Teachers’ perceptions of health education practice in Northern Ireland: reported differences between policy and non-policy holding schools

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SUMMARY

It is generally accepted that schools should devote resources to developing and disseminating a health education policy, yet there is little empirical evidence to establish the value of policy in this context. This study examined teachers’ perceptions of health education practice in policy and non-policy holding schools. A questionnaire measuring aspects of health education practice was issued to a random sample of schools. This consisted of 276 primary and 119 post-primary schools. In this cross-sectional study, significant differences in teachers’ evaluations were found between policy and non-policy holding schools. It was evident that the presence of a health education policy was associated with higher ratings of health education practice. This evidence suggests that policy has intrinsic value in terms of health education practice. The development and dissemination of policy documents were also examined to assess the workload involved.

Key words: schools; health education; policy; practice

INTRODUCTION

Schools are organizations designed to influence and promote cognitive development and behavioural change. Health education provided by teachers may have an immediate effect on pupils and may influence pupils’ healthy behaviours into adulthood (McGinnis, 1992; Nutbeam, 1992; Nutbeam, 1998; McBride et al., 1999). Additionally, healthy pupils are likely to perform better at school (Lavin et al., 1992; Levinger, 1994) and their learning may be faster, more comprehensive and enjoyed (St Leger, 1999). Given such benefits it is, perhaps, surprising to find that the importance of health education is not readily acknowledged. As Seffrin observed: ‘...the gap between common practice and “what ought to be” is greater for health education than for most other areas in the school curriculum’ [(Seffrin, 1992), p. 394]. There have, furthermore, been concerns in relation to health education provision and McBride et al. suggest that encouraging schools to adopt ‘comprehensive health education programs is often difficult...with a crowded curriculum and an increasing number of curriculum areas vying for status and time...’ [(McBride et al., 1999), p. 18].

In recent years whole school approaches have been advocated through the ‘health promoting school’ initiative (Health Education Board for Scotland, Health Promotion Wales, Health Education Authority (England), and Health Promotion Agency for Northern Ireland, 1996; Barclay and McGuffin, 1996). In the context of the health promoting school, participating
schools are asked to promote empowerment and participation of staff, pupils and parents through a whole school approach to health education (DHSSPS, 2002).

Policy is often considered as central to supporting teachers in effective management and delivery of learning since it may promote a shared understanding of health education practices among staff. Policy development and dissemination, however, can be a demanding, time consuming and financially bearing task, potentially involving many individuals, internal and external to the school. Equally, there remains a need to ascertain, empirically, the value of policy in this context (St Leger, 1999); and an evidenced-based approach is often preferred when attempting to assess the relationship between policy and practice (Nutbeam, 2004; Rychetnik and Wise, 2004).

The primary aim of the current study was to examine whether the existence of a health education policy influences teachers’ perceptions of health education practice in their school in light of the observation that some teachers and school health education coordinators may not consider the absence of a policy as a barrier to delivering effective health education (Adamson et al., 2001).

In schools in Northern Ireland a school curriculum policy is formally approved by the school Board of Governors; hence, the decision to introduce a policy requires commitment to resourcing, implementation and dissemination across the stakeholders. The study was designed to discover whether the introduction of a policy made a significant difference to practice through raising the profile of the health cross curricular theme. In relation to the determination of the role of policy, a school representative was asked whether the school had a policy and, if the response was in the affirmative, was then, asked to clarify how the policy was developed, whether there was a working party associated with the policy, and which stakeholders were consulted (e.g. teachers, pupils, external agencies, parents, other). For the purposes of the study, a judgement was made on the basis that the school had declared a policy and the intention was to discover whether this commitment had impacted on health education in the schools. The term ‘health education’ was interpreted in relation to the implementation of Department of Education’s policy on health education as a curricular theme (DENI, 1992) implemented across the school subject disciplines including influencing behaviour outside school and embedding health behaviours within everyday life.

METHODS

Questionnaire and sampling

A postal survey of primary and post-primary schools in Northern Ireland was conducted. The sample of primary and post-primary schools was selected randomly. Three hundred and ninety-five schools were posted questionnaires, 276 primary and 119 post-primary schools.

A covering letter stated that the school’s health education coordinator should complete the questionnaire, but where a coordinator was not available, the person with most knowledge of health education in the school should complete the questionnaire. The questionnaire was designed to elicit information on teachers’ perceptions of health education practice in the school. Health education practice was operationalized in terms of 10 bipolar constructs, which measured aspects relating to the health promoting school ethos. These constructs were devised in consultation with a committee headed by the Department of Education and including representatives from external bodies such as the Health Promotion Agency (HPA) and were synthesized from previous research and development, including curricular specifications (Northern Ireland Curriculum Council, 1994), and HPA school support documentation (HPA, 2000). Each bipolar construct contrasted the ‘traditional’ perspective of health education with what is considered as the more effective, wider ranging, health promoting school perspective (Figure 1). Using a 101-point visual analog type scale, respondents were required to indicate the extent that their school had moved along this continuum. In addition, teachers provided information on persons and organizations involved in policy development, the mechanisms used for dissemination and the persons who received the policy.

A stratified sampling procedure was used whereby both primary and post-primary schools were selected randomly from the population of schools in Northern Ireland. One hundred and
ninety-nine schools took part in the study: 129 primary schools and 70 post-primary schools. Three schools (1 primary and 2 post-primary) failed to provide information about the existence or otherwise of a health education policy and were therefore excluded from further analysis, giving a total sample size of 196 schools.

<table>
<thead>
<tr>
<th>Tradtional Health Education</th>
<th>Bipolar Constructs</th>
<th>Health Promoting School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title: understanding of practice – traditional v contemporary</td>
<td>Takes a wider view including all aspects of the life of the school as a caring community.</td>
<td></td>
</tr>
<tr>
<td>Title: defining health – narrow v broad definition</td>
<td>Is based on a model of health which includes the interaction of physical, mental, social and environmental aspects.</td>
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<tr>
<td>Title: using pedagogy - instruction v participation</td>
<td>Focuses on active pupil participation with a wide range of methods, developing pupil skills.</td>
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<tr>
<td>Title: recognising influences – less coherent approach v recognition of other influences</td>
<td>Recognises the wide range of influences on pupils' health and attempts to take account of pupils' pre-existing beliefs, values and attitudes.</td>
<td></td>
</tr>
<tr>
<td>Title: responding to problems – reactive v pro-active</td>
<td>Recognises that many underlying skills and processes are common to all health issues and that these should be pre-planned as part of the curriculum.</td>
<td></td>
</tr>
<tr>
<td>Title: comprehending psycho-social factors - limited understanding v recognition of broad range of factors</td>
<td>Views the development of a positive self-image and individuals taking increasing control of their lives as central to the promotion of good health.</td>
<td></td>
</tr>
<tr>
<td>Title: recognising school environment factors- limited recognition v broader recognition</td>
<td>Recognises the importance of the physical environment of the school in terms of aesthetics and also direct physiological effects on pupils and staff.</td>
<td></td>
</tr>
<tr>
<td>Title: understanding the roles of staff – not considering the role of staff v recognising the importance of the staff role</td>
<td>Views health promotion in the school as relevant to staff well-being; recognises the exemplary role of staff.</td>
<td></td>
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<tr>
<td>Title: involving parents- not involving parents v recognition of central importance of parental role</td>
<td>Considers parental support and cooperation as central to the health promoting school.</td>
<td></td>
</tr>
<tr>
<td>Title: conceptualising the role of school health education – narrow preventative approach v broader preventative and integrative approach</td>
<td>Takes a wider view of the school health services which includes screening and disease prevention but also attempts actively to integrate services within the health education curriculum and helps pupils to become more aware as consumers of health services.</td>
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Fig. 1: Detailing the 10 bipolar constructs relating to health education practice.
RESULTS

School characteristics
In Northern Ireland, most pupils attend schools which have either ‘catholic maintained’ status or ‘controlled’ status, the latter schools being predominantly protestant in terms of pupil affiliation with 5% of pupils attending integrated schools, designed to offer education to both denominations. Approximately 56% of primary schools were ‘controlled’, 39% were ‘catholic maintained’, 2% ‘other maintained’ and 3% ‘controlled integrated’. For post-primary schools 39% were ‘controlled’, 35% were ‘catholic maintained’, 24% were ‘voluntary’ and 2% were ‘controlled integrated’. These school management types are representative of their proportion in the population of schools in Northern Ireland. Similarly, the ‘mixed’ to ‘single sex’ ratio in the sample is representative of the population, with ~92% of primary schools ‘mixed sex’ and 8% ‘single sex’; and 66% of post-primary schools ‘mixed sex’ and 34% ‘single sex’.

In Northern Ireland, the type of post-primary education received is determined by a selection process designed to allocate pupils to ‘secondary grammar’ or ‘secondary intermediate’ schools. Approximately 69% of post-primary schools were ‘secondary intermediate’ and 31% were ‘secondary grammar’. This is typical of the school population in general.

Respondent characteristics
In total, ~70% of teachers were responsible for coordinating the health education in primary schools, while for post-primary schools 73% were health education coordinators. For primary schools, ~70% of respondents were female, with 19% aged 35 years or younger, 32% aged 36–45, 41% 46–55 years and 8% aged 56 years and over. For post-primary schools 71% of respondents were female, with 4% of respondents were aged 35 years or younger, 39% were aged 36–45, 52% were aged 46–55 and 5% were 56 years and over. Respondents also provided their position in the school: for primary schools, 45% of respondents were ‘head of school’, 9% were ‘deputy head’, 2% were ‘head of department’, 9% were ‘senior teacher’, 33% were ‘teachers’ and 2% had ‘other’ positions. For post-primary schools, ~6% were ‘head of school’, 7% were ‘deputy head’, 36% were ‘head of department’, 14% were ‘senior teacher’, 32% were ‘teachers’ and 5% identified their position as ‘other’. It is interesting to note that for primary schools the largest single category is ‘head of school’, suggesting that head teachers retain responsibility for health education. Most respondents appear to be experienced teachers, as suggested by their position in the schools and age profile.

Perceived health education practice
Primary and post-primary teachers were categorized into schools that had a health education policy and those that did not. The means and standard deviations of teachers’ perceived health education practice in their school across the 10 bipolar constructs were calculated and these estimates are displayed in Table 1.

| Table 1: Means and standard deviations across the 10 health education constructs for school type and for policy holding and non-holding schools |
|----------------------------------|------------------|---------|------------------|---------|---------|------------------|---------|
| School type                      | Primary (N = 128)|         | Post-primary (N = 68) |         |
| Health policy                    | Yes (N = 78)     | No (N = 50) | Yes (N = 47) | No (N = 21) |
| Constructs                      | Mean  SD         | Mean  SD | Mean  SD         | Mean  SD |
| One                             | 72.40 19.97      | 61.32 22.08 | 70.90 20.23      | 61.36 25.18 |
| Two                             | 70.82 18.28      | 57.66 18.29 | 73.10 17.49      | 62.21 23.13 |
| Three                           | 68.67 19.43      | 60.22 17.73 | 69.67 20.60      | 58.95 26.48 |
| Four                            | 72.73 18.33      | 56.17 19.82 | 72.25 18.68      | 52.14 27.03 |
| Five                            | 64.48 20.78      | 55.32 19.70 | 67.39 19.59      | 60.10 24.02 |
| Six                             | 77.26 18.17      | 64.11 21.63 | 76.50 16.82      | 66.76 26.02 |
| Seven                           | 75.97 17.95      | 73.42 20.45 | 70.31 20.39      | 61.50 28.78 |
| Eight                           | 75.37 19.39      | 64.75 22.35 | 62.01 24.19      | 57.58 32.10 |
| Nine                            | 66.70 24.20      | 60.54 24.99 | 56.21 28.91      | 41.69 29.93 |
| Ten                             | 68.21 18.56      | 61.11 20.01 | 63.21 25.15      | 58.50 25.83 |
On initial inspection of the results in Table 1, it is clear that, on average, teachers indicate that their schools perform fairly well in relation to many of the constructs, which suggests that health education practice is, in general, evaluated positively by teachers. It does appear, however, that teachers’ perceptions of health education practice vary considerably across policy holding and non-holding schools. To further explore the perceived health education practice in schools, data were analysed using the general linear model to statistically assess differences between non-policy and policy holding schools and between primary and post-primary schools. In relation to the 10 constructs, results at the multivariate level indicate statistically significant difference between policy and non-policy holding schools (Pillai’s Trace = 0.193; \( F = 4.38; \) df 10, 183; \( p < 0.0001 \)) and also significant differences between primary and post-primary schools (Pillai’s Trace = 0.189; \( F = 4.27; \) df 10, 183; \( p < 0.0001 \)).

Further analysis revealed that significant differences were apparent between policy and non-policy holding schools in relation to constructs ‘One’ (understanding of practice—traditional versus contemporary) (\( F = 9.33; \) df 1, 192; \( p = 0.003 \)), ‘Two’ (defining health—narrow versus broad definition) (\( F = 16.31; \) df 1, 192; \( p < 0.0001 \)), ‘Three’ (using pedagogy—instruction versus participation) (\( F = 8.88; \) df 1, 192; \( p = 0.003 \)), ‘Four’ (recognizing influences—less coherent approach versus recognition of other influences) (\( F = 33.49; \) df 1, 192; \( p < 0.0001 \)), ‘Five’ (responding to problems—reactive versus proactive) (\( F = 6.28; \) df 1, 192; \( p = 0.013 \)), ‘Six’ (comprehending psychosocial factors—limited understanding versus recognition of broad range of factors) (\( F = 13.19; \) df 1, 192; \( p < 0.0001 \)), ‘Eight’ (understanding the roles of staff—not considering the role of staff versus recognizing the importance of the staff role) (\( F = 4.24; \) df 1, 192; \( p = 0.041 \)) and ‘Nine’ (involving parents—not involving parents versus recognition of central importance of parental role) (\( F = 6.12; \) df 1, 192; \( p = 0.014 \)). These results suggest that the presence of a policy has a significant influence on how teachers view health education practice within their respective school. For those schools that have a policy, teachers’ perceptions were significantly greater across 8 of the 10 constructs; the exceptions being constructs ‘Seven’ (recognizing school environment factors—limited recognition versus broader recognition) (\( F = 3.00; \) df 1, 192; \( p = 0.085 \)) and ‘Ten’ (conceptualizing the role of school health education—narrow preventative approach versus broader preventative and integrative approach) (\( F = 2.97; \) df 1, 192; \( p = 0.086 \)), which were greater but not statistically significant.

Statistically significant differences between primary and post-primary schools were found in relation to constructs ‘Seven’ (recognizing school environment factors—limited recognition versus broader recognition) (\( F = 7.20; \) df 1, 192; \( p = 0.008 \)), ‘Eight’ (understanding the roles of staff—not considering the role of staff versus recognizing the importance of the staff role) (\( F = 7.88; \) df 1, 192; \( p = 0.006 \)) and ‘Nine’ (involving parents—not involving parents versus recognition of central importance of parental role) (\( F = 12.31; \) df 1, 192; \( p = 0.001 \)). It is interesting to note that where significant differences occur, primary school teachers rate their schools higher than post-primary school teachers. The significant differences between primary and post-primary schools could be explained in terms of the relatively larger size of post-primary schools. For example, in relation to construct ‘Seven’ (recognizing school environment factors—limited recognition versus broader recognition) it could be that the relatively larger size of the school environment in post-primary schools makes change more difficult. In smaller primary schools, principals may have more autonomy of action or it may be easier to gain consensus across a smaller number of staff. Similarly, construct ‘Eight’ (understanding the roles of staff—not considering the role of staff versus recognizing the importance of the staff role) refers to staff well-being and since there are generally more staff in post-primary schools, so it is perhaps a more demanding task to recognize and accommodate the needs and requirements of all staff. Likewise, construct ‘Nine’ (involving parents—not involving parents versus recognition of central importance of parental role) refers to parental support and, as there are generally more pupils in post-primary schools and therefore more parents, it may be more demanding to communicate effectively with all parents. The results from primary and post-primary schools do appear to affirm the sensitivity of the measurement instrument used, since the items distinguish salient aspects of health education practice associated with institutional size.
Development and dissemination of health education policies

In total, ~61% of primary schools had a health education policy, as had 69% of post-primary. Schools alone (64% of primary and 56% post-primary schools) mostly undertook policy development, but in a number of occasions the school's respective ‘Education and Library Boards’ (five geographically located regional management structures) contributed to policy development (35% primary and 44% of post-primary schools). A relatively small number of schools (23% of primary and 36% of post-primary schools) had a working group associated with development of policy. Members of the working group were mostly teachers, but in some instances a school nurse, dental nurse or health promotion officer was involved in the working group. A range of external agencies contributed to the policy development, for example, the ‘HPA’ and ‘Health and Social Services'; however, a minority of schools used such agencies. Teachers were also asked to identify groups or individuals, who were associated with the school and who contributed to the health education policy. Primary and post-primary teachers were the main contributors to the health education policy (94 and 87%, respectively). Board of Governors appeared to be involved in policy development in some schools (24% for primary and 25% for post-primary schools). Interestingly, both parents (11% of primary and 10% of post-primary schools) and pupils (6% primary and 10% post-primary schools) were consulted in a small number of schools. These results suggest that policy development was, for the most part, an in-house undertaking.

For schools that have a health education policy it is obviously important that members of staff can access the information. The vast majority of respondents reported that policy was disseminated to all teaching staff (~86% of primary and 83% of post-primary schools). A variety of staff members, other than teachers, also received policy information: school governors (~67% of primary and 53% of post-primary schools); and kitchen staff (18% primary and 21% post-primary schools). Most interestingly, only 20% of schools reported that a health education policy was forwarded to all pupils’ parents. Respondents were asked which dissemination mechanisms were used to convey health education policy to staff. Across schools, the major method used was through a policy document (56% of primary and 62% of post-primary schools), although a number of alternative dissemination methods were also used (departmental meeting: 37% primary and 10% of post-primary schools; training session: 9% primary and 12.8% of post-primary schools; individual oral communication: 17% primary and 10% post-primary schools). It appears from these results that, in the main, schools disseminate health education policy widely among the teaching staff, mostly in the form of a document, although a number of other dissemination mechanisms were used, sometimes independently, but mainly in conjunction with the written policy. Dissemination to parents, however, was at a low level.

DISCUSSION

It is important to note that teachers reported the situation in the school as they perceived it and no direct or objective measure of the actual health education practice in the school was obtained. The analysis nevertheless points to robust variations between policy and non-policy holding schools in terms of perceived health education practice.

The statutory basis of cross-curricular themes is likely to lead to greater visibility in whole school policies and planning (Whitty et al., 1996). Notwithstanding, the current research shows that not all schools have a health education policy, although a larger proportion of schools do have a policy compared to the findings of previous research (Denman et al., 1999). Similar to previous research, the results indicate that proportionately more post-primary schools than primary schools have a health education policy. Possible reasons are that more staff are available in post-primary schools to share the administrative workload, evidenced by a greater percentage of health education coordinators in post-primary schools, whereas in primary schools head teachers generally retain responsibility for coordinating the health education theme (Denman et al., 1999). While post-primary schools are more likely to have a policy, primary schools perform relatively better on a number of aspects. In particular, primary schools appear to recognize the ‘impact of the environment (construct “Seven”); the health of staff (construct “Eight”); and parental support (construct “Nine”)’ more so than post-primary schools.

The main finding of the study is that policy has a significant effect on teachers’ perceptions of the
health education practice in their school. Across the 10 constructs teachers’ evaluations were significantly higher in 8 of the 10 constructs in policy holding schools, compared to the non-policy holding schools. It would therefore seem reasonable to suggest that policy has intrinsic value in relation to advancing the perceived health education practice in schools. Indeed, this finding goes someway in affirming the assertion of many researchers, who consider policy as a prerequisite for the effective health education (Nutbeam et al., 1987; Smith et al., 1992; Tones and Tilford, 1994). For those schools that had a policy it appears that policy generally covered a wide range of issues, since teachers’ evaluation of many of the constructs were positively affected. Nevertheless, a worthwhile approach in future work would be to examine policy content in relation to health education practice more closely, with a view to distinguishing which aspects of policy impact on effectiveness. This approach might be particularly worthwhile in the light of a crowded curriculum, as teachers could place emphasis on those policy aspects that where found to be most effective.

It is clear that differences exist between policy and non-policy holding schools in terms of how teachers perceive health education practice in their respective schools. The major question concerns why these differences occur. Teachers’ perceptions of health education practice may have been enhanced during the policy development process, which may have a consequent effect on how teachers interpret the situation in the school. Alternatively, policy may have had a real effect on schools’ health promoting approach, which is reflected in teachers’ responses. While it is acknowledged that practice can precede policy, it appears from the current data that policy may act as a mediator for change, since teachers’ perceptions of health education practice in policy holding schools are more favourably relative to non-policy holding schools. The obvious implication flowing from this finding is that schools should seek to develop and implement a health education policy, and the evidence suggests that effective health education is less likely in the absence of health education policy.

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REFERENCES


