Education and Training Inspectorate

Report of a Survey of

Health Education in Post-Primary Schools in Northern Ireland

NOVEMBER 2002

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The Education and Training Inspectorate - Promoting Improvement

Providing Inspection Services for:

Department of Education
Department for Employment and Learning
Department of Culture, Arts and Leisure

INVESTOR IN PEOPLE

Education and Training Inspectorate

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Contents

1. INTRODUCTION

1.1 The report summarises the findings of a survey of health education in a sample of post-primary schools in Northern Ireland (NI). The survey was undertaken by the Education and Training Inspectorate (Inspectorate) during October and November 2002. The objectives of the survey were to:

- evaluate the quality of provision for health education in the post-primary phase;
- evaluate the contribution of external agencies to the support of school-based health education programmes;
- provide exemplars of good practice in health education.

1.2 Health education has been an educational theme in the Northern Ireland Curriculum (NIC) since its inception in 1992. (Department of Education (DE) circular 1992/20). The theme aims to:

- enable pupils to achieve their physical, psychological and social potential and to improve their self esteem;
- promote positive attitudes towards health;
- provide a sense of responsibility in respect of individual, family and community health;
- provide a knowledge-base and enable pupils to acquire an understanding of this knowledge and the skills to interpret it.

1.3 Many statements have been made about the importance of health education to young people and the impact that unhealthy lifestyles have on young people in particular and on society in general. Interdepartmental groups, representing a range of government departments, have been established over the years to consider how health education might be provided, with a particular focus on how aspects such as the misuse of drugs and alcohol can best be tackled.

1.4 The last major survey conducted in Northern Ireland post-primary schools on a health-related issue was the Inspectorate's survey of drug education in 1996-98. The findings of this survey identified a number of issues for action including the need for schools to:

- ensure that drug education forms part of the school's programme of health education;
- ensure that the drug education policy appears in the prospectus;
- ensure that there are clear procedures for handling drug-related incidents;
- co-ordinate drug education and prevention programmes across all subject departments;
- provide a co-ordinated system of pastoral care, with the involvement of relevant external support agencies, for all pupils;
- develop approaches to drug education which increase pupils' awareness of drugs and their effects, and enhance their ability to cope with pressures to experiment with, or to use, illegal substances.

1.5 Although the '96-'98 drug education survey provided useful data, the focus was specifically on drugs rather than on the broader aspects of health education. The report, however, identified issues and raised questions concerning the quality of more general aspects of health education in schools; for example, smoking, relationships and sexuality education (RSE), personal development including physical fitness, healthy eating and personal safety in the environment.

1.6 The current survey was conducted at a time of a major review of all aspects of the curriculum in schools in NI. A key element of this curriculum review concerns the study of personal, social and health education (PSHE) in which it is proposed to integrate the educational theme of health education with a more formal approach to the teaching of pastoral issues. This report and the survey findings establish a baseline for future work by the Inspectorate in the context of the implementation of the revised curriculum arrangements.

1.7 The findings of the survey are based on evidence from visits by the Inspectorate to a sample of 24 post-primary schools (see Appendix). The sample schools were representative of the various management types in NI. (Table 1)

Table 1: The Management Types of the Schools Visited In the Survey

Management Type	Number of Schools
Maintained Secondary	6
Controlled Secondary	6
Grammar	8
Integrated Secondary	3
Irish Medium	1

1.8 During the visits, inspectors observed 90 lessons across key stage (KS) 3 and KS4. Discussions were held with principals, members of the senior management team, health education co-ordinators, teachers and pupils. In total, approximately 160 members of the school staff and over 300 pupils were interviewed.

1.9 Prior to the inspection, the senior managers of all post-primary schools in NI were invited to complete a brief questionnaire in order to provide the Inspectorate with important background information and an overview of health education in schools throughout NI. A high return rate of 63% was recorded; the Inspectorate appreciates the helpful contribution made by these schools to the database on which the survey could draw.

1.10 A number of quantitative terms are used in the report when commenting on aspects of the provision for health education. These terms should be interpreted as follows:

More than 90% - almost/nearly all
75%-90% - most
50%-74% - a majority
30%-49% - a significant minority
10%-29% - a minority
Less than 10% - very few/a small number.

1.11 In assessing the various features of the provision for health education in schools, the inspectors related their judgements to four performance levels which may be interpreted as follows:

Grade		
1	Significant strengths	good (ranging to outstanding)
2	Strengths outweigh weaknesses	satisfactory (ranging to good)
3	Weaknesses outweigh strengths	fair (ranging to satisfactory)
4	Significant weaknesses	poor

2. SUMMARY OF MAIN FINDINGS

2.1 Whole-school planning for health education is satisfactory - with approximately one-third of the planning demonstrating significant strengths. Most planning is generally good at ensuring that the content of the main strands of health education is covered.

2.2 Where personal and social education (PSE) is the main curricular area through which health education is taught, the planning supports continuity and progression of the content; in the best practice, the subject co-ordinator also ensures that an appropriate range of teaching strategies is identified clearly in the planning.

2.3 Where health education is taught mainly in a cross-curricular manner, the quality of the planning is more uneven; the role of the co-ordinator becomes more important in this case in ensuring that there is a coherent, consistent and progressive approach to the planning for, and teaching of, health education.

2.4 Most schools make extensive use of a range of external agencies to support their work. The quality of the contribution that these agencies make to the breadth of the health education programme and the range of the pupils' learning experiences is generally good; the effective integration of their contribution into the school's total programme is uneven.

2.5 The quality of the planning at departmental level and by individual teachers varies. Where health education has been given a high profile in the school, and the co-ordinator and senior management team (SMT) are active in promoting health education issues, there is greater awareness among teachers and departmental heads of the importance of sound planning for health education, both for the content and the teaching strategies that are required to develop the pupils' skills. This combined focus in planning was evident only in a minority of schools.

2.6 Schools that have been involved in the Health Promoting Schools Project* or have entered for other external award schemes plan more effectively for health education. In these schools there is a greater awareness of the importance of the teaching strategies that are most effective in relation to health education topics.

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* A project in 1996/97 organised as part of The European Network of Health Promoting Schools project and co-ordinated by the Health Promotion Agency for Northern Ireland with the co-operation, and participation, of the Department of Education, the Department of Health and Social Security, the Education and Library Boards, the Council for Catholic Maintained Schools (CCMS) and the Council for the Curriculum, Examinations and Assessment (CCEA). All post-primary schools in NI were invited to take part, 39 applications were received of which 13 were accepted.

2.7 Almost all lessons observed during the survey visits displayed either significant strengths or the strengths outweighed the weaknesses.

2.8 In most lessons, the quality of the relationships was very good and was based on mutual respect. The teachers did not patronise the pupils or dominate the discussion; they generally allowed pupils to explore their own, and one another's, values and insights.

2.9 The best teaching of health education topics was generally observed within PSE lessons. In these lessons, a good range of teaching and learning strategies was employed. These strategies usually involved many active learning approaches which, the pupils report, they found helpful to their learning in this area of the curriculum. The teachers report that this is due partly to the availability of good quality resources for teaching and learning including the supporting guidance that accompanies these materials. The teachers also report that they are more likely to follow the suggested strategies in PSE than they would in their own specialist subjects; they are more reliant on the PSE resources and guidance materials as they do not see themselves as experts in this area of the curriculum. In addition, they report that they do not have to work within the constraints of an examination syllabus which often leaves them with insufficient time in their own subject specialisms to follow up interesting issues that may arise during class discussion.

2.10 The standards of health education achieved by the pupils in PSE lessons, and in work associated with health education within other curricular areas, were generally good.

2.11 The small minority of lessons which were less successful tended to be poorly planned and managed. The teacher often dominated the lesson allowing the pupils few opportunities to explore their own understanding of the issues and to discuss their feelings with others in the class. The quality of the written resources used to support teaching and learning, and the pupils' written records kept in these classes, was often poor; in many instances, the level of recording was confined to the completion of poor quality worksheet materials. Insufficient time was given at the end of the lesson to consolidate and reinforce the key learning objectives.

2.12 Assessment in health education is underdeveloped in a majority of schools. A small minority of schools have introduced a dimension of pupil self-assessment and target setting within PSE classes which includes many elements of health education, for example, pupils maintaining a healthy lifestyle by taking more exercise and/or taking more care with their diet.

2.13 One school visited has undertaken a more formal approach to the assessment of the pupils' knowledge and understanding of health education issues as part of a wider assessment of the development of their self-awareness skills.

2.14 In general, the opportunities for assessing the key skills within health education have not been developed adequately.

2.15 In many schools, the formal health education programme is supplemented by an extra-curricular programme which provides the pupils with opportunities to extend their work in specific aspects of health education.

2.16 The programmes provided for drug and alcohol education are generally good. Further work is required on the development and teaching of programmes that deal with the mental health and well-being of young people and RSE.

2.17 One-sixth of the schools visited expressed concerns about the quality of food provided in the school canteens; they felt that this often undermined the work they were doing to develop the pupils' healthy eating habits. The provision of school tuck shops and vending machines which dispense sweets and sugar-based drinks often countered the healthy lifestyle ethos that the schools stated they aimed to promote.

2.18 Most schools have arrangements to keep parents informed about the health education programme, particularly when outside agencies have been invited to contribute to the provision.

2.19 Various systems to manage health education have evolved in schools over the years since the introduction of the cross-curricular theme in 1992. Most schools visited in the survey have appointed a health education co-ordinator who reports directly to the co-ordinator of PSE. It is the co-ordinator of PSE who is generally the senior member of the partnership. This management system is most effective where the lines of communication are clear and where both of these key post holders are clear about their roles and responsibilities. In a significant minority of cases observed during the survey, however, these roles and responsibilities were not defined clearly enough; consequently there were aspects of the health education programme which were not co-ordinated effectively.

2.20 At KS3 in most schools, health education is taught mainly through PSE, with some aspects being covered or reinforced through other subjects in the curriculum, mainly science, home economics, religious education (RE) and physical education (PE). A significant minority of schools has reduced the time allocated to PSE in KS4 or has re-allocated most of the time to the study of other areas such as careers. The expectation in these schools is that health education will be taught within the limited time allocated for PSE and the other curriculum areas. Many schools supplement this cross-curricular provision with programmes provided by external agencies.

2.21 In a small minority of schools, the co-ordinators were effective in monitoring the standards achieved by the pupils in health education topics. They also ensured that the pupils' learning experiences were consistent from one class to another. In most schools, however, there is a need for the development of appropriate strategies for monitoring and evaluating the pupils' experiences in health education.

2.22 A minority of schools monitor and evaluate the quality of the contributions made to the health education programme by external agencies. These review processes need to ensure, more securely than they do currently, that the contributions made by these agencies meet the aims and objectives of the school's health education programme, and that the content is taught in a manner which is consistent with the ethos of the school.

2.23 Just under half of the schools visited had conducted an audit of the health education programme. This process was useful in determining the extent to which the content of the health education theme was being covered and in identifying areas which required further development. In the main, however, these audits focused only on the content of the programme and did not focus sufficiently on the development of the appropriate skills and values in relation to health education issues.

2.24 Staff development was identified as being an area for improvement in the majority of schools visited. Around one-third of schools visited had allocated little or no time to in-service training (INSET) on health related issues in recent years.

2.25 The teachers identified the need for additional INSET in RSE and on issues associated with the mental health and well-being of young people. They felt more secure in teaching aspects of drug and alcohol education. In all aspects of health education, however, the teachers felt that the focus of the INSET should be less on the content and more on the teaching strategies that promote and help the pupils to develop appropriate values based on a sound knowledge and understanding of the key health issues that are relevant to them. The findings of this survey endorse these views.

2.26 In a small minority of schools visited, there was a good emphasis on the induction of newly qualified teachers into the health education and PSE programmes. In some of these instances, the newly qualified teachers were not given responsibility for the teaching of the programme but were able to shadow more experienced colleagues for a year. This induction process was important in allowing new teachers to develop the appropriate relationships with the pupils as well as their own teaching strategies. This good practice needs to be disseminated more widely.

3. PLANNING FOR LEARNING IN HEALTH EDUCATION

3.1 The quality of planning for health education in the schools visited in the survey was generally satisfactory, with just over one-third of schools demonstrating significant strengths in this area. In a small minority of instances, there were a number of weaknesses in the overall quality of the planning which outweighed the strengths.

3.2 Whole-school planning for health education generally identifies the content to be covered with each year group. This method of planning helps to ensure that all the relevant topics are covered at the appropriate stage. The planning, however, often provides inadequate information on the appropriate teaching strategies to be used in health education lessons.

3.3 The quality of the planning for health education at departmental level is more variable than the whole-school planning. In the best practice, departments have identified clearly the cross-curricular links for the main educational themes, including health education. This co-ordination is often facilitated by the work of SMT which highlights the importance of ensuring a coherent approach to the educational themes by conducting regular reviews of the departmental planning. These reviews help to ensure that unnecessary overlaps are avoided and provide opportunities for the heads of departments to meet to discuss where, when and how the theme of health education is being covered in their individual subjects. For example, in one school, when sexual reproduction is being taught in science the topic is also covered from the moral and ethical viewpoint in RE and PSE. In another school, the issue of the unborn child's right to life was covered in RE and also as a topic for writing within English. In the main, there is a need for the whole-school planning to be developed further to ensure that teachers are provided with adequate support in the development of their own more specific planning.

3.4 A minority of teachers' individual planning is particularly detailed in highlighting clear teaching and learning objectives specifically in relation to the HE aspects of the topic they are teaching. For example, in one non-selective girls' school, a teacher of physics not only had completed this planning for a science topic but had also identified an appropriate range of teaching strategies that he would use in order to achieve these objectives. This good practice is not widespread.

4. TEACHING AND LEARNING IN HEALTH EDUCATION LESSONS

4.1 All of the 90 lessons observed during the survey were satisfactory; just under half displayed significant strengths. In many schools, the teachers put a great deal of effort into their health education lessons. The standard achieved by the pupils ranged from good to very good. In only a small minority of instances did the weaknesses in the lessons outweigh the strengths.

4.2 In many schools, the classroom and corridor walls were used effectively to display examples of the pupils' work relating to health education. Written and photographic records of the pupils' achievements were displayed and, in a small number of instances, opportunities were presented for the pupils to record issues that they wished to cover in their health education programme. In one instance for example, in an all girls' school, the older pupils had been allocated a notice board where they could display materials and relevant information on issues that they felt to be particularly important to them. At the time of the visit this notice board displayed information relating to osteoporosis, breast cancer and breast-feeding.

4.3 A central aim identified by many schools is the development of the pupils' self-esteem. The survey found evidence that, in some schools, this was promoted actively through health education. In the best practice, schools are aware of the need to cater for the physical, social and emotional needs of the pupils. In most schools, the ethos established not only makes the pupils feel valued but also creates an environment where they feel secure enough to discuss important aspects of health education such as drugs and RSE issues. Most schools state that this environment is created most effectively through the pastoral system and, in particular, the relationships that are developed between the pupils and their form teachers. The SMT in these schools emphasises the importance of developing good relationships between the pupils and their form teachers, and in promoting a climate within form classes that develops the pupils' self-esteem.

4.4 In all of the lessons observed, the quality of the relationships between the teacher and the pupils, and amongst the pupils themselves, was good. The pupils felt secure and confident enough to discuss complex issues in the knowledge that their views would be respected. In many instances, the form teacher also has the responsibility for the teaching of much of the PSE programme. Schools often arrange for form teachers to stay with the same set of pupils as they move up the school; this continuity allows the relationships between the teacher and the pupils to develop over a longer period of time. More recently,

a small number of schools have appointed a core team of specialist teachers of PSE. The pupils are timetabled with these teachers for PSE as they would be in any other subject. The advantages in this approach are that the teachers are likely to be more comfortable with the subject content and the range of strategies best suited to the teaching of this content and, as a result, the pupils receive a more consistent range of learning experiences than would be likely were a larger team of teachers to be involved.

4.5 In many lessons observed, a good range of teaching strategies was used including open-ended discussion, paired and group work, role-play and drama, as well as more extended written work, poetry writing and debates. In the main, the quality of the pupils' responses in these lessons was very good. In one lesson with a year 9 class, for example, which dealt with the setting of personal targets, the pupils were encouraged to participate through the effective use of good quality teaching resources. The good range of learning activities effectively maintained the pace of the lesson. The teacher's sympathetic interventions skilfully engaged all of the pupils and ensured that the learning objectives of the lesson, which had been set out for the class at the outset, were achieved. Good questioning techniques were used to maintain the concentration of individual pupils and to assess the extent to which the lesson objectives were being achieved. The written tasks were matched appropriately to the pupils' ability and the quality of their written and oral responses was good. In another well-structured and carefully managed lesson with a KS4 class, the pupils worked purposefully, and confidently, in groups to discuss reasons for teenagers starting to consume alcoholic drinks. Each group had an opportunity to present their responses to the remainder of the class before working together in their groups to design a leaflet to warn teenagers of the dangers of alcohol. The quality of the pupils' responses in this lesson was very good.

4.6 Information and communication technology (ICT) was used in a small number of lessons. In one lesson observed during the survey, year 11 pupils had developed a web page on the topic of pollution. The pupils gave presentations using their web pages and responded to questions from their peers and their teacher. They discussed the key environmental health issues and governmental responses, and were well-informed, responsive and confident. The quality of the web pages was very good and the pages have subsequently been placed on the school's web-site. This good practice needs to be disseminated more widely.

4.7 In a significant number of lessons, the pupils were not involved actively in their own learning. In these lessons, the pupils were more likely to work independently using worksheet materials which required little thought or reflection to complete, or which were completed as a whole-class exercise. In a minority of instances, the lessons were conducted in a very formal atmosphere where the teacher controlled too tightly the discussion. In other examples, poor time management resulted in the lessons ending too abruptly for the teacher to assess appropriately the extent to which the main learning objectives of the lesson had been achieved.

4.8 Much of the teaching in health education takes place in PSE lessons. In the main, teachers are willing to use a wider range of teaching and learning strategies in their PSE lessons than in the other curriculum areas. The quality of written guidance for PSE in the commercial teaching resources, and the worksheet materials on which many schools rely, is generally very good. These materials direct the teachers to the use of more open-ended teaching and learning strategies. The teachers, many of whom do not see themselves as specialists in either PSE or health education, tend to follow the guidance very closely. In addition, the teachers also report that they are more willing in PSE classes to let discussions take their course and to use more creative and diverse teaching approaches. This practice is, they report, because they feel under less pressure as there is no terminal examination. In the best practice, which was observed in a significant minority of lessons, the pupils were encouraged to make decisions, to consider what the consequences of these decisions might be, and how to make decisions which would lead to the best outcome for all.

4.9 Where health education topics are dealt with within subjects the teachers tend to use more didactic and formal teaching approaches. Nevertheless, there were some good examples of teachers using their subject specialist skills within a health education context. In one KS4 PSE lesson, for example, the teacher, an English specialist, used extracts from two Irish films, 'Divorcing Jack' and 'Angela's Ashes', to highlight the effects of alcohol on the family. During this lesson the teacher, through the use of effective questioning, assessed skilfully the pupils' knowledge and understanding of the concept of units of alcohol.

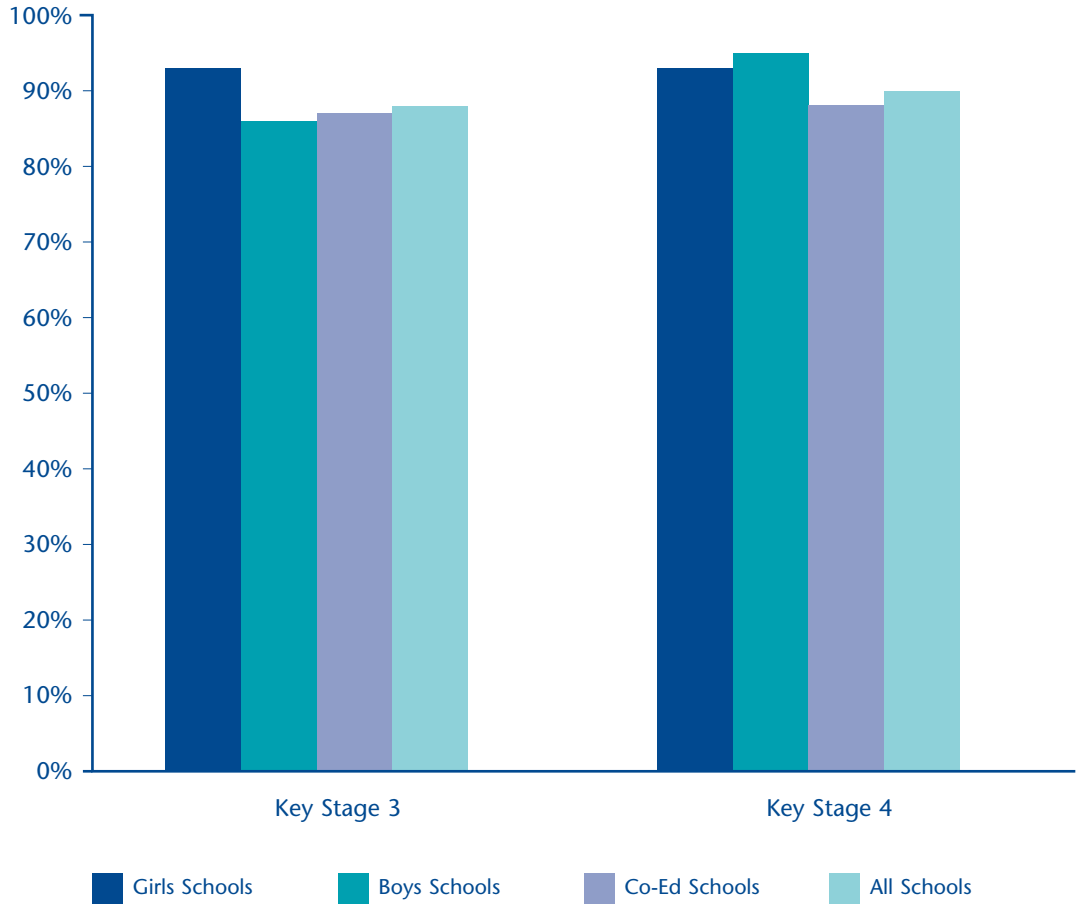
4.10 Drama is often used effectively to raise and explore complex issues related to broader aspects of health education. In two schools visited, for example, drama was used to stimulate discussion about family break-up and the associated feelings that young people have when they are involved directly. Skilful intervention and questioning by the

teacher ensured that the whole class was involved in the activity and that sufficient time was given to the exploration of the key issues.

4.11 Schools also plan significant whole-school, or year group, events that aim to raise the pupils' awareness of health issues. In some instances, these events are targeted at specific year groups or smaller groups of pupils who are deemed to be most in need of the information. For example, in one school an annual healthy eating week is organised; a feature of this event is the extent to which the school canteen staff are involved in the planning and operation of the week. In another school, a 'Brain Day' is organised during which all subject areas focus on the appreciation of the importance of the brain and how it may be developed, this includes aspects of a healthy diet and healthy lifestyles. In some schools, events are planned for specific times of the year when the experience of the teachers suggest that the need is greatest. For example, in one school a PSE week is organised at the end of the school year for the year 11 girls as the school feels that the issues raised, and the information given, just before the long summer break will support the pupils in making appropriate decisions throughout the summer.

4.12 Most of the schools which responded to the questionnaire made use of a wide variety of external agencies to support their work in health education (see Figure 1). The use of guest speakers also formed a significant component of the programmes provided in the schools visited during the survey. In the best practice, the relationships between the external agency and the school have been developed over a period of years and the programme provided by the agency is integrated effectively into the whole-school planning for health education. The pupils generally speak highly of the quality of these programmes and see the contribution as being provided by specialists who have often developed a wider range of approaches than those adopted by many teachers who are non-specialists in PSE. They also state that the content of these programmes is very relevant as many of the individuals are from local community groups and are aware of the problems that confront the pupils in their area. In a small minority of instances, the schools do not plan sufficiently for the inclusion of external agencies. In these instances there is little preparation before the visit and little follow-up discussion on the issues raised after the visit; consequently much of the educational impact is lost. In a small number of other instances, schools have invited agencies to contribute to their programmes only to be disappointed by the quality of the material and the manner in which it has been presented. In the best practice, schools monitor and evaluate the contributions that all agencies make to the overall programme of health education, and take appropriate steps to ensure that any necessary adjustments are made to the programmes.

Figure 1
Percentage of schools using guest speakers and/or external agencies to deliver aspects of Health Education at Key Stage 3 and Key Stage 4

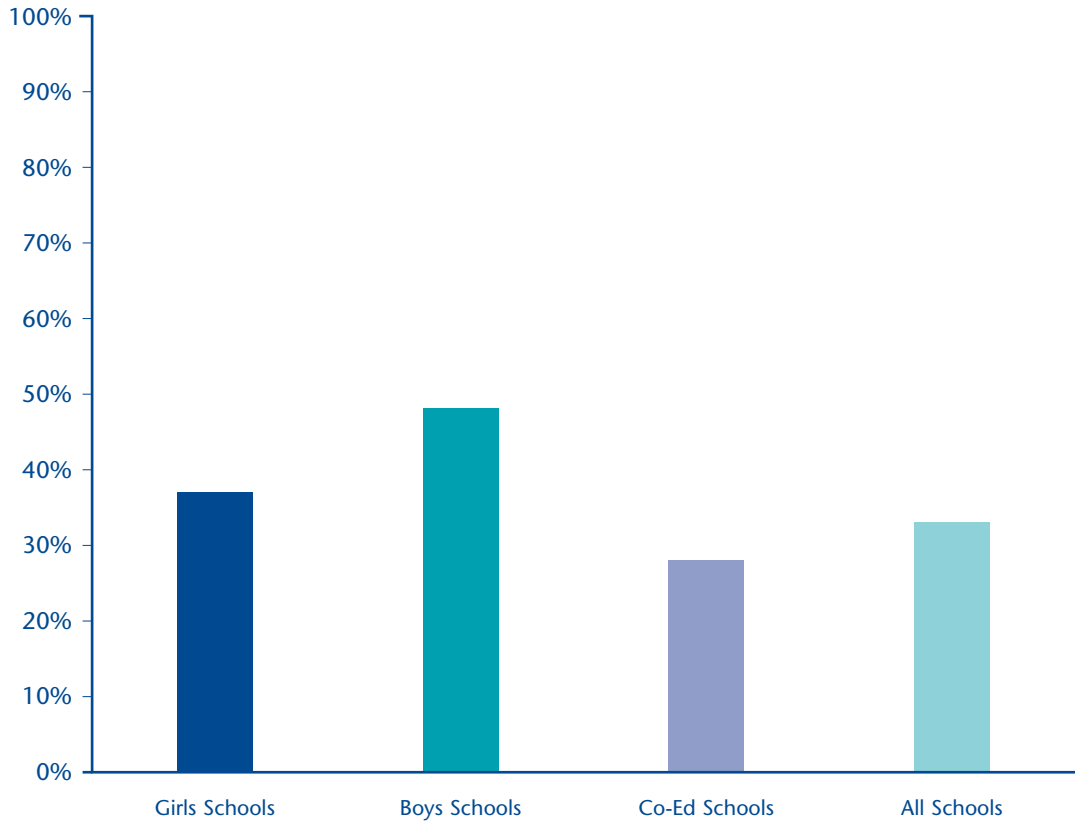


4.13 One school in the survey is part of the Communities in Schools (CIS) initiative. The health education co-ordinator is a member of an inter-agency forum and this participation has given her a clearer understanding of the wide range of agencies dealing with health-related issues operating in the local community and the role they can play in supporting the school in the provision of a relevant health education programme. A key benefit of the development of these relationships, and one which was demonstrated in a small number of the other survey schools, is the extent to which the physical, social and emotional needs of the pupils and the challenges they face within their local community are taken into consideration in the planning for, and the implementation of, the health education programme.

5. ASSESSMENT OF HEALTH EDUCATION

5.1 In approximately 35% of schools visited, the strengths of the assessment procedures outweighed the weaknesses. In the remaining schools, there were either significant weaknesses or the weaknesses outweighed the strengths.

Figure 2
Percentage of schools which formally assess Health Education

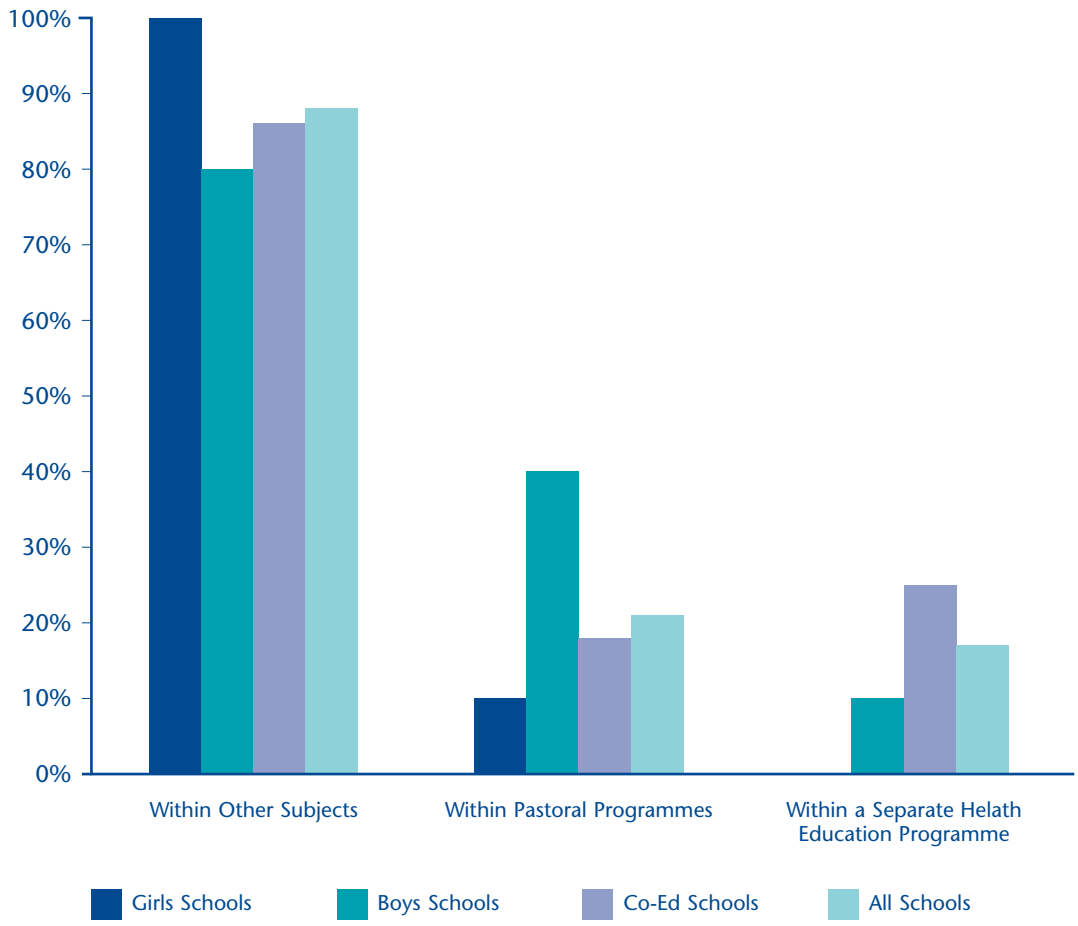


5.2 The majority of schools that responded to the questionnaire did not assess health education in a formal manner (Figure 2). A similar pattern was evident in the schools visited during the survey, with most having no formal policy for the assessment of health education. Where whole-school policies for the marking of the pupils' work were in place, however, these were applied to the work in health education and PSE. In a minority of schools, the pupils keep a profile of their work in PSE and evaluate their own progress both in PSE and other areas of their work. This approach to self-assessment is not as widespread as it could be. In discussion, the pupils who have been involved in this approach to assessment are very good at identifying their strengths and areas which require further development. Most have a secure understanding of what they need to do in order to improve.

5.3 No schools in the survey entered pupils for an external qualification in PSE. The only report that is generally issued to the parents and which is likely to contain an element of information on health education is located within the pupils' Records of Achievement. Schools adopt a variety of approaches to these and the quality of the information on health education is also variable; in the main, however, the attention given to health education needs to be strengthened.

5.4 The results from the questionnaire support the findings of the survey visits that show that where health education topics are taught within subjects of the curriculum other than PSE, such as RE, science, home economics or PE, these are assessed as part of the normal assessment for that subject. There are no arrangements for recording or reporting on health education attainment separately. (Figure 3)

Figure 3
Of those schools which formally assess Health Education, the percentage which utilise specific methods for assessment.



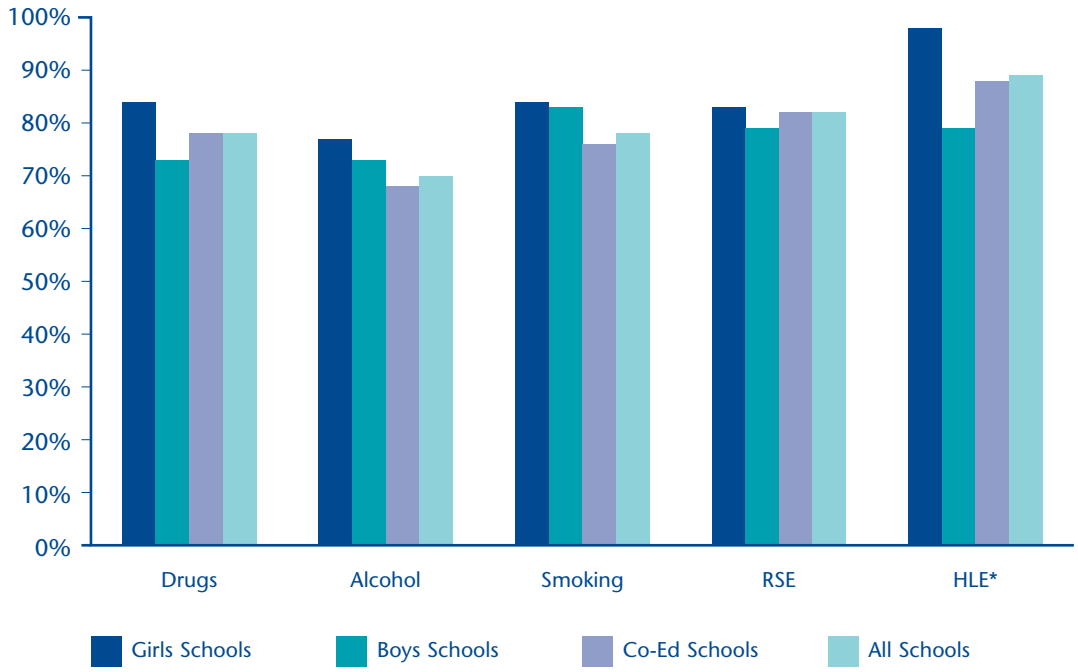
5.5 Informal assessment of the pupils' knowledge and understanding of specific health education issues does occur in a small number of schools. This is usually done within the context of competition entries. This form of assessment, however, does not include the knowledge and understanding of all of the pupils nor does it cover all of the strands of health education.

5.6 In one school, a more formalised approach to the assessment of health education, as part of a wider programme of assessing the pupils' life skills, has been carried out for a number of years. This programme is funded, and monitored, by an external agency and is known as the Higher Education Liaison Programme (HELP). The programme assesses aspects of health education areas such as the development of the pupils' self-esteem and health and well-being. Included in the programme are summer and Saturday school activities which include health education elements such as drug education, dealing with peer pressure, physical well-being, healthy food choices, health and beauty, and assertiveness training. Assessment of individual pupils, involving pupil interviews, is used to provide a personalised action plan which is reviewed regularly. This method of assessment provides a very useful addition to the information the school has on individual pupils and enables it to fulfil, more effectively, its stated aim of developing the pupils' self-esteem. Whilst this programme is helpful, it is unlikely that all schools would be in a position to undertake such an intensive programme as they would not have the necessary resources, including teachers' time. There is a need for additional research to evaluate the methods of assessment in aspects of health education and to develop additional methods which would not add significantly to the workload of teachers. Such assessment is likely to involve more formative approaches rather than terminal examinations as these would be more effective in assessing the key skills of the subject.

6. THE PUPILS' EXPERIENCES

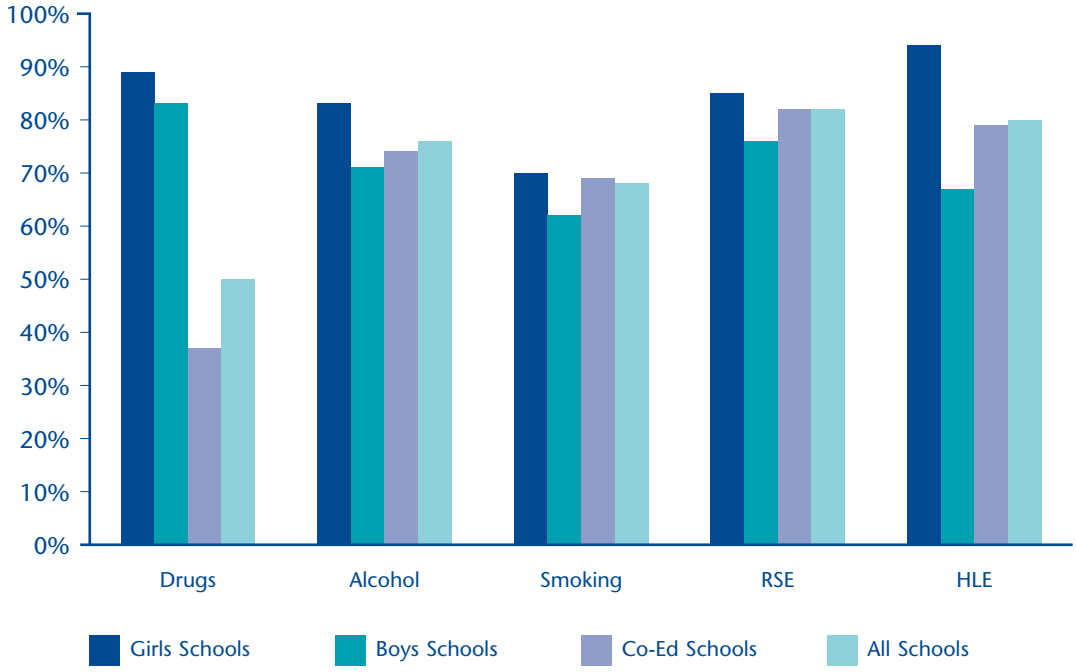
6.1 Most schools responding to the questionnaire report that they cover the main elements of health education (Figures 4 and 5). In the main, almost all of the schools visited provide a programme in health education which is coherent and covers the main elements of the educational theme. Most schools focus extensively, but not exclusively, on the core themes of drug and alcohol abuse and include smoking, RSE and healthy lifestyles which incorporates the importance of a healthy diet and exercise. The questionnaire returns suggest that more girls' schools than boys' schools are providing pupils with the full range of health education experiences. For example, approximately 10% fewer boys' schools offer drug education at KS3. A small minority of schools are in the process of reviewing their provision for RSE and developing appropriate resources to support teaching and learning in this area. Of all the aspects in health education, RSE gives teachers most concern. Many state that they are unhappy not only with the content but also with the teaching strategies that are required to teach the topic effectively. Some schools have addressed this issue by creating special teams who have responsibility for teaching the more sensitive aspects of health education; classes are organised in such a manner that the pupils have these teachers for specific topics. In one school there was little provision for RSE apart from the factual information that was given within biology lessons. In this school there was some input from external agencies but this tended to lack sufficient planning to ensure coherence and continuity in the pupils' learning.

Figure 4
Percentage of schools teaching Health Education topics at Key Stage 3



* Health and Lifestyle Education (HLE) - a term used to cover some of the more general aspects of health education such as exercise and healthy diet.

Figure 5
Percentage of schools teaching Health Education topics at Key Stage 4



6.2 A minority of schools are developing programmes that include elements relating to the mental health and well-being of young people. A number of external agencies offer programmes on aspects of mental health. Schools report, however, that the quality of these programmes is variable and most are therefore carefully monitoring the situation. In general, the elements of health education which relate to the mental health and well-being of the pupils are still underdeveloped in many schools. A few schools offer the services of a trained counsellor. A small minority of schools are training older pupils to act as mentors for the younger pupils.

6.3 Many schools complement the formal curriculum with a range of extra-curricular activities such as competitions. A significant example of this is the Rock Challenge which involves a large number of pupils who meet regularly to prepare a drama and dance production on the theme of drug education. A feature of this competition is not just the involvement of a large number of pupils in the event but the commitment to a drug education programme that is required from both the pupils and their parents. Other extra-curricular activities, broadly related to PSHE, include gardening clubs which aim to enhance the school environment, recycling clubs, after-school clubs and drama clubs.

6.4 Many schools make strenuous efforts to involve the parents in the programme for health education. Parental involvement is sought through the issue of regular letters and newsletters and, in some cases, formal meetings. Schools report varying degrees of success in attracting the parents to meetings. For example, one school arranged an information meeting for the parents of year 9 pupils who were about to undertake a new programme in drug education. The meeting had to be cancelled due to lack of interest. When the pupils were about half way through the programme, however, the meeting was re-arranged and attracted approximately 90% of the parents.

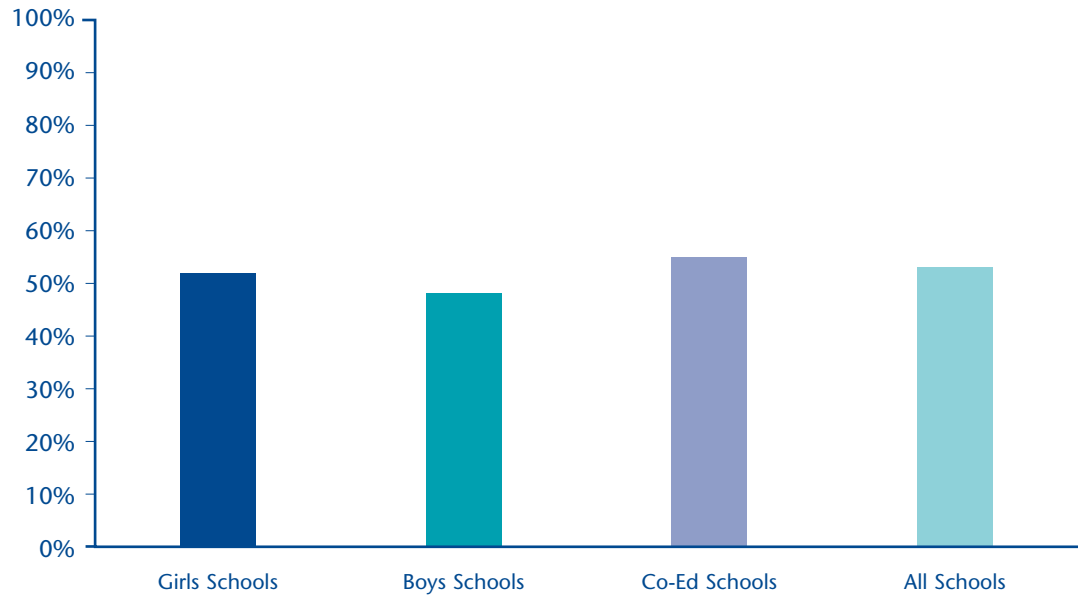
7. MANAGEMENT

7.1 In just over four-fifths of schools, the quality of the management of health education was good. In the remaining one-fifth there were a number of weaknesses which outweighed the strengths.

7.2 Most schools visited during the survey had a range of policies to guide and support the work in health education. The quality of these policies was, in the main, very good. At the time of the survey a majority of the schools visited were in the process of reviewing some or all of the policies. Whilst the policy for drug education was generally well established, and was included in the school's prospectus, the policy for RSE was, in a majority of schools, either under review or was on the school development plan for review in the near future. The variability in the quality of provision for this important aspect of health education is a matter of concern; a significant number of schools have not addressed RSE at senior management level.

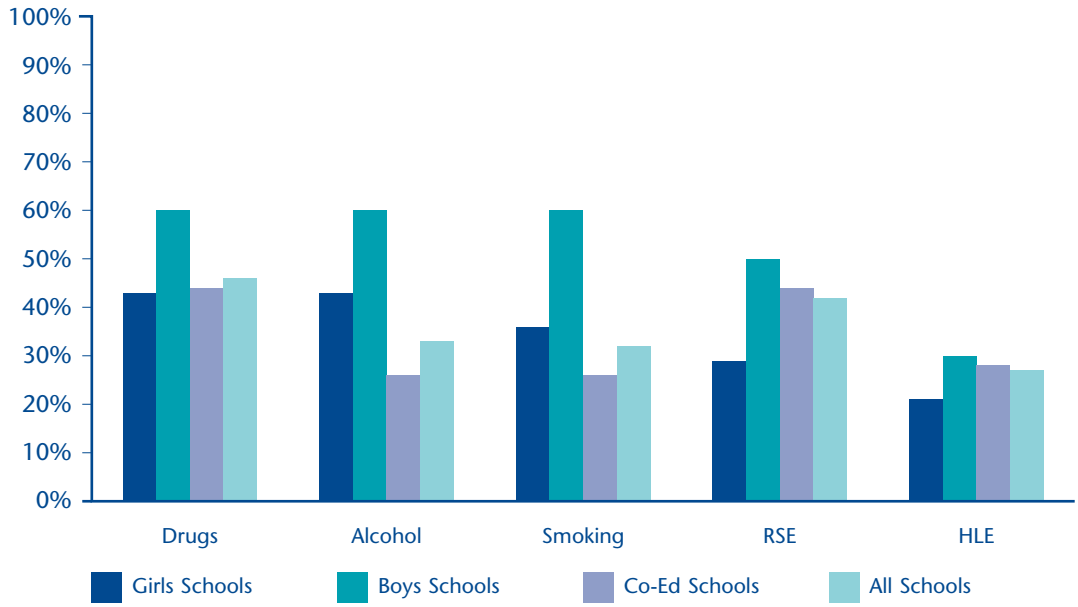
7.3 There was no clear pattern in the manner in which the policies were presented. In some instances, there was an overarching policy for health education whilst in others there were discrete policies for the various strands of the theme including drug and alcohol education and RSE. Approximately half of the schools that responded to the questionnaire had a written and agreed health education policy which had been approved by the Board of Governors. (Figure 6)

Figure 6
Percentage of schools which have written and agreed policies on Health Education, which have been approved by the Board of Governors



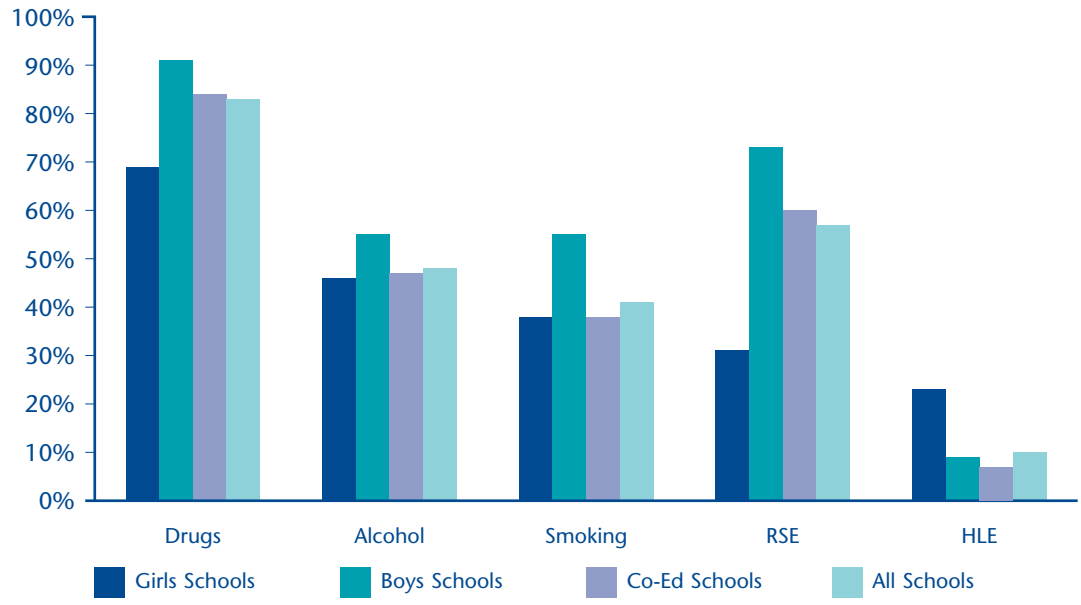
Only a minority of these general policies on health education had separate sections on issues such as RSE, drugs, alcohol and smoking. (Figure 7)

Figure 7
Of those schools with agreed policies on Health Education, percentage with separate sections on a range of topics



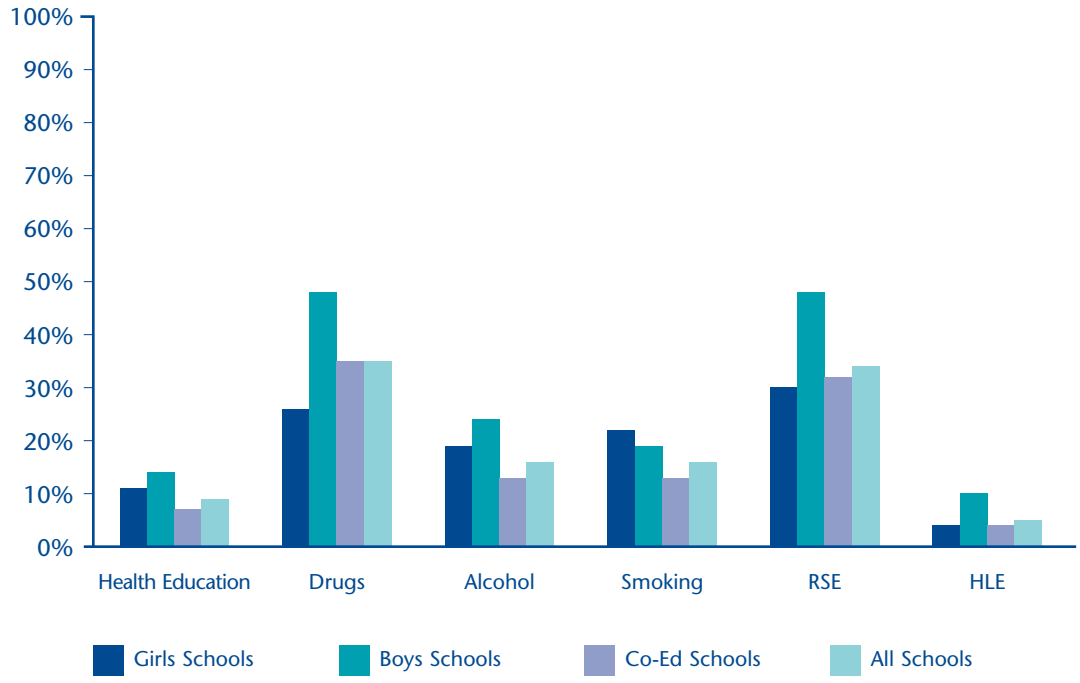
Of the schools that stated that they did not have a general policy on health education, most had a separate drug education policy but only 57% had a policy on RSE. (Figure 8)

Figure 8
Of those schools without agreed policies on Health Education, percentage with separate sections on a range of topics



The current position is that only the drug education policy is a requirement* and should appear in the school prospectus but in practice a significant minority of schools have good quality policies for all aspects of health education which are communicated effectively to the parents. A feature of the drafting of health education policies recorded in a small number of schools visited is the extent to which the parents and pupils are consulted as an integral part of the process (Figures 9–11 show the extent of this consultative process in the schools that responded to the questionnaire). In one school, for example, the RSE policy was drafted initially by the health education co-ordinator and later discussed at four separate meetings with a focus group of parents before a final draft was produced and presented to the Board of Governors.

Figure 9
Percentage of schools which consulted parents during the formulation of a range of policies



* DENI Circular 96/16 Misuse of Drugs: Guidance for Schools.

Figure 10
Percentage of schools which consulted pupils during the formulation of a range of policies

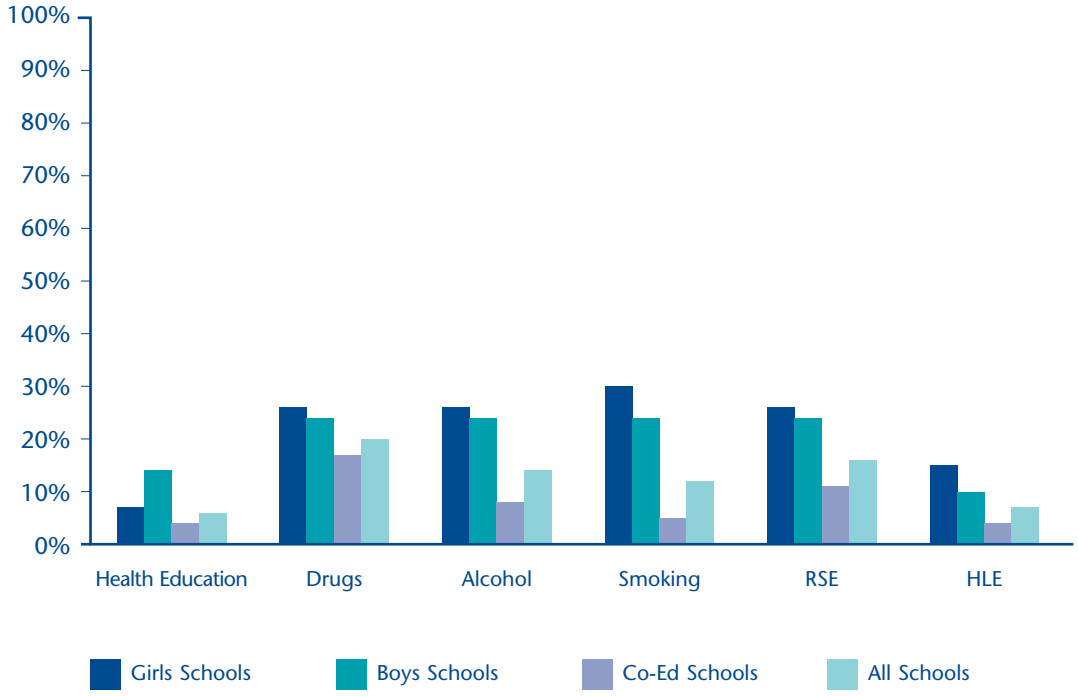
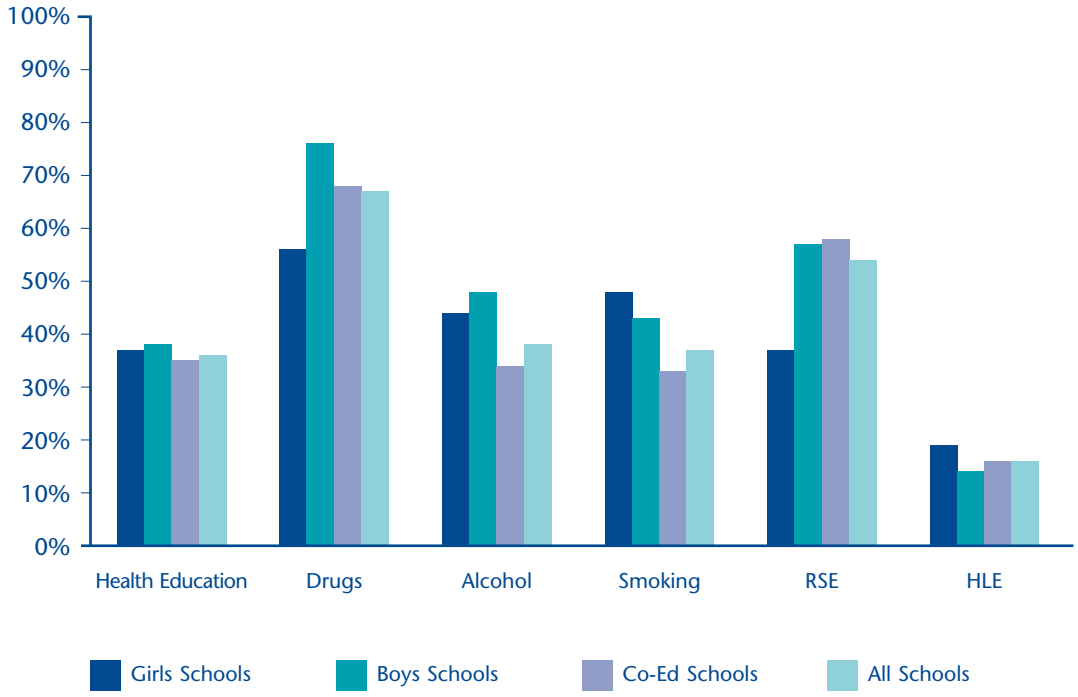


Figure 11
Percentage of schools which consulted the Board of Governors during the formulation of a range of policies



Department of Education circular 2001/15 on RSE states clearly that the school policy should be the subject of consultation with parents, and should be endorsed by the school's board of governors. In formulating any policy relating to health education issues the need for systematic approaches to consultation is very important. The consultation process helps ensure that that the health education programme is appropriate to the needs of the pupils and is based on their previous knowledge and understanding of the issues. In addition, parents and boards of governors are more likely to understand and accept the policies if they have been consulted effectively at the drafting stage. The relative lack of consultation with parents and pupils identified by this survey is an issue which needs to be addressed.

7.4 In order to manage coherently, review effectively, and ensure understanding of their provision for health education, schools find it helpful to have (i) a policy on health education which has, at its core, the aim of promoting the health and well-being of everyone in the school community (ii) supplementary guidance materials to support implementation of the programme. At their best, the guidance and procedures, together with current policy and guidance:

- describe the purpose, nature and management of health education within the school;

- include reference to the school as a health promoting institution through its curricular and extra-curricular provision;

- take account of the requirements of the 'Curriculum (Educational Themes) Order (Northern Ireland) 1992' with particular reference to health education;

- make reference to other DE circulars that relate to health education issues such as:
  - Relationships and Sexuality Education (RSE): Circular 2001/15;
  - Misuse of Drugs: Guidance for Schools: Circular 1996/16;
  - Pastoral Care in Schools: Child Protection: Circular 1999/10;

- reflect a wide-ranging consultative process which includes the Board of Governors, the teaching and non-teaching staff, pupils, parents and external support agencies;

- include procedures for the monitoring and evaluation of the provision within the school. The role of the health education co-ordinator in this aspect of the management of the programme should be clearly defined;

- outline the school's position on smoking, healthy eating, safety, discipline and relationships with parents.

In particular instances there may be value in having separate policies giving additional detail on areas such as RSE and drug education.

7.5 In a minority of schools, mostly in areas of significant social deprivation, breakfast clubs are provided to help ensure that the pupils begin the day with a healthy breakfast. Good relationships between the school's SMT and the supervisors of the school canteen are crucial for the success of such a venture. One-sixth of the schools raised concerns about the quality of the food provided by the school canteen at lunchtime. In one instance, the canteen had conducted its own survey to determine the range of foods the pupils would like to be provided. As a result of the findings, the menu is dominated by chips and burgers. On the other hand, where relationships between the school's SMT and the canteen staff are good, the canteen can play an integral part in the creation of a healthy ethos within the school. In one school visited, for example, the canteen provides a wide range of healthy foods and identifies clearly the healthy eating options on its menu. In addition, as the school operates a swipe-card system for payment of food in the canteen, the canteen staff are able to monitor the food selection of individual pupils. At regular intervals the pupil who has had the healthiest diet is rewarded by the canteen. The quality of the liaison between the canteen staff and the health education co-ordinator in this instance is excellent.

7.6 Most schools visited in the survey had a number of vending machines which sold confectionery products including soft drinks. In the majority of instances, the drinks offered for sale were sugar-based fizzy lemonades and colas. Whilst it is understandable that schools should wish to raise funds through the provision of vending machines, there is a need for the school SMT to consider the extent to which this provision conflicts with, or can support, the school health education policies.

7.7 In most schools health education was taught both within PSE and as a cross-curricular theme. In a significant number of schools, the programme provided for KS3 pupils is more extensive than that which is provided for KS4 pupils. The schools reported that there is less time available for PSHE programmes at KS4; there are examples of schools scheduling one hour of PSHE per month for KS4 pupils.

7.8 In the main, where there were separate co-ordinators for PSE and health education, the quality of the communication between these individuals was good. In most cases, the PSE co-ordinator was a

member of the SMT whereas the health education co-ordinator was an assistant teacher. This reflects the responses to the questionnaire which showed that three quarters of the schools which responded had a co-ordinator for health education (Figure 12). Just over one-quarter of these co-ordinators were members of the school's SMT. (Figure 13).

Figure 12
Percentage of schools with a co-ordinator for Health Education

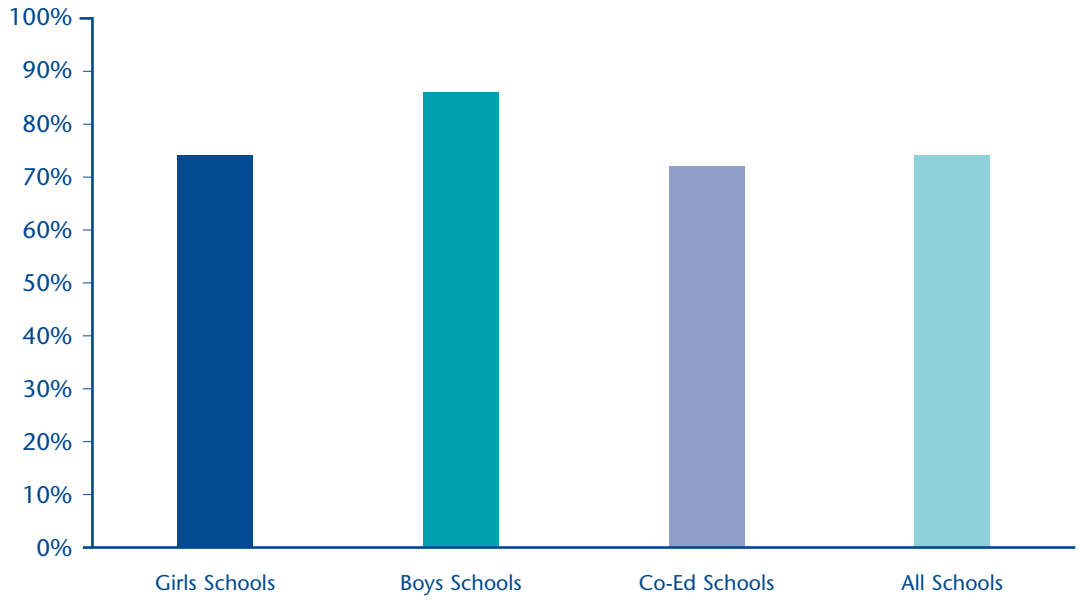
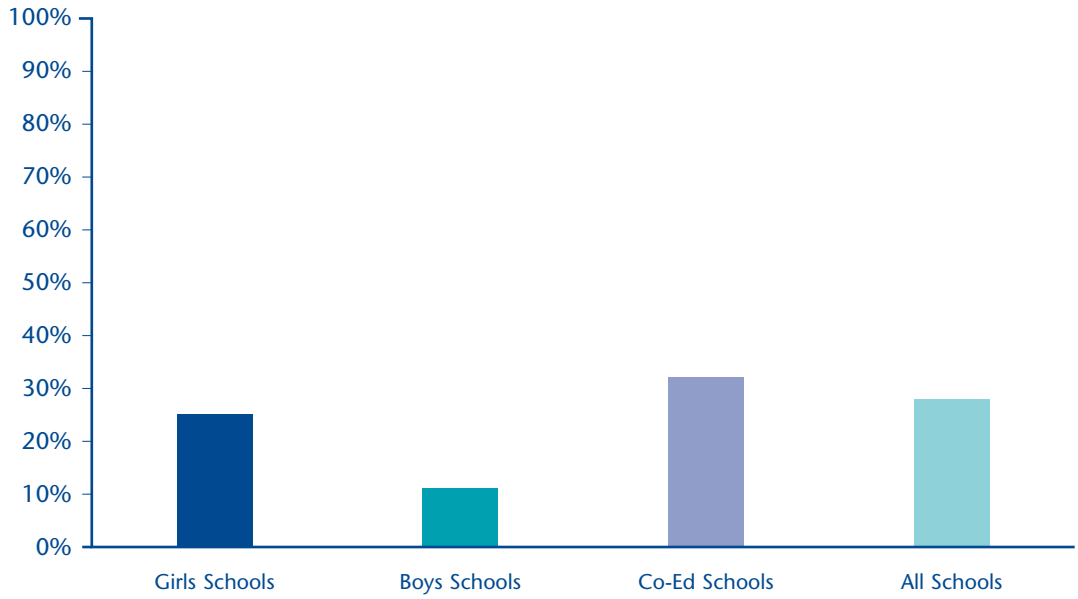
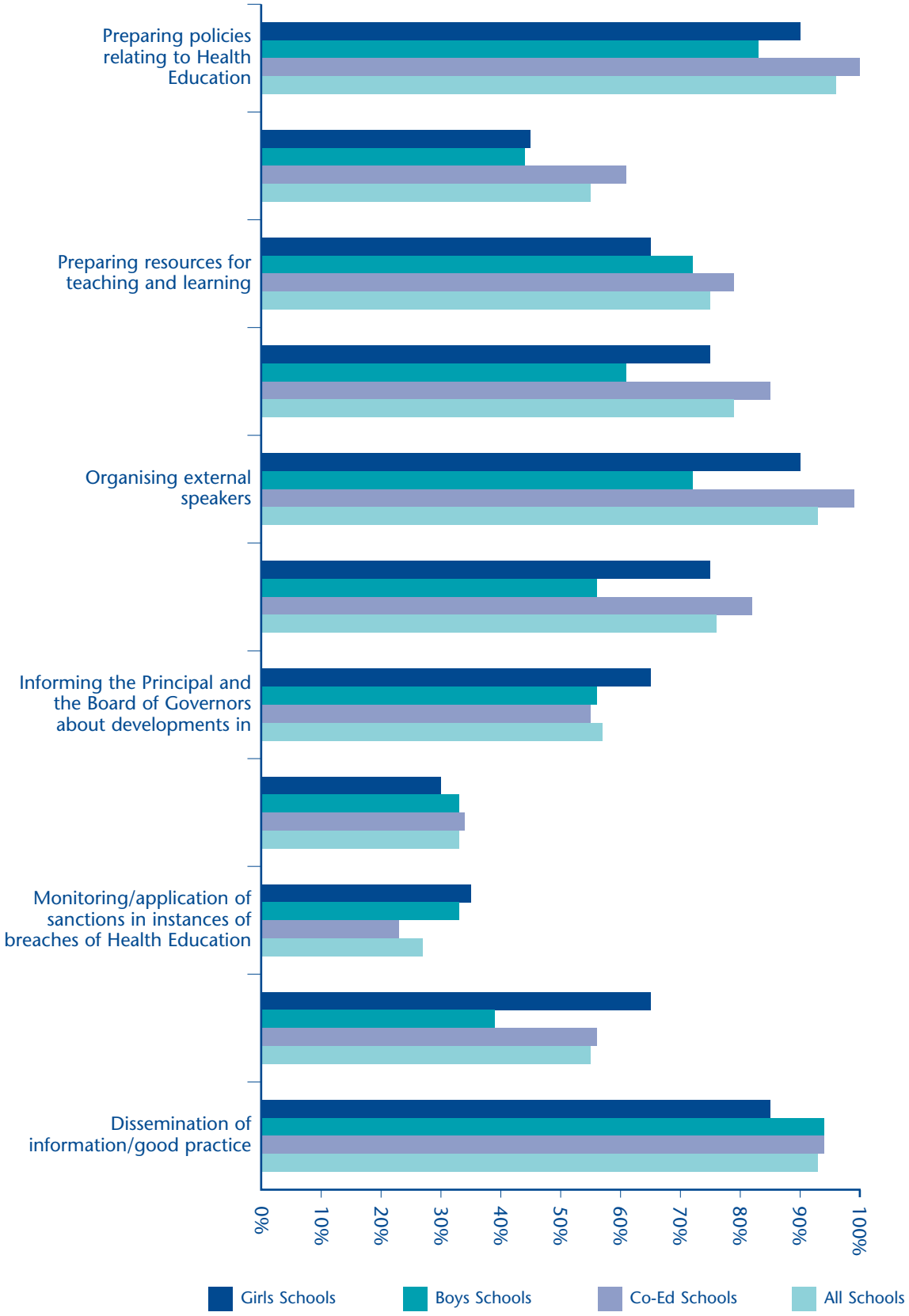


Figure 13
Of those schools with a co-ordinator for Health Education, percentage in ehich he/she is a member of the Senior Management Team



7.9 Whilst the health education co-ordinators were mostly highly committed to, and enthusiastic about, the subject, they often lacked sufficient seniority to influence school policy at a strategic level. In addition, in a number of instances the health education co-ordinators felt that they were unable to monitor and evaluate the quality of teaching and learning across the main contributory subjects due to their lack of seniority. As a consequence, the extent to which the health education experiences of the pupils were monitored and evaluated varied but was, in the main, inadequate. In the best practice, schools were pro-active in looking at a wide range of evidence as part of a systematic approach to the evaluation of their programmes. In a small number of schools, the health education co-ordinator made every effort to seek the views of the pupils as part of the evaluation process, particularly relating to the programme provided by the external agencies. Where monitoring was most effective the co-ordinators were able to report with confidence that an appropriate range of teaching strategies was being used in the delivery of the health education programme. Figure 14 identifies the roles performed by the health education co-ordinators in the schools that responded to the questionnaire. This shows clearly that the main responsibilities are seen to be in the preparation of policies, organising guest speakers and disseminating information.

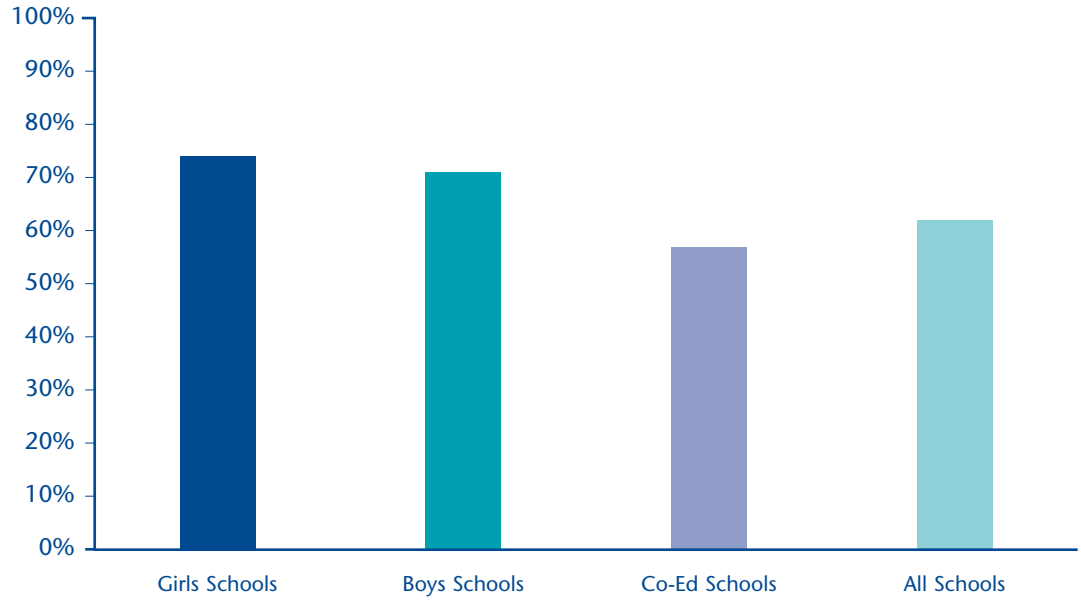
Figure 14
Of those schools with a co-ordinator for Health Education, percentage in which he/she is responsible for specific issues



7.10 Just under half of the schools visited during the survey had conducted audits of the health education to determine where, in the curriculum, the discrete elements were being covered. The co-ordinators in these schools were aware of the areas that were in need of development. In the main, however, these audits focused on the content of the programme and did not focus sufficiently on the strategies that were used to teach the programmes. There is a need for a more systematic approach to the monitoring and evaluation of health education in most schools, particularly of the cross-curricular element. Audits need to focus more sharply not only on the content that is covered but also the effectiveness of the teaching strategies that are employed in the implementation of the programme. It is clearly important that the pupils' skills and understanding are developed in a progressive and coherent manner.

7.11 A majority of the schools visited during the survey had identified the development of health education as a priority on the school development plan. Just under two-thirds of the schools which responded to the questionnaire had also placed health education issues on their development plan (Figure 15). It is appreciated that schools have competing priorities with which to deal, however the fact that one-third of schools are not considering health related issues as a priority for development is a matter for concern.

Figure 15
Percentage of schools which list Health Education issues on their Development Plan

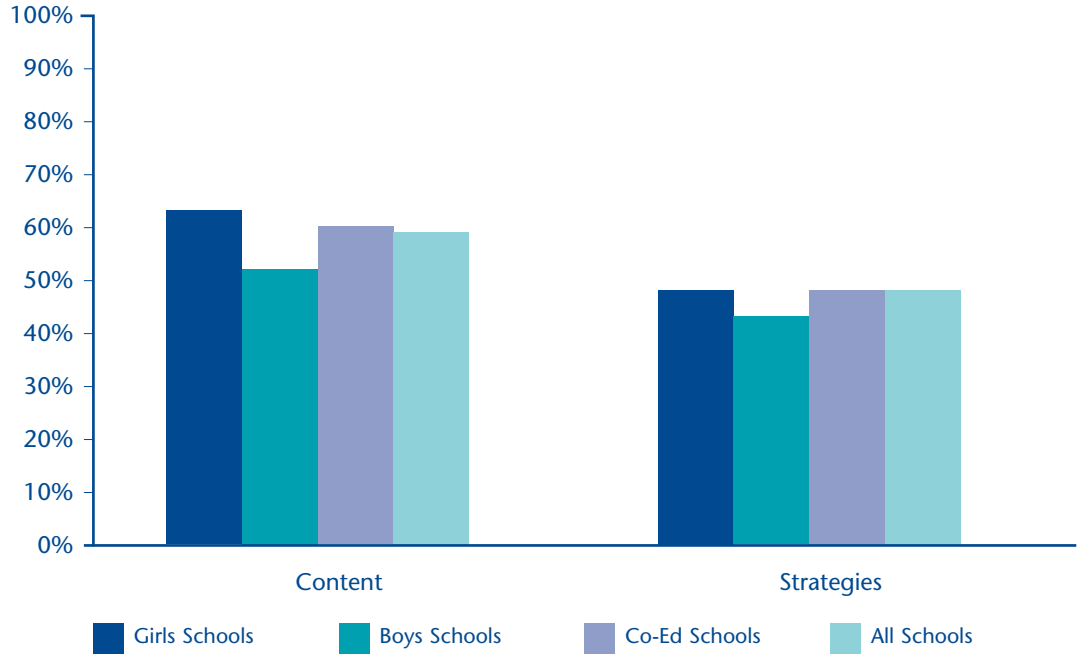


8. STAFF DEVELOPMENT

8.1 In a majority of schools visited during the survey there were weaknesses identified in the quality of the INSET provision and the training provided for the teachers in elements of health education.

8.2 The school visits identified a wide range in the quality, and quantity, of INSET provided for the teachers. Just under 30% of the schools visited reported that they had provided no INSET support for the teachers in recent years. In a majority of the remaining schools, INSET was mostly content-based and did not focus adequately on the teaching strategies and methodology that would help the teachers cope with the more challenging aspects of health education such as RSE and the mental health and well-being of young people. These findings reflect the responses to the questionnaire which showed that just over half of the teachers had received training on the content of health education but just under half on the teaching strategies. (Figure 16)

Figure 16
Percentage of schools in which teachers have received INSET training to help them with Health Education content/strategies



A minority of schools reported that they were content with the level of support they had received from their Education and Library Board's Curriculum Advisory and Support Service (CASS) in developing health education and pastoral programmes for the pupils. These schools appreciated the support provided by CASS officers in the review and

re-structuring of the management arrangements for PSE and health education. In some schools, there are flexible arrangements in place to enable teams of teachers who have specific responsibilities for the teaching of key elements of the health education programme, such as RSE, to receive support from CASS. This system enables schools and the CASS support teams to focus the limited INSET time available on these teachers.

8.3 New programmes such as the Health Promoting Schools Initiative have the potential to address many of the shortcomings in staff development. It will be important, however, to focus the training resources on the development of the teaching methodologies; particularly those strategies that encourage pupils to develop their own knowledge and understanding to inform their personal decision-making in areas of health.

8.4 A small minority of schools have identified appropriately the need to provide INSET for newly qualified teachers in aspects of the teaching of the PSE programme. The newly qualified teachers interviewed in this survey who had received such support felt that it was most valuable. In the best practice, these teachers shadowed a more experienced colleague before being allocated a form group for which they would take responsibility for the implementation of the PSE programme. These arrangements enabled the newly qualified teachers to gain a good first-hand understanding of the PSE programme, including the teaching strategies, and identify and strengthen those areas where their own competence in PSE may be less well developed.

9. CONCLUSION

9.1 There are many strengths in the provision of health education in schools in Northern Ireland. These include the following:

- the content of the educational theme of health education is being covered effectively in the vast majority of schools;
- the quality of the relationships in classes is very good;
- the teachers are generally hard-working and committed to the aims and objectives of health education;
- the quality of teaching is good or better in the vast majority of schools;
- the quality of the teaching resources is generally very good;
- many schools make effective use of a wide range of external agencies to support and complement their health education programmes;
- schools have developed a range of approaches to the management of health education which are effective in the majority of instances;
- most schools have an appropriate range of policies relating to health education.

9.2 The report has identified a number of areas for improvement; these include the need for:

- better management of health education across the school;
- a more co-ordinated approach to the teaching of health education;
- wider consultation when drawing up health education policies;
- more effective auditing of the pupils' experiences across the main subjects which contribute to health education;
- more details on relevant and effective teaching strategies to be included in the planning;
- additional INSET for teachers in relation to RSE and the mental health and well being of the pupils;

- assessment strategies that evaluate, record and report effectively on the pupils' knowledge and understanding of health education as well as their inter-personal skills and attitudes;

- schools to develop appropriate induction strategies for beginning teachers who have no, or limited, experience of PSE;

- many schools to strengthen the liaison between the senior managers in schools and the canteen staff to promote more consistent messages about healthy eating;

- schools to provide more healthy choices in the vending machines on the school premises.

10. RECOMMENDATIONS

- There is a need for additional research on the development of an assessment strategy which would record the pupils' knowledge and understanding of the main elements of health education.

- The Curriculum Advisory and Support Service needs to provide additional INSET on key elements of health education, especially RSE and mental health and well being of young people, and on the range of teaching strategies that are most effective for health education.

- A co-ordinated approach should be developed between the school management and the management of the schools meals service, particularly with regard to the nature of vending facilities within schools.

- Initial teacher education needs to be more pro-active in the preparation of subject specialist teachers for the wider range of experiences they will face on appointment to post-primary schools. In particular, this should include the development of a teaching pedagogy suited to the implementation of a PSE/HE programme.

As the survey has shown, there is a solid foundation of practice, and much commitment to health education on which future developments can build. The survey has also identified a number of areas that require further development to ensure that all pupils receive a broad and balanced programme of health education. The evidence from this survey indicates that schools are well placed to address these issues.

APPENDIX

Schools Visited

Ballymoney High School

Ballyclare Secondary School

Belfast High School

Belfast Model School for Girls

Coleraine Academical Institution.

Coleraine High School

Cookstown High School

De La Salle Secondary School, Downpatrick

Drumglass High School Dungannon

Erne Integrated College

Loreto College, Coleraine

Meanscoil Bhride (IME unit, St Brigid's College, Londonderry)

Omagh High School

Our Lady's Grammar School, Newry

Our Lady Of Mercy High School, Strabane

Regent House, Newtownards

Slemish College, Ballymena

St Fanchea's College, Enniskillen

St Joseph's Boys' Secondary School, Londonderry

St Louise's Comprehensive College, Belfast

St Mary's College, Londonderry

St Patrick's Grammar School, Downpatrick

St Patrick's Girls' Academy, Dungannon

Strangford Integrated College, Carrowdore.

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