemporary burden of ill-health. In fact, it has been argued that "the organised health care system ... can do little more than serve as a catchment net for victims"3. Health budgets have been restricted and more limited financial resources are available at the curative end of the health spectrum. As a consequence, preventative medicine and
health education are being considered in a new light, offering a cost-efficient focus for health care. Increasingly, health boards are recognising the value of investing in the future health of their communities through programmes of health education. Schools offers a captive audience to whom pertinent health messages can be transmitted, so that appropriate behaviours can be fostered. The fact that virtually the entire young population is obliged to attend for an extended period of compulsory education guarantees the widespread inculcation of the desired messages and behaviours. In the context of the primary school, health education places emphasis on the establishment, early in life, of secure foundations, upon which positive attitudes to health can be built, so that wise decisions regarding health behaviour can be made throughout the life of the individual. This, in the long-term, will lead to the emergence of a healthier adult population and a concomitant reduction of morbidity, premature mortality rates and health care costs.

Health board educational intervention, while occasionally questioned by some educationalists, is in line with the health boards' statutory obligations, charging them with 'making arrangements for the dissemination of information and advice on matters relating to the health and health services' under the Health Act, 1970.

3. Concepts of Health Education

In coming to a definition of 'health education', it is necessary to consider how its constituent elements, 'health' and 'education' are individually defined.

3.1 'Health' and 'Education'

'Health' is an Anglo-Saxon word for 'wholeness' and the definition most frequently adopted today is that formulated 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'. Though this definition is frequently criticised for being idealistic, elusive and all-embracing, it appropriately implies that there are few, if any, aspects of life which are not directly dependant on a good quality of health.

The aims of Curaclam na Bunscoile reflect an acceptable definition of education for the primary school child. These are:

(i) to enable the child to live a full life as a child,
(ii) 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.
Clearly, the definition of education which generated these aims was one which had a concern with the development of the child's potential in both the short and in the long term. There is a remarkable degree of harmony between this view of education and a view of health which states that "...by health I mean, I want to be all that I am capable of becoming".

3.2 Health Education

While 'health education' is the generic term most frequently used, discussions of the area are hampered by the diversity of terminology and the unfortunate reality that individuals may use a common terminology without sharing a definition of the terms in question. Terms such as 'health promotion', 'health instruction', 'health conservation', etc. are regularly used without due recognition of the implications for the perspectives offered by them.

The following definition of health education, is considered appropriate to the Irish context:

Health Education in the primary school aims at providing each child with a foundation for healthy living in all its aspects. It is concerned with the physical, social, mental and spiritual development of the child as an individual and as a member of society in the communal and global sense.

Carefully planned and systematic intervention in the classroom would strive:

1. to establish and maintain a desire for healthy living in the child;
2. to cultivate a sense of responsibility for personal and community health;
3. to develop a capacity for effective social interaction;
4. to promote a sense of identity and positive self-esteem as well as an ability to cope with change in themselves and in their environment;
5. to help 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 made will influence their future health.

We may say that health education is concerned with the collective experiences that are accumulated by the pupil at an early stage in their health careers.
As such, it refers to all those experiences, both formal and informal, which are acquired inside or outside the classroom environment, from which the child derives knowledge, attitudes, values and skills which influence health behaviour. This clearly specifies a distinction between the health education that can take place at a formal level in schools, through curricular interventions, and the informal health education acquired in the home and community or through the 'hidden curriculum' of the school. It is possible to view the outcome as a product of the interaction between the developing personality of the child and these influences. It is important for the school to note that certain influences will be dominant at a specific time. For example, when a child has just started school, it is likely that the main influences on the child's health will stem from the home and school, while at an older age, the influence of peers will play a greater role and the learning experiences planned for the child must take due account of this.

This focus may be contrasted with the narrower concept of health education embodied in Curaclam na Bunscoile, in which it is recommended that teachers formally address the physical health of children during the Corpoideachas class. The limitation of such an approach is that all other aspects of children's health can be given recognition only by chance, in an informal manner, in the course of teaching the core curriculum. Given the aims of health education and its contribution to equipping children with vital skills for living, this must be considered an incomplete and therefore an inadequate approach.

3.3 Health Promotion

Essentially then, health education is directed at the individual with a view to providing the knowledge, skills and attitudes which will encourage a healthy lifestyle. However, a clear distinction can be made between the role of health education and health promotion in attempting to positively influence the decisions individuals make regarding their health. Health promotion happens at a level beyond the individual when a multisectoral collaboration is set up to influence the health status of individuals. Two distinct levels of action may be involved in health promotion; a policy level and a community level. At a policy level, this refers to the focussing of available resources within the health sector as well as the extension of responsibility for promoting health into other government departments such as Education, Agriculture, Environment, Social Welfare, the public authorities and the various other organisations which control or influence many of the basic features of society. At a community level, health promotion entails support of local and individual initiatives for health.

In the context of primary schools, health promotion requires the collaboration
of parents, community groups and health workers in the promotion and enhancement of children's health. Practically, this can be effected in schools by utilizing the skills and competencies of the people working in the school and in its catchment area who can nurture the health promoting actions and ethos of the school.

3.4 The Health Promoting Environment

Certain actions need to be taken by the school in order to successfully implement a health education programme. The selection and use of an appropriate curriculum is but one aspect of the intervention process. In addition, an examination of the school environment, both social and physical, and the degree to which it is conducive to health, needs to be undertaken. The health promoting environment requires a school to possess a clean, safe working area, in which children acquire positive reinforcement from parents, teachers and ancillary school staff, as well as from their peers, in a stress-free atmosphere. Further, it requires a level of consistency between the health messages received by the child in the home and school settings. Similarly, it needs an understanding of, and commitment to, the concept of the spiral curriculum which implies that basic health messages should be introduced, repeated and amplified, as appropriate, at different levels of understanding throughout the course of the child's schooling. Unless the school places a premium on health education and on the various strands of health promotion outlined above, it is unlikely that the aspirational goals of this area will be reached. Williams, in this regard, points out the necessity for the school 'to think through the real implications of this for the way in which the curriculum, both in terms of content and method of teaching, is organised for its pupils'.

4. Approaches to Health Education in the Primary School Curriculum

In reviewing the means by which health education may be implemented in schools, one finds four typical approaches, each of which is considered below.
4.1 The Subject-Centred Approach

Under this approach, health education is taught as a separate, time-tabled subject and little attempt is made to link its content with other aspects of the curriculum. In a survey of primary school teachers' perceptions of health education conducted by the Mid-Western Health Board in 1984, it became apparent that this was an approach most commonly used by teachers, though they expressed strong dissatisfaction with it. It is considered that this approach has little to recommend it since it restricts the scope and direction of health education to a particular subject area, thereby denying the contribution of many other disciplines.

4.2 The Co-ordinator-Centred Approach

Within this approach, a designated member of the school staff takes responsibility for the planning and coordination of health education topics and ensures that they are taught as part of the traditional subject areas. Such an approach may be considered an option for the primary school Health Educator if it is to form part of the Plean Scoile and if all the teaching staff agree to its implementation. The adequate training of teachers and the existence of a comprehensive syllabus for all class levels in the school is a necessary prerequisite for this approach.

4.3 The Specialist Teacher Approach

Within this structure, health education is also a timetabled subject in its own right, though not necessarily for all class levels, in the hands of a specialist health education teacher. At present, no such specialists have been trained and there are strong arguments against the introduction of specialist teachers who do not have the close relationship with children which the generalist teacher develops. The adoption of this approach is hindered by the current lack of particular space in the curriculum for its inclusion, and the burden for teachers of absorbing another subject area into what is frequently termed 'the overloaded curriculum'.

4.4 The Counsellor Approach

Health education in the primary school under this approach would be the responsibility of a health educator with a special health education or appropriate counselling qualification, but who is not necessarily a teacher by background. In the current educational climate, such qualifications are not offered to teachers and the training of such counsellors cannot be facilitated in the absence of particular degree or diploma courses in health education being made available in universities and colleges of education.
These approaches serve to profile options open to Irish primary schools when undertaking work in health education. Each of them was carefully considered when developing the Bi Folláin programme and weaknesses were identified in all four. Instead, an approach which would utilise the skills and competencies of existing teachers was adopted, where a cross-curricular model, spanning all areas of the curriculum would be utilised. In order to be effective, however, this type of an approach requires careful planning on the part of teachers, individually and collectively, so as to ensure that health education maintains the profile in the timetable of schools that its objectives justify. Yet, it can successfully operate when teachers are adequately supported through in-service education to draw up schemes of work which suit their varying circumstances, conditions, priorities and preferences.

5. Models of Health Education

An examination of four established models, or philosophical bases, for health education provides a vehicle for determining the most suitable structure for implementing health education in schools. These structures influence the criteria by which health education curricula may be assessed.

5.1 The Medical Model of Health Education

This model is associated with the alteration of attitudes, habits and practices which are not conducive to health, such as cigarette smoking, alcohol and drug abuse, insufficient exercise, etc. The intervention involved is that of providing information in a variety of forms. This approach has often been likened to a fire brigade service, since it is reactionary in nature, and it is usually provided when a health crisis occurs. Within the primary school structure, this approach manifest itself in the form of lectures and formal presentations given by the class teacher or other appropriate personnel, with a view to influencing the health behaviour of the child through increased knowledge of the facts. It frequently involves outside 'experts' coming to give a 'talk' in the school. The limitations of this approach give grave cause for concern since it is incorrectly assumed that the child will be adequately enlightened through the provision of knowledge and facts and will thereby make informed decisions about their health. Experience demonstrates, however, that a void exists between the acquisition of knowledge and the internalisation of the messages. There is no clear assurance that the information will influence the child's code of health behaviour.
5.2 The Educational Model of Health Education

The educational model views the primary goal of health education as facilitating the individual to make informed decisions and healthy choices by providing them with necessary knowledge, skills and attitudes. In the context of the primary school, this approach involves the provision of educational experiences to children, during which they can actively participate in the learning process. In this regard, the educational approach to health education resembles the child-centred model of learning advocated for the Irish primary school child in Curáclam na Bunscoile. Two issues relating to this model need to be highlighted and addressed by the Health Educator.

(i) can the teacher ensure that the pupil's choices will be informed and enlightened when active pupil participation is involved?

(ii) Is it appropriate that very young children and the intellectually impaired be expected to make rational decisions regarding their health?

Such concerns serve to highlight the need for schools to ensure that health education objectives are clearly stated and achievable, whatever the circumstances of the particular group of children being targeted. Health education curricula must provide a level of flexibility which will allow for individual needs and differences. So too, its content and methodology must ensure that children are guided in their learning by the teacher so that the desired health messages are received and retained.

5.3 The Radical Model of Health Education

This model is based on the underlying philosophy that the root causes of ill-health can be found in the social structures of nations and communities. The implications of this radical approach for school health education are that it is concerned with raising the awareness of the pupil of the social origins of ill-health and persuading them to take action. As such, this raising of critical consciousness may be more the indirect product of increased self-esteem and social training than a particular aim in itself.

5.4 The Self-Empowerment Model of Health Education

This model seeks to facilitate informed decision-making through the medium of personal growth and development, more than through the provision of information. For schools, it involves the enhancement of self-esteem and a truly child-centred approach to education. As such, it requires ideal health promoting conditions in schools. Yet, the reality is that many school
environments are less than ideally suited to such a model and this factor limits its success in the primary school setting.

The Mid-Western Health Board, in its “Bi Folláin” programme, adopts an eclectic model of health education, incorporating the strengths of each of the models outlined, while focusing particularly on the educational model. Active participation of pupils is achieved in the learning process and schools are required to examine their environments both social and physical to ensure that they are conducive to health. Bi Folláin reflects the educational approach to health education by providing the child with carefully planned, sequenced, child-centred, educational activities that are appropriate to children’s stages of readiness, interest and development. It provides teachers with a menu of educational material from which they can select a programme that suits their individual needs and circumstances. It anchors the work firmly in the practical considerations of operating the class and also cultivates a balanced and positive self-image. It places emphasis on the school ethos, which permeates all aspects of the child’s school experience.

We strongly advise that every attempt be made by teachers and curriculum planners to ensure that information-based health education programmes be avoided for the primary school age group.

6. **The Role of Parents in the Health Education Process**

As health education is concerned with the whole life of the child, there are marked advantages in involving parents and the wider community in school health education. Parents and teachers share the common goal of helping young people towards adulthood, whose health is founded on an understanding of themselves and the world in which they live. In order that an effective health education partnership can take place between the parent and the primary school teacher, it is recommended that the following four considerations be taken into account:

(i) consistency of messages and approach should be ensured,

(ii) the content and methodology of the health education curriculum should be clarified for parents,

(iii) information on health services and their uptake should be furnished to parents through the work of health professionals on school medical teams,

(iv) the school may view the involvement of parents as having
important implications for the whole work and ethos of the school, allowing direct access to and easy contact with parents, in a context more conducive to learning than on visits prompted by problems.

Where teachers and parents share a joint responsibility to cultivate an understanding of health issues, this joint responsibility, especially in the context of the very young, is fundamental to successful health education. Health Education depends upon the interplay of influences on the child’s life, to which teachers, parents, caretakers and health professionals make an important contribution, in providing a health-enhancing learning environment. As part of its support for schools and parents, the Bi Folláin programme offers assistance in facilitating parental involvement in Health Education, by providing three parent support courses, on request, in schools viz.

(i) 'Know your Child' course which addresses all aspects of young children’s development through a participatory, ten week programme;

(ii) 'Know Yourself' course which focuses on the individual parent, their health and parenting skills over an eight to ten week period in the school;

(iii) 'Lifewise' which offers parents a comprehensive health and fitness course over a ten week period.

Such courses are coordinated and funded by the Mid Western Health Board, without cost to the school.

7. **Existing Curriculum Provision for Health Education**

In the 1971 Curriculum, we find health education located within Physical Education. The inclusion of this area on the final pages of the Teachers' Handbook, Part 2, is evidence that the model of health education adopted at the time of its compilation was a more limited one than that needed today. In a world of major threats to public health, it is imperative that health education be valued for the contribution it makes to the aims of education, as outlined in *Curaidh na Bunscoile*. The Department of Education, through its involvement in, and ongoing consultation with writers of the Bi Folláin programme, has indicated a readiness to adopt a more holistic approach to health education, and further recognises the need for a new curriculum in the area of health education for the primary school.
Health Education in the Primary School

Arising from the review of the Primary Curriculum undertaken in 1989, certain recommendations on the approach to health education were specified in the ensuing Quinlan Report, viz.

- health education is of sufficient importance to warrant inclusion in the primary school curriculum,

- health education should be treated as a cross-curricular theme,

- aims, objectives and content of health education should be identified,

- the Department of Education should co-ordinate, supervise and monitor all curricular developments in the area,

- parents should be involved,

- content and approaches should be appropriate to the children's stages of development and readiness,

- in-service education for teachers is vital,

- broad consultation is necessary.

The Mid Western Health Board welcomes these recommendations and calls for their implementation. B' Folláin clearly fulfills each of the requirements, incorporating as is advocated, a child centred, integrated model of health education which takes account of the broader education of the child.

The inclusion of a reference to the health promoting school in the introduction to the Green Paper on Education, (1992), is a positive indication of the Department of Education's commitment to fulfilling the recommendations of the Quinlan Report. However, the perception of health education offered is narrow and appears to be based on a medical model of health, as outlined earlier in section 5 of this paper, thereby inhibiting a comprehensive school approach. A broader view of the role of the school in promoting health is required, the rationale for which has been outlined in preceding arguments. We would, therefore recommend

(i) that a holistic approach to the teaching of health education be adopted,

(ii) that teachers implement an approved syllabus which allows
flexibility in planning to meet the individual needs of schools,

(iii) that adequate pre-service and in-service education be made available for teachers,

(iv) that health education work in schools be monitored by the Department of Education Inspectorate,

(v) that due recognition be given to the role of parents in the health education partnership.

8. **Towards a Policy for Health Education**

It is recommended that consideration be given to the following aspects of health education policy:

(i) The aims and objectives of health education are of sufficient importance to warrant inclusion in the curriculum of Primary Schools. Health education should be cross-curricular in nature, taking into account the total life of the child - physical, emotional, spiritual, social, environmental.

(ii) The Quinlan Report's recommendations which offer a positive approach to health education in schools should be implemented. The Mid Western Health Board requests their implementation.

(iii) A comprehensive syllabus in the area of health education is needed which is designed by teachers and which meets the varying needs of schools and pupils of all age levels throughout the country. In addition, parents, Church representatives and health professionals should be consulted.

(iv) While differing in content and level of difficulty, the focus of the primary school health education syllabus should be in harmony with approaches at second level.

(v) Each school should formulate its own policy in health education and this policy should be approved by the school Board of Management.

(vi) The primary school should involve parents in the health education process. Similarly, the school should contribute to the
health education of parents by encouraging appropriate parent support courses.

(vii) Appropriate training programmes, both at pre- and postgraduate levels, should be offered to teachers in Colleges of Education. Appropriate remuneration should be available to teachers who acquire recognised post-graduate qualifications in health education.

(viii) The Department of Education Inspectorate should recognise the importance of health education and, in undertaking assessments of the work of the school, should monitor the provision made for health education, ensuring that it is included in the Plean Scolé.

9. **Bi Follain, a Curriculum Initiative**

Bi Follain is a programme of Social and Health Education for primary schools developed by the Mid-Western Health Board. The project originated in 1984 in response to requests received from principal teachers in the region. They were concerned at the level of anti-social behaviour and other health-related problems that were being manifested in their schools, all of which resulted in a deterioration in the standard of students’ academic attainment. In order to counteract this trend, The Limerick Principals’ Association (Second Level) called for the introduction of programmes of Health and Social Education in both Primary and Post-Primary schools in the region. In response to this request, the Mid-Western Health Board provided financial support for a second-level health education programme, where emphasis was placed on cultivating teachers’ skills for implementing health education programmes. In addition, a primary school programme was initiated and the absence of an appropriate health education curriculum at this level was the immediate focus of attention. A Working Party, comprising Health and Education professionals, was established to examine approaches to the project. In 1984, the Health Board undertook a comprehensive survey of teachers’ attitudes to the area, so as to obtain baseline data on the needs and preferences of teachers in relation to any future intervention. The responses showed that:

(i) teachers considered health education to be a vital, though much neglected part of the curriculum of the primary school. The majority of respondents were not familiar with the health education guidelines in Curraclam na Bunscoile. Those who were defined health education as being related to the physical health of the child;
the curriculum guidelines provided by the Department of Education were seen as inadequate in helping teachers to implement a comprehensive programme of health education. Consequently, the work undertaken by teachers was of an incidental nature and the area was almost always relegated to an insignificant position in the timetable of schools;

there appeared to be little consensus between teachers as to the health-related topics they addressed in schools. Similarly, there was no evidence of consistency of approach, other than an emphasis on the provision of information for pupils;

teachers expressed dissatisfaction with the level of support from parents in the health education process, especially in cases where children presented with marked social and other disadvantages in the school.

This data provided the impetus for all further interventions by the Mid-Western Health Board in primary school health education in the region. As a first step, the working party adopted the aims and objectives of health education for primary schools as outlined earlier in section 3 of this paper. The Department of Education officially nominated a local Inspector to represent its views and concerns throughout the project's development, and this nominee has been involved since the inception of the project in 1984. Similarly, drafts of all Bi Follain materials produced to date have been examined by this representative and by a designated team of Inspectors.

Financial support for the project was provided by the Mid-Western Health Board, with some assistance from the Health Education Bureau, until its demise in 1986. Since then, the Health Promotion Unit of the Department of Health has provided some support for the project's development.

Existing curricula in the area of health were examined by the team, including Irish draft curricula, though none were considered entirely satisfactory or suitable for implementation in the region, given their varying philosophies, content and methodologies. Consequently, the team decided that a new curriculum in health education should be designed which would reflect the needs of teachers, as expressed by respondents in the survey. A primary school teacher was employed by the Health Board, on a contract basis, as Health Education Officer for Primary Schools to develop this curriculum and to co-ordinate the project.

In 1986, a comprehensive survey of parents' attitudes to Health Education
Health Education in the Primary School

was conducted in the region. Parents responded most positively to the proposal that a health education curriculum be formulated for use in their children's schools. They stated that the primary school had a responsibility to educate children for health and that such education should involve parents.

As a result of the findings of the surveys of teachers' and parents' attitudes to Health Education, and the deliberations of the working party and Health Education Officer, the following structure for the Bifollain project evolved:

(i) the project caters for all age ranges of children in the primary school, Junior Infants to Sixth Class;

(ii) project materials are developed for four levels: level 1 caters for Junior and Senior Infant Classes, level 2 caters for First and Second Classes, level 3 caters for Third and Fourth Classes, level 4 caters for Fifth and Sixth Classes;

(iii) each level is provided with a flexible programme of materials, specially designed to cater for the different stages of readiness and motivation of the children at different ages. Each level comprises six units of material, viz,

Unit 1: Nutrition
Unit 2: Hygiene
Unit 3: Safety
Unit 4: Media Education
Unit 5: Personal and Social Development
Unit 6: Environmental Care.

It is recommended that the teacher implement one unit from the programme each term of the school year. Thus, over a two year period, the child will have been exposed to a comprehensive programme of health education in the school;

(iv) an activity-based approach is utilized throughout the programme, where the child is the active participator in the learning process. All health education messages are derived from the child's involvement with the work and the teacher's role is that of guide, ensuring that the required learning outcomes are achieved;

(v) the material in each unit is organised in theme format, each theme constituting a week's work for the teacher. Ten educational, child-centred activities are presented for each theme,
from which the teacher selects the most appropriate items or materials:

(vi) each theme provides specific direction for the teacher in planning, implementing and processing the learning experience for the child. Similarly, the teacher is free to choose the most opportune time during the school day when pupils should implement the activities;

(vii) the cross-curricular approach is used throughout and the project ensures that the teacher is not overburdened with additional work as the themes are incorporated into the day-to-day curriculum of the school;

(viii) home school links are established throughout the programme and parent support courses, specially designed to complement Bi Follain, have been formulated to increase parental involvement.

Bi Follain has been extensively piloted in a representative sample of schools throughout the catchment area of the MidWestern Health Board, with the support of the Department of Education. The piloting, development and continuous evaluation of the work since 1984 has ensured that teachers' interests have been adequately represented throughout, a factor which has resulted in very high levels of satisfaction with Bi Follain among teachers.

In addition, Steering and Consultative Committees were established in the early years of the project's development to oversee its direction and to make recommendations, as appropriate. Members were officially nominated to represent the organisations and associations which had a legitimate interest in the development of the project, among them I.N.T.O. representatives. Meetings are held once per school term throughout each school year and all materials produced to date have been examined and approved by committee members.

Further, the National Council for Curriculum and Assessment has been consulted by way of written submissions and oral presentations. The Council is satisfied that Bi Follain fulfills each of the Quinlan Report recommendations in relation to health education. On-going consultation will be maintained with Council and it is understood that future reviews of the curriculum will involve an examination of health education approaches at primary level.

The Mid-Western Health Board officially launched the Fifth and Sixth class unit of Bi Follain in September, 1992 and it will be disseminated throughout
the region, together with comprehensive in-service training. The Board will maintain all copyright and dissemination rights over the programme. However, because of the extensive piloting of this project, the materials are considered by other Health Boards to have application in their areas also. The Board wishes to express its intention to make the programme available to any other region on request, subject to appropriate levels of support being made available to teachers and schools, and to the fulfilment of certain basic requirements, for example, appropriate in-service training. The remaining three units of material designed for Infants to Fourth classes, will be published at six-monthly intervals after the publication of the initial set of materials.

Teachers can avail of support from the Health Education Officer for Primary Schools and the Health Education Resource Centre of the Mid-Western Health Board, thereafter.

Ní Táinte go sláinte
REFERENCES

1. Peig Sayers, "Peig".


10. Ibid., p.8.

Health Education in the Primary School

THE NORTH WESTERN HEALTH BOARD APPROACH
BY ANNE McATEER

Health Promotion

As with other Health Boards, the North Western Health Board has been actively promoting the positive health of the community over the past two decades, through vaccination programmes for infants, screening and developmental clinics in schools and the use of environmental officers to ensure that the environment is safe and healthy.

However, since it is now widely recognised that much of the ill health that affects people is a result of the way we live and that many of these so-called lifestyle diseases could be prevented by developing healthy habits from the earliest age, the Board decided some years ago to embark on a range of health education and information programmes in schools and in the community.

The development of this policy in relation to Health Education dates from the adoption in 1977 by the World Health Organisation of a programme entitled "Health for all by the year 2000". This programme provided guidelines for the development of health services. Two of its central concerns were:

(1) an emphasis on health promotion and prevention of disease, since many of the illnesses that people develop later in life, and which require treatment by our health services, are the result of decisions made earlier, often during the years when people attend primary and second level schools.

(ii) the need for multisectoral cooperation between the health services and other bodies, such as schools, to work towards developing healthy life styles.

The Health Education Programme in Second Level Schools

In 1979, in line with the objectives set out in the WHO programme, the NWHB set up a working party to investigate "the development and implementation of a Health Education programme within second level schools in the region". Following the adoption of the working party report, a project team was established to develop a syllabus and implement a teacher training programme, which could be taken on by all schools in the Board area. It was decided that 'lifeskills teaching' was the most appropriate approach to Health
Education in schools in the North West. A five year programme was developed in 1981 to introduce the programme to all schools on a phased basis, and through all classes within these schools. Curriculum materials have been developed for teachers and students.

**THE WORKING PARTY REPORT FOR PRIMARY SCHOOLS**

As the programme for second level schools developed, it became apparent that intervention to encourage healthy living was needed much earlier when habits are formed by the child. In response to this and as a result of frequent requests from primary teachers a working party was set up by the Chief Executive Officer, Mr. Donal O'Shea on the development and implementation of a Health Education programme within primary schools.

The working party which consisted of parents' representatives, teachers, school principals, an INTO representative, a Department of Education inspector and psychologist, a diocesan adviser and Health Board staff met between January and June 1989. They considered the rationale, aims and content of a Health Education Programme in primary schools and conducted surveys of parents and teachers.

The working party acknowledged the work already being done by teachers. In almost all schools some Health Education was being done informally. The new programme was not to supersede the work already taking place but to complement it.

**AN APPROACH TO HEALTH EDUCATION IN THE PRIMARY SCHOOL**

The working party emphasised the approach in Curaclam na Bunscóilé that a positive attitude to good health and the harmonious development of personal and physical resources are a central part of the aims set out for primary education "to enable the child to live a full life as a child and to equip him/her to avail himself of further education so that s/he may go on to live a full and useful life as an adult in society".

The report recommended that a properly structured Health Education programme should be part of the curriculum in each primary school. The aim of this programme should be to enable primary school pupils to take more responsibility for their health, through developing their own self awareness and through developing the personal skills they need to make good health decisions. The programme should include teaching about self-esteem, relationships, food and nutrition, personal hygiene, leisure, drugs, the environment, safety and growth and development appropriate to the age and
stage of development of the pupils.

In the current primary school curriculum, Health Education is included formally as a sub-section of Physical Education. The Teachers' Handbook also states that it should be integrated with all sections of the curriculum. Many elements are to be found in the curricular areas entitled Environmental Studies and Civics. It does not appear in the table of contents. Therefore, it tends to get less prominence than it should. The working party recommended that the programme should be implemented by combining formal timetabling under Environmental Studies with an integrated approach through other subjects where appropriate, and should be incorporated in the school plan. This is in line with the thinking of the Report of the Review Body on the Primary Curriculum.

THE NORTH WESTERN HEALTH BOARD PROGRAMME

The North Western Health Board's Health Education programme is designed to be taught in all classes in the primary school across the curriculum in a developmental fashion. Children's attitudes to health and healthy living evolve continuously as they grow. The programme allows for timely interventions by the teacher during the process of attitude formation at each stage of the child's development.

The normal curricular principles apply to the programme; it is a child centred, activity based and can be easily integrated with other areas of the curriculum. The teachers' books provide a comprehensive and structured programme of activities designed to provide the children with planned experiences on matters concerning their present and future health. The programme allows for freedom on the part of the teacher to select or omit activities in drawing up an individual programme of work to meet both the needs of the pupils and the teacher in their given situation.

A major aim of any Health Education programme is to enable children to make informed choices or decisions related to their health. This entails increasing the child's factual knowledge and promoting healthy beliefs and values. However, the transmission of knowledge is not enough. Health Education must also involve children in the decision making process. Various activities in the teachers' books call upon the children to make choices in a productive way, using what they have learned. The strategies suggested emphasise personal involvement, participation and responsibility. This approach facilitates the children in making what they have learned relevant and meaningful in their 'real' lives. Learning to listen, discuss, ask, give answers, explain reasons for an answer given and learning to follow simple
task directions are essential elements of the programme. The emphasis is placed on the process of 'doing' rather than on the standard of the product of a given activity.

**TEACHING MATERIALS**

To date curriculum materials have been developed for the first three levels in the primary school:

'First Steps' a programme for use in Infants Classes  
'Up and Away' a programme for use in First and Second Classes  
'Out and About' a programme for use in Third and Fourth Classes.

The materials for the Fifth and Sixth Class programme are currently being compiled and will be ready for the inservice course in July 1993. Each level is divided into three major themes:

**Theme 1:** "Taking Care of Myself" focuses on health issues related to the pupil - personal hygiene, nutrition, safety, growth and development and drugs/medicines.

**Theme 2:** "Myself and Others" enhances the self esteem of pupils and heightens their awareness of their network of people. It also provides a range of activities to teach the pupils about the needs of others.

**Theme 3:** "Me and My World" focuses the child's attention on his/her responsibility in caring for the surrounding environment and on the importance of maximising discretionary or leisure time in the interests of good health.

In all, there are nine key areas under the three themes and these are revisited from infants to 6th class, providing opportunities for the children to develop and expand upon ideas and concepts learned earlier. The teachers' books contain a choice of activities for each of the key areas and the book indicates what area of the curriculum the activity would suit.

Each teachers' book is accompanied by two workbooks. These are designed to reinforce the lessons contained in the activities outlined in the teachers' manual. With the many cartoon characters and puzzle type assignments they add a fun dimension to the lesson. The workbooks also contain "home link" assignments which are designed for use in the home with parents.
Implementing the Programme

A primary teacher was seconded by the Health Board in September 1989 to work full time on developing a syllabus and materials for the Health Education programme and to plan its introduction to primary schools in the north west.

In recognition of the pivotal role of the principal he/she is the first point of contact for the Health Board when recruiting a new school to the programme. An initial visit is carried out by a member of the Health Education team to inform the principal about the programme and to provide an inspection copy of the materials. A second visit is then organised to meet with the school staff. After this has been carried out the principal, in consultation with the staff, decides whether the school will introduce the programme.

The working party recommended that the various groups concerned with the management of schools should also be informed as fully as possible about the programme. The principal is requested to inform the Board of Management of the forthcoming programme. The Health Board have also provided information for the Patrons of schools in the region. The Department of Education is kept informed about the programme by liaising with local school inspectors who have been very supportive of the programme. Their interest has given status to the programme and has done much to promote its success.

As the materials were developed an Advisory Group was established to advise the project team on the design and suitability of materials and recruiting procedures. The group consists of a divisional and local inspector, a diocesan adviser, an area medical officer. They meet with the project team once per term during the school year. All materials produced have been examined and approved by the Advisory Group.

Materials have also been forwarded to the INTO for inspection. The working party recognised the importance of creating an awareness at every level of the organisation of the place of Health Education in the primary school curriculum and recommended that support be sought for the programme at local and district meetings.

Training

Once a school has made the decision to introduce the programme the teachers are invited to attend one of the training sessions organised by the Board. This takes the form of a five day course at the beginning of the school
holidays or five evening sessions during the first term of the school.

The inservice training courses seek to motivate teachers and make them more confident in undertaking the programme. The courses examine the rationale and aims of the programme, its contents and provide an opportunity for planning. They are conducted by staff from the Board’s Health Education Officer and other Board staff working in areas of mutual interest such as speech therapy, psychology and social work also participate. As a direct result of this, the relationship between the various sectors of the Health Board and schools has been greatly improved. The working party recommended that separate training should be made available for principals. Regular meetings are held between principals and the project team to update them on the progress of the programme.

Other training sessions have been organised at the request of teachers. These have included seminars on First Aid, Behavioural Problems, Coping with Epilepsy, Diabetes and Asthma in the classroom and Bullying.

A continuing relationship with teachers is maintained through ‘cluster group’ meetings in each local area. At these meetings teachers can exchange views and relate their experiences of the programme. In the light of teachers’ observations the draft curriculum materials have already been revised and improved.

**THE ROLE OF PARENTS**

Health Education is not the sole responsibility of schools. It is shared with others, in particular parents - the primary educators of children. It is essential that parents be consulted about the appropriateness of any programme of Health Education to be taught in school. Home experiences have a crucial influence on children’s health related behaviour. Therefore, promoting good home school relationships is emphasised in the North West Programme.

When drawing up the programme initially, the expectations of parents were taken into account. In a survey of 160 parents in the region, the working party found that over 90% were extremely positive about the development of a Health Education programme in schools. The parents expected that schools should complement the work of the home in protecting and enhancing the health of their children. The report outlined the requirements of parents in relation to the programme as follows:

(a) To know of the existence of the programme in schools;
(b) To be aware of the rationale behind the programme;
(c) To be aware of the content of the programme and how it is taught;
(d) To be in a position to reinforce, at home, the work being done in schools.

The working party recommended that parents should be fully informed about the programme in schools and be encouraged to continue at home the work undertaken in school. A special leaflet has been produced outlining details of the programme and the anticipated role of parents. At present, many schools use this to provide initial information for parents when first introducing the programme. Schools have also availed of the opportunity to have a number of the Board's Health Education team address parents' meetings. This also provides parents with the opportunity to raise and discuss issues of particular interest. A seminar on bullying has been organised for parents and it is the Board's intention to provide other courses.

The children's workbooks also contain a number of pages designated 'home links'. These are designed for completion at home, and contain a short note for parents on the underlying theme. Parental participation is thus maximised in teaching Health Education and the work of the school is reinforced at home. The participation, active support and interest of parents in the implementation of a programme has been a major asset.

**CONCLUSION**

In 1990 fifteen schools were invited to pilot the infant programme. Fifty teachers attended in-service courses in Letterkenny and Sligo. Last year, a further thirty five schools were recruited and ninety teachers attended in-service courses. In 1992, many schools, having heard about the programme through the 'grapevine', requested to be participants in the project. Sixty new schools were recruited. Due to pressure of numbers, an extra two in-service sessions were organised in two new centres - Donegal and Carrick-on-Shannon. Over 240 teachers attended the courses.

Teachers have expressed themselves well satisfied with the courses. Some of the comments from the evaluation sheets include: "thorough and informative", "stimulating and practical", "educationally refreshing", "very valuable" 'a major step in education". The feedback from schools has been very positive. Both teachers and children are enthusiastic about the programme. One school principal noted: "I feel the programme has brought something new, fresh and challenging to the school. I hope the enthusiasm of the teachers piloting the programme will be contagious. If all children experiencing the programme
develop a good sense of self esteem and self respect through good happy relationships, choices and the standard of hygiene recommended in the programme, isn't it all worthwhile?

REFERENCES


2. North Western Health Board, (1992), Products, Donegal, North Western Health Board.