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IMPROVING PRIMARY SCHOOL HEALTH EDUCATION
THROUGH ACTION RESEARCH

- A CASE STUDY -

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This Thesis is Submitted as Partial Fulfilment of the
Requirements For

Master of Education (Research)
Faculty of Education
Deakin University

May 1994
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CANDIDATE’S STATEMENT

I certify that this thesis, entitled Improving Primary School Health Education Through Action Research, and submitted for the degree of Master of Education (Research) is the result of my own research, except where otherwise acknowledged, and that this thesis (or any part of the same) has not been submitted for a higher degree to any other university or institution.

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ACKNOWLEDGEMENTS

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SUMMARY

Limited research has been conducted concerning the actual practice of health education in Victorian schools.

This study investigates the health education curriculum at a large primary school in the south-eastern suburbs of Melbourne. The investigation involves a critical analysis of current practices in health education in the upper school through the development of a 'small' action research group. Data were gathered through document collection, questionnaires, interviews, discussions, diary and reflective journal entries.

The action research group, consisting of the teacher-researcher and upper school teachers, developed, implemented and reflected upon units of work piloted with upper school students. Alternative approaches to health education were explored. The aim was to accommodate critically informed discourse amongst colleagues to promote self-reflective enquiry and facilitate improvements to existing pedagogic practices.

During the course of the investigation, factors limiting and facilitating action research and curriculum change in health education, became evident. These included personal, practical, curriculum and organisational constraints operating externally and internally on the school and classroom environments. Despite these constraints, it was demonstrated in this study, that action research can contribute to the improvement of pedagogic practices in health education. Small 'authentic' action research projects may provide alternative internal professional development structures for teachers and consequently improve learning opportunities for students.
1.0 INTRODUCTION

1.1 Broad Context of the Study

In Australia, drastic changes in social structures and exposure to the electronic media requires schools to extend their role far beyond that of simply imparting knowledge (Wolcott, 1987). Schools need to provide children with a forum for reflective discussion, which can accommodate social awareness. Alternative approaches to health education, which support a holistic view of health and recognise the need to cater to children's 'lived experiences', may potentially give children greater control over their lives. The chance to participate in learning opportunities which emphasise real life skills and require active involvement, in a safe and supportive environment, may challenge students thinking and should be an essential element of contemporary primary school health education (Ministry of Education, Victoria, 1989a; Ministry of Education, Victoria, 1989b).

While Australia is dubbed the 'lucky country' unhappiness is a common problem which is experienced within all income groups (Biddulph, 1988). In today's society one in three marriages ends in divorce, one quarter of adults use medication to relax, and one in every five adults will require psychiatric assistance in their lifetime (Biddulph, 1988).

These circumstances have placed increasing demands on the lives and minds of children. The traditional extended family is less common and the structure and composition of families is changing. The number of single parent, de facto and step families have increased and are continuing to rise (Wolcott, 1987).
The economic situation is uncertain with many families suffering from unemployment and incomes below the poverty line (Ochiltree, 1990).

These trends and situations have changed the structure of childrens’ support systems, placing greater emphasis on the role of the school in terms of personal development, health and social education. If schools are expected to accommodate social changes, including a pluralistic society which supports non-traditional values, and compete with the electronic media children are excessively exposed to, then the traditional modes of transmission which remain dominant in today’s schools (Baird and Mitchell, 1989) are long overdue for review.

While progressive approaches to health education in Victoria have been advocated in state guidelines, expressed in The Personal Development Framework P-10 (Ministry of Education, Victoria, 1989a), limited documentation is available concerning the actual 'practice of health education in schools' (Kirk and Gray, 1990).

The purpose of this study was to explore the impact of action research on improving the school health education curriculum (development and implementation), at a state primary school located in the eastern suburbs of Melbourne, Victoria.

1.2 Statement of the Problem

The Liberal government was elected in Victoria in October 1992. The government’s economic rationalisation of state education is creating many changes to long established education practices. It is argued that the people of Victoria are witnessing changes with a degree of speed and enormity never before seen in the history of
education in this state. The state government claims that cuts in expenditure on education are necessary if Victoria is to reach the position of a sustainable economy in the future (Directorate of School Education, Victoria, 1993b).

To accommodate reduced staffing levels and dissemination of support services and resources, the Directorate of School Education and schools themselves, will need to consider new structures to support curriculum development and improved implementation in the eight learning areas of the proposed National Curriculum, including Health and Physical Education (Directorate of School Education, 1993b).

This thesis considers the continued improvement of primary school health education, in a climate where reduced expenditure is limiting teacher access to professional development activities, and support through external curriculum consultancy is declining. The thesis has been developed from a practical perspective of ‘teacher as researcher’.

This passage by Sarason describes the conception of this research thesis:

"Those who are at home in the world of ideas and theory usually have never experienced the creation of a setting. They are interested in what is, has been and should be, but they themselves have rarely, if ever, put themselves in a situation where the centre of action was moved to the creation of what should be where they will experience the problems as participants rather than observers, and where theory and practice take on new relationships".

(Sarson, 1972, p.183 cited in Kemmis et al. 1988)
I will argue throughout this thesis a case for providing teachers with the resources, structures and support required to develop 'critical friend' relationships within their working environment. It will be argued that such relationships may facilitate self-reflective enquiry by teachers into their teaching of health education, and provide opportunities for informed, critical discourse between teachers.

Critically informed, pedagogic discourse has the potential to improve teaching and may consequently contribute to the development of valuable learning opportunities for students.

1In this thesis, in the context of the school based action research project, the term 'improve' has been used in accordance with Kemmis and McTaggart’s (1990) definition: "Action research is an approach to improving education by changing it and learning from the consequences of change".

(Kemmis and McTaggart, 1990, p.22)
1.3 **Defining Health and Health Education In The School Context**

Definitions of health have changed over the years from that of an absence of diseases to focus more on the positive aspects of health. For example, Hetzel and McMichael (1989) define health as 'a state of physical, mental and social well-being that facilitates personal fulfilment and enjoyment of life (p.3)'.

An alternative view of health is that expressed by the World Health Organisation (WHO) where the focus is from a family and community perspective rather than an individual one (World Health Organisation, 1981).

The Victorian Ministry of Education’s (1989a) definition of health education considers health from an individual and community perspective, and recognises action as an essential component.

"Health education may be defined as a combination of learning experiences which affect the way students think, feel and act in relation to their well-being and that of others. It has regard for the dignity, privacy and the uniqueness of the individual".  
(Ministry of Education, Victoria, 1989a, p.45)

Green defines health education as:

"...any combination of learning experiences designed to pre-dispose, enable and reinforces voluntary adaptations of behaviour conducive to health".  
(Green, 1982, p.3)
Green's definition can be expanded in its application to school health education as having an individual and social focus and acknowledging that there are forces outside the control of the individual that influence health behaviour (Fisher, Howat, Binns, Liveris, 1986).

This view has been acknowledged in the Ottawa Charter for Health Promotion (1986) which describes health as 'a positive concept emphasising social and personal resources, as well as physical capacities' (World Health Organisation, 1986).

Jackson (1985) takes this point further with her behavioural-environmental model of health problems by identifying factors which contribute to an individual's health status.

**Figure 1.1 A Behavioural-Environmental Model of Health Problems**

(Source: Jackson, 1985: Community Health Studies, p.3)
Jackson acknowledges that although behavioural choice and lifestyle effect the health status of an individual, freedom of choice is often regulated by the physical, socio-economic and family environment (Jackson, 1985).

In the school context it may be necessary to consider a broader view of health education, as behaviour change may be only one of many expected outcomes.

Tones suggests:

"Effective health education may produce changes in understanding or ways of thinking; it may bring about some shift in belief or attitude; it may influence or clarify values; it may facilitate the acquisition of skills; it may even effect changes in behaviour or life-style".

(Tones, 1990, p.2)

Williams and Aspin (1981) suggest that health and health education can only be defined in relation to a specific context, such as a particular school community. This will allow for consideration of individual community needs which may include race, religion housing, lifestyle and many other facets which influence health.

According to Kirk and Gray (1990) contemporary definitions of school health education:

"...go(es) beyond the simple delivery of facts and information to treat more complex matters such as belief, assumptions, values and ways of life; that ...go(es) beyond the classroom to embrace a healthful school environment and the provision of health services....and more recently adopts a health promotion approach to health education and a reaching out to the community".

(Kirk and Gray, 1990, p.70)
The Health Education Association of Victoria (HEAV) extends the definition of school health education even further to:

"Provide learning opportunities (particularly through "doing") to enable students to become fully functioning, well-rounded, confident, understanding, responsible and creative individuals with well developed interpersonal skills, friendship networks, a strong sense of self, a sense of control over their world, and able to experience and enjoy life". (HEAV, 1993, p.4)

The definitions and relationships between health education and health promotion have been given a considerable amount of attention by academics in the field. No consensus on the use of the two terms has been reached.

Green defines health promotion as:

"...any combination of health education and related organisational, economic and environmental supports for (individual, group and community behaviour) conducive to health." (Green, 1982 p.3)

According to Fisher and his colleagues (1986) health education in the school context is always health promotion. It would therefore be fair to assume the use of the terms health education and health promotion synonymously in this thesis, as is often the case in health education policies and programs. Fisher, Howat, Binns and Liveris (1986) argue that health promotion is not health education when changes in practice are implemented using enforced policy or regulations. They suggest that this type of legislation does not usually come under the umbrella of ‘specifically designed learning opportunities’.
In the school context this would include changes to canteen policies to ensure only nutritious items for sale, eliminating freedom of choice (Fisher, Howat, Binns, Liveris, 1986).

The literature in the area suggests health education\(^2\) encompasses a diverse range of meanings, which can be extended and adapted to suit individual school environments. However, any acceptable definition would need to recognise the limitations an individual has over his or her own state of health (Jackson 1985), and view health education in an holistic sense.

For the purpose of this thesis the definition of health education used will recognise that there are forces outside the individual which effect health knowledge, attitudes and behaviour and that these forces are socio-environmentally based. Education for health will be viewed from an inclusive perspective where physical, social, emotional and personal well-being are expressed as equally important, therefore supporting a comprehensive, interrelated view of health education.

\(^2\)The term 'health education' will be used throughout this document except when referring to material written by other authors who specifically use the term health promotion.
CHAPTER TWO

2.0 REVIEW OF LITERATURE (Part One)

2.1 Introduction

To gain an insight into the developments of school health education I will review the discipline from three perspectives. Firstly, an historical overview of school health education will be examined. Secondly, models of health education applicable for primary education will be considered. Thirdly, contemporary views of school health education will be explored and their application to school and classroom situations will be considered. Recent developments in health education in Australia, Britain and the United States will be briefly considered.

2.2 An Overview of School Health Education in Australia

In Australia, concepts of school health education have traditionally involved imparting knowledge regarding personal hygiene, parasitic diseases, infections and malnutrition (Owen, Coonan, Worsley, 1989). A contents approach has often been used based on providing facts and information (Irwin, 1981). School health educators have traditionally come from within the home economics and physical education disciplines promoting healthy eating habits and the 'sound body' - fitness paradigm (Sargent 1983).

During the 1960's new models of health education emerged which aimed to empower the students, through education, to learn basic life skills and develop the personal attributes necessary to make informed choices.
The content adopted in this era focused largely on epidemiological, disease-centred school health education which Sargent (1983) suggests supported public health programs designed to assist the population to change ‘self-destructive’ behaviours.

According to Sargent (1983) this preventive, medical approach to health education was more readily accepted into traditional Australian schools because knowledge was perceived by both teachers and parents as ‘education’. The late 1960’s saw a flood of curriculum materials into schools designed to support this ‘disease and crisis centred’ approach to health education (Sargent 1983).

This lifestyle related, chronic diseases approach to health education was carried well into the eighties. Owen (1988) questions this approach to school health education arguing that the emphasis should not be about motivating children and adults to ‘clean up’ their unhealthy lifestyles. He believes this approach provides no scope for addressing socially disadvantaged individuals and communities and communicates a ‘victim blaming’ stance. Owen recommends that the new public health movement needs to be considered in relation to broader social changes. He suggests that education about health must aim to facilitate health related behaviour which can be maintained over time (Owen 1988).

Sargent (1983) also criticised what he describes as ‘disease-fact focused education’ which he suggests has been determined by reference to epidemiological information. He believes this approach to health education ignores the concept of empowering the individual and consequently fails to address the reality of social inequality in school communities. Again the ‘victim blaming’ concept is reflected, disregarding the decision making process
which provides students with the scope to consider 'realistic options' (Sargent 1983).

Sargent (1983) describes his futuristic view of health education as:

"Education about and towards health: towards feeling worthy, feeling good about and being knowledgeable of self; feeling lovable and able to give love; feeling fit and well; towards holding self and others in regard: such health education will not only require a different "designed combination of methods", it will most likely also have very different goals".

(Sargent 1983, p.45)

Sargent (1983) argues that preventive health education needs to be preceded by comprehensive school health education where physical, social, emotional and personal well-being are expressed as equally important. Sargent supports a skills-based approach that addresses content areas such as stress management. The problem of school health educators being 'attracted to the packaged facts' and 'objectively assessed outcomes' (Sargent, 1983) limits health curriculum designed to address the specific needs of diverse school communities (Anderson, 1985; Sargent, 1983).

Contemporary school health education programs in Australia have focused heavily on behavioural perspectives in an attempt to decrease excessive ill-health behaviours (Fisher, Howat, Binns, Liveris, 1986; Colquhoun, 1990). Health education programs have addressed health issues such as smoking (Powell, 1989), alcohol and drugs (Life Education Centre, 1987), nutrition (Cooper, Freeman and Dobney, 1993), exercise (National Heart Foundation, 1993) and sexually transmitted diseases (Ministry of Education and Health Department, Victoria, 1987). Hetzel and McMichael (1989) warn against programs that take a limited, fragmented approach to
health education and argue that such approaches often encourage experimentation.

Tomlinson (1981) supports Sargent’s argument for comprehensive health education and suggests a cross-curriculum approach would be appropriate. If well organised, this approach would address the problems encountered with fragmented approaches.

Tomlinson suggests:

"The task of the school is to ensure that children are given knowledge about human development, good diet, health promoting habits and ways of organising families and other social groups which promote cohesion and self-confidence rather than stress and breakdown. This cannot be done by merely adding another 'subject' to an already overloaded curriculum".

(Tomlinson, 1981, Foreword)

It has been suggested school health education should adopt an approach from broader perspectives rather than the almost exclusively behavioural approaches currently used (Howat, Fisher, 1984; Colquhoun, 1990). An understanding of the various constraints operating within the context of the school environment and on the school and broader community, would need greater consideration before such an approach could be fully recognised and implemented.

Some of these constraints have been recognised by a State initiative in South Australia, the Teacher Education and Community Health (TEACH) project, and a national initiative the School Development In Health Education (SDHE) project based in the Australian Capital Territory.
In South Australia in 1989 the Teacher Education and Community Health (TEACH) project was established to act on a report formulated by the Interagency Challenge Group. The report argued the case for preventive school-based health education with a particular emphasis on social justice issues.

Initial evaluation by the TEACH project indicated:

"....despite two decades of hard work and commitment by many people both inside and outside the education departments there was little evidence of comprehensive school community (health) programs".  
(Kennett, 1990, p.4)

While the TEACH project embarked on a program to implement school-based health education more effectively and efficiently from a state perspective, the SDHE project continued to document and disseminate information on effective implementation. Stage One of the research of the SDHE project in 1989 identified critical factors for success in the implementation of school based drug/health education programs. Teachers were seen as critical to the process of school-based change with other essential supporting factors which included:

- support from the education system at both central and local levels
- participation of the principal in all initiatives
- support of all teachers for new programs
- to work with committed teachers in a collaborative group planning for and leading the change process
- adequate resources
- relevant up-to-date teacher training which includes
  - input from a credible, outside facilitator
  - classroom-based action research
  - a planned program of student feedback
- structure and time for teacher/group reflection on
According to Kennett (1990) in the South Australian context the SDHE model has been seen to be successful because it suits a resource scarce environment, potentially involves all members of the school and local community and provides a collaborative approach to ongoing comprehensive health education.

Little (1990) outlines the critical factors experienced by successful programs in the Queensland phase of the SDHE project. The factors indicated echo those outlined by Irwin (1991b, 1993) and Kennett (1990) and includes the support of non participating colleagues in the school environment.

The Personal Development Framework P-10 developed as guidelines for Victorian schools in 1989 recommends a comprehensive approach to health education. The framework document removes the emphasis of health behaviour from the individual as it expresses health education as a life long process which values critical thinking about ‘personal’ and ‘community’ well-being. It promotes active interaction between the ‘school’, the ‘home’ and the ‘broader community’ (Ministry of Education, Victoria, 1989a).

The document moves towards the approach advocated by Howat, Fisher and Colquhoun recommending school health education:

"...develops a critical approach towards personal and social factors which influence the quality of life enjoyed by an individual or a community".

(Ministry of Education, Victoria, 1989a, p.45)
The Personal Development Framework acknowledges the difficulty of organising comprehensive health education in the primary school, due to the complexity of developing a curriculum model suited to diverse school communities, whilst supporting two major points made by other authors. The first is that school health education content should be broad and balanced allowing for health issues to be dealt with in context rather than being treated in isolation. This view is supported by Hetzel and McMichael (1989) who suggest a fragmented approach to health education can actually be detrimental to students’ health behaviours. Secondly the Personal Development Framework (Ministry of Education, Victoria, 1989a) supports the development of a school-wide health education curriculum based on a situational analysis and needs assessment (Irwin, 1993) of parents, teachers and students.

It has been suggested that the ‘School Development in Health Education (SDHE) project is one of the most theoretically complete implementations of the new public health in Australia’ (Butt, 1992). According to data compiled from the SDHE project, successful Australian school health education projects display common elements which include ‘total in-context, sequenced and technically supported responses for local situations’. An essential component of an effective program is a needs assessment to provide the basis for planning and evaluation (Irwin, 1993).

According to Bartlett (1981) school health education can be effective in improving knowledge and to some degree attitudes but has less impact on changing the health priorities of children. He believes the reason for this to be the teaching methods used in schools which emphasise cognitive learning and lecture type formats, social and environmental factors, and the failure of schools to co-ordinate with community health resources. It appears
there are many problems with school-based health education programs, including an emphasis on individual behaviour change, which need to be addressed if improvement is to take place (Colquhoun, 1990; Owen, Coonan, Worsley, 1989).

It has been argued that health education for children should be extended into the community and serious consideration be given to further implementation of community based models of health education (Bartlett, 1981; Owen, Coonan, Worsley, 1989).

The development of programs using schools as the initial site of instigation, which promote interaction between the school and the community, can capitalise on the 'captive audience' element. This view is supported by Notwothy (1989) who states:

"Healthier lifestyles for the Australian adults of tomorrow depend on the preventive health and health promotional programs offered to the primary school children of today".  
(Notwothy, 1989, p.309)

Wagner and Zins (1985) support the view that health education should be initiated in schools. They take this point further and suggest:

"Many important characteristics and life-long behaviours are established during a child's elementary and secondary school years. During these years schools are in a unique position in that they have access to virtually all children, and further more they have been assigned the responsibility of influencing appropriate cognitive, affective, social, and physical development".  
(Wagner and Zins, 1985, p.5)

It would appear there is enormous potential for improvement in the content and delivery of school health education. Research by
TEACH and SDHE suggest funding and resources need to be provided to address the problems at the school level. This would involve developing a school-community approach to health education where curriculum innovations can be tried and tested in a supportive school environment, where critically informed discourse between teachers and their colleagues, and the broader community, is seen as essential.

Owen (1988) endorses addressing the problem of improving school health education from the school level in the following statement:

"School systems, education department administrators and politicians habituate to new ideas before they are properly put into practice. We need somehow to find a formula or mechanism for more strongly institutionalising the process of innovation and development in the school health and physical education areas."

(Owen, 1988, p.18)

2.3 Models of School Health Education

In Britain a recent article addressing models of health education indicated that at least seventeen published models currently existed (Taylor, 1990). Many of the models of health education have been developed from a community health perspective which usually deal with adults rather than children. Community health models may be suitable in school health education with modifications.

It is the intention here to present a review of models seen as pertinent to this investigation of school health education.

Schools viewing health education from a traditional perspective use the preventive medical model. This model supports the use of didactic or coercive methods to focus on individual lifestyle and behaviour change believed to be conducive to improved health.
Health professionals, or in the case of schools, teachers, are seen as the experts holding all of the pertinent knowledge required to establish in individuals appropriate health behaviours. Criticisms of this model include the emphasis on individual responsibility without consideration of the social context and the assumption that free choice exists (Ritchie, 1991; Taylor, 1990; Tones, 1990).

Rodmell and Watt (1986) provide a critique on existing practices in health education. They describe conventional health education as being set in the medical model and subscribing to changing the health behaviour of the individual which they suggest may be ‘unhelpful’. In the school context this might include nutrition education to support reduced heart disease using teacher directed information to a group of students who frequently come to school without breakfast, due to disadvantaged family circumstances.

The preventive medical model places huge unaccounted for emphasis on changing individual behaviour by providing information. Considering there is limited research available regarding effective content and strategies conducive to changes in health-related behaviour (Owen, Coonan, Worsley, 1989) it is questionable why this approach is emphasised in many curriculum materials developed for use in primary school health education programs.

Tannahill (1990) discusses the problems associated with what he refers to as ‘disease-orientated health education’ and ‘risk factor-orientated health education.’ These two models of health education are most evident in the primary school setting. The latest publication from the National Heart Foundation ‘Food Smart’ (1990) adheres to the two models discussed. The deficiencies of
these two models as reported by Tannahill (1990) include their ‘expert-dominated orientation’, ‘making a community diagnosis’ and issuing a population ‘prescription’ and neglecting the positive dimension of health (p.195). Both models neglect the impact of social factors on lifestyle.

Tannahill advocates a health-orientated model of health education which can be adapted for use in the school environment. The priorities in this instance are people and places. The emphasis is directed towards developing ‘comprehensive programs’ of health education which are defined by the participants (school communities) and therefore relevant to them. The model includes the process of shaping and implementing ‘action’ for better health. Consideration is given to social factors which supports an ‘holistic view of health and its determinants’ and emphasises ‘wellness’ rather than ‘illness’ (Tannahill, 1990).

Figure 2.1  Health-Orientated Health Education

(Source: Tannahill, 1990: Health Education Journal, p.196)

Tannahill suggests this approach facilitates ‘multidisciplinary and intersectoral collaboration’ where teachers can be involved from the beginning rather than having a ‘hotch-potch of initiatives dropped on them from above’ (Tannahill, 1990, p.196). This model for school health education is supported by Colquhoun and
Robottom (1990) who believe school health education needs to become ‘multisectoral’ through involving areas of the community in programs.

The ‘hotch-potch’ as described by Tannahill certainly appears to be the case with current school health education. Education programs developed by corporate organisations for primary school teachers include Life Education (Life Education Victoria, 1987), Safety House, (Maher, 1990) Food Smart, (Cooper, Freeman and Dobney, 1993), Living with Sunshine (Anti Cancer Council, 1991), Jump Rope for Heart (National Heart Foundation, 1993), Be Smart, Don’t Start (Powell, 1989) and Personal Safety (Headey, 1992). These programs may be useful to support comprehensive health education in schools but should not be seen as the extent of the health program which I fear is often the case (Hawthorne, Garrard, Dunt, 1993).

2.4 Contemporary Views of Health Education

A recent article titled, "The New Public Health - Rhetoric or Reality" written by Butt (1992) explores policy development and implementation with a number of prominent health professionals. Butt (1992) reports that Dr Kickbusch believes the link between social reform and health needs to be re-established as a priority of any social health strategy.

The difficulty of instigating a connection between social reform and health, in an effort to realise the themes promoted in the World Health Organisations (WHO) Ottawa Charter, have been explored by Bunton (1992), Director of Alcohol Concern in Wales.
He suggests:

"Policy is a process which involves not only government statements and WHO statements, but also involves organisational change, regional policy development and local activity development".

(Bunton in Butt, 1992, p.9)

Baum, Senior Lecturer in Primary Health Care in South Australia supports Bunton’s concerns in her reflection of the Healthy Cities Projects funded in an attempt to promote and influence health in local communities. Baum stated:

"The rhetoric of Healthy Cities, however, belies the difficulties of actually bringing it (change) about in practice".

(Baum in Butt, 1992, p.10)

These comments highlight the diversity and complexity of health improvement strategies, while at the same time acknowledging the difficulty of bringing about change, despite strong policy development. School health education is facing the same problem with policy development experiencing limited action at the school and classroom level (Irwin, 1981). Kirk and Gray (1990) suggest while progressive approaches to health education are evident in policy development and materials, little is known about the actual ‘practice of health education in schools’.

While academics in the health field call for ‘radical structuralist’ approaches (Fisher, Gay, Howat, 1984) which challenge dominant ideologies, classroom teachers and school communities struggle to improve health education for their students with limited funding, decreasing resources, lack of time, and a reduction in professional
development support.

Howat and Fisher (1984) recommend the adoption of school health education for social policy change which they call health education for 'structural perspectives'. This is based upon the belief that school health education that focuses on behaviour change should also consider addressing the 'primary causes of unhealthy behaviours' including environmental and social causes of ill-health. The development of skills in the areas of decision-making, values clarification, interpersonal communication, self management, assertiveness and self-esteem are recommended as the basis for 'survival skills' into adulthood (Fisher, Gay and Howat, 1984). Fisher and his colleagues suggest teaching strategies that incorporate 'student involvement and interest, will enhance health education for structural perspective' (Fisher, Gay, Howat, 1984, p.9).

Rodmell and Watt (1986) acknowledge the difficulty faced by health educators who attempt to work against the dominant ideologies.

Rodmell and Watt state:

"...lifestyle is both the material expression of an ideology - and ideology as it is experienced in day-to-day living and the framework within which the day-to-day living is structured and patterned. The relative stability of these patterned sets of actions indicates that individual members of a social group cannot be expected to easily alter their lifestyle in the response to recommendations of professionals. Making 'healthy choices easier choices' is therefore, likely to require significant transformations of the social conditions under which any choice is made".

(Rodmell and Watt, 1986, p.5)
Rodmell and Watt point out that providing knowledge is not a total means to facilitating choice and freedom of choice does not necessarily mean a 'healthy choice'.

The limits to health education which focus on individual behaviour change are discussed by Naidoo (1986). She critiques individualism on three counts. She argues health education based on individualism, is ineffective in promoting good health, ignores the social and cultural issues defined by Jackson (1985) and assumes freedom of choice exists. Naidoo (1986) suggests the persistence of strategies aimed at the individual which accommodate perceived freedom of choice, do not interfere with the ethics of human rights of the individual. She suggests that cognitive evaluation measuring increased knowledge can easily be used (Naidoo 1986).

Naidoo states:

"To be effective in prevention, health education must concentrate more on the social and environmental determinants of health. To do this requires going beyond an individualistic framework".

(Naidoo, 1986, p.35)

Cribb (1986) acknowledges the difficulties faced by schools in evaluating a health curriculum which moves away from the traditional focus on knowledge and skills:

"It is relatively straightforward to measure specific changes in pupils' knowledge, but attempts to define achieve and evaluate changes in attitudes, conceptual or social skills, locus of control or self-esteem are fraught with difficulties".

(Cribb, 1986, p.109)
He views health education in a cross-curricular form and suggests the personal development and self-empowerment aspects of health lead to 'issues of political literacy' (Cribb, 1986, p.109).

Colquhoun and Robottom (1990) identify the link between health and environmental education and recognise the potential for political literacy through a socially critical curriculum. They suggest:

"No longer will the individualistic, behavioural, lifestyle approach to health education suffice. Health is about more than individual behaviour change - social, environmental, economic and political issues need to be encountered in the curriculum. However, it is clear that the focus for contemporary school health education is individual behaviour change through the supposedly rational process of decision-making".

(Colquhoun and Robottom, 1990, p.111)

Cribb (1986), Kirk and Gray (1990) acknowledge the difficulty of creating change in a school system where measurable outcomes and credentials are a priority. These traditionally structured systems have produced a position of prestige to examinable subjects, with non-examinable subjects relegated to a lower status.

Cribb (1986) suggests that generally health educators view their role as preparing students for life rather than 'academic success'. This is in opposition to the view that education should be aimed at vocational preparation. Apple (1987) argues against schooling for technological vocation suggesting technological know how and career enhancement are statistically overstated. He believes the powerful influence of a minority in industry and business are beginning to dictate the way we think about schooling with the emphasis on vocation, threatening concerns for a democratic
curriculum where social justice issues are addressed. Apple suggests growth in the job market will come in the areas of employment where post-secondary education is not necessary questioning the over emphasis on schooling for vocation (Apple, 1987).

Beckett (1990) explores Apple’s theory in relation to health education, suggesting that ‘people involved in education for health have to resolve the practical and political intentions of both schooling and health education’ (Beckett, 1990, p.92).

Beckett (1982) argues that limited, if any, improvement in societies ill-health will be made unless health educators break free from ‘the confining limits of conventional rationality and its behaviourist formula’ (Beckett, 1982, p.55). She believes that the current emphasis on lifestyle changes of the individual in school health education focuses on today’s unhealthy society ‘idealising’ a healthy way of life in the future (Beckett, 1986).

Beckett suggests:

"The driving force for change is people, individually and collectively acting on the social world in the basic interest of human health and well-being, rather than passively consuming ‘health’ as part of an individual lifestyle”.

(Beckett, 1986, p.156,157)

Despite calls by contemporary academics (Colquhoun and Robottom, 1990) for schools to take broader approaches to school health education, which include health education from social and political perspectives, approaches to the curriculum remain conventional and conservative.
School health education programs in Australia and other countries have continued to focus on epidemiological information which supports individual behaviour change. In Australia this is confirmed by the curriculum packages available from corporate organisations including the National Heart Foundation and the Anti Cancer Council. In Victoria the 'Life Education' program developed to accommodate drug education in schools, concentrates on the individual behavioural model. The Health in Primary Schools (HIPS) project developed, in Victoria, was an attempt to move away from the individual behavioural model and towards a school-community approach to health education. The successful elements of each project varied between individual schools (Went, 1991).

In Britain the 'Happy Heart Project', the 'My Body' and 'Health for Life' programs (Sleap, 1992) have been developed to accommodate school health education based on individualism.

In the United States the 'Life Skill Training Program' (Botvin, 1985) and 'The Know Your Body Programs' (Cross, Renshaw, 1993) are two programs which use early intervention strategies to address changes in lifestyle habits related to heart disease and cancer.

In the United States The Alcohol and Substance Abuse Prevention (ASAP) program is a community and school-based prevention project which has been developed for adolescents. The project promotes empowerment education which emphasises the participation of people in group action (Wallerstein and Bernstein, 1989). The project illustrates an attempt to move away from the individual behavioural model of health education. However, literature which demonstrates the implementation of participative rather than individual models of health education are scarce, suggesting school health education remains heavily defined by the
individual behavioural framework questioned by Beckett (1982), Colquhoun and Robottom (1990), and others.

2.5 Summary

In this chapter I have highlighted the persistence of the individual behavioural approach to health education based on the medical model. There has been calls by educators in the field for changes in pedagogic approaches to health education. The literature concerning current programs illustrates, while there has been some attempt to move away from the individual behavioural model (Wallerstein and Bernstein, 1989) the individualistic model remains the dominant form of school health education.

The persistence with the individualistic model demonstrates its entrenchment, not only in Australia, but also in other developed countries. This emphasises the limited impact alternative approaches, advocated by contemporary writers in the field, have had on changes at the policy and application levels. Anderson (1985) suggests it is at the application level of curriculum implementation in the classroom 'where most curriculum innovators are silent (p.192)'.

Classroom research in the area is certainly limited, suggesting little is known about the actual process of health education in the school environment. It would appear there is a great deal of scope for improving school health education to produce 'the forms of pedagogy effective health education requires' (Kirk and Gray, 1990).
Before this can be achieved we need to consider current practices in health education at the school and classroom levels. This will allow us to analyse the process of health education in the school environment and explore influences facilitating and limiting change. We can then provide a framework for developing strategies to improve practice. An investigation of school and classroom procedures and practice in the area may contribute to an understanding of why traditional, behaviourist health education remains the dominant form.
CHAPTER THREE

3.0 REVIEW OF LITERATURE (Part Two)

3.1 Introduction

In this chapter I will examine curriculum theory, in particular critical theory, and its relevance in improving school health education. I will explore the influences that political, economic and social ideology have had on educational change. Changes in education have influenced curriculum development at state and federal levels. These influences on curriculum development will be considered in relation to school health education. Professional development and in-service education will be discussed in relation to the potential for improving teaching and learning. School based curriculum development (SBCD) as a form of empowering school communities will be considered. The factors constraining and controlling teachers, and the theory of social reproduction through education, will be considered throughout the chapter. A critical framework for considering improving school health education will be presented.

3.2 Curriculum Theory in Practice

If we examine curriculum theories, we can consider approaches to curricula in school health education which move away from those based on traditional models. Alternative approaches to curriculum based on critical theory, may promote understanding in developing concepts and exploring issues in health education within the school environment, and provide the foundation necessary for empowering students and teachers.
Jurgen Habermas (1972), anthropological philosopher, developed a 'tri-paradigmatic framework' which has been adapted for use by curriculum theorists to explain levels of knowledge, and their relevance to curriculum inquiry and development. Habermas viewed knowledge as the result of human activity motivated by natural needs and interest (Carr and Kemmis, 1986). Habermas' first level of knowledge is the empirical-analytic or technical type of knowledge which emphasises facts, generalisations, cause and effect laws and theories.

Curriculum developers who aim to emphasise technical knowledge may employ methods of curriculum development based on Tyler’s (1949) Objectives model. This model is based on a linear progression of steps which commences with the stating of measurable objectives. Evaluation of this type of knowledge, using Tyler's (1949) model, is goal based and achievement orientated. Curriculum developers in Australia in the sixties and seventies based their work on Tyler’s principles (Marsh and Stafford, 1990). It has been argued (Marsh and Stafford, 1990) that in practice curriculum development does not happen in such an organised way.

According to Smith and Lovat (1991) technical knowledge is emphasised in schools because it is the easiest to measure. McLaren (1989) believes the preferred use of behavioural objectives by teachers highlights their desire for technical control of knowledge. Using this model the teacher is viewed as the expert with the responsibility of ensuring that the learner can reproduce the explicit knowledge imparted. The pedagogic practices which support the technical view of knowledge have been discussed by Hoetker and Ahlbrand (1969) and further explored by Westbury (1973).
The problem of emphasising technical knowledge in school health education has been discussed in chapter two (Sargent, 1983; Tannahill, 1990). Curriculum development models which emphasise knowledge are inappropriate for developing curricula in school health education, because knowledge alone does not necessarily change behaviour, (Tones, 1986, 1990) if in fact behaviour change is the prime concern of school health education. The information approach to health education denies that health is socially constructed.

Baird (1989) suggests that little has changed in schools in the past eighty years where classroom ‘activity’ reflects students involved in mental inactivity.

Baird (1989) suggests:

"...school systems produce apparently successful learners who in fact lack understanding of much that they have absorbed".

(Baird and Mitchell, 1989, p.4)

Wassermann (1990) suggests that many primary school classrooms operate to support the emphasis on technical knowledge, at the expense of empowering children through active learning experiences.

Wasserman states:

"...operating conditions in many primary classrooms...attest to what some teachers, deep in their hearts, believe really counts: seatwork! Seatwork and other pencil-and-paper tasks seem to be the 'real' stuff of classroom life".

(Wasserman, 1990, p.15)
The second level of knowledge outlined by Habermas (1972) is at the situational interpretive or the historical-hermeneutic level. Carr and Kemmis (1986) explain this level as ‘grasping the social meanings constitutive of social reality’ (p.135) which allows us to give meaning to social situations. In relation to curriculum practice phenomenological interpretive evaluation is used, based on communication between teacher and learner. Using this interpretation of knowledge the teacher is a partner in the learning process in which he or she cannot coerce or force the learner to negotiate meaning. Curriculum development to address this level of knowledge might be based on Stenhouse’s (1975) ‘Procedural’ approach which provides the scope to emphasise negotiated and experiential types of learning.

Carr and Kemmis (1986) believe,

"...the interpretive approach cannot assess the extent to which an existing form of communication may be systematically distorted by prevailing social, cultural or political conditions”.

(Carr and Kemmis, 1986, p.135)

Habermas’ third level of knowledge is self-reflective or critical knowledge which requires critical evaluation to determine underlying assumptions, interest, values, motives and implications for action to improve human conditions. This form of knowledge reverses the traditional role of the teacher and the learner. Here the learner is in control and evaluation may only be possible through the teacher facilitating communication, which will assist the learner to verbalise his or her learning experience. However, verbal communication may not be sufficient to allow the teacher to actually understand the ‘lived experience’ of the learner.
Curriculum development to promote critical knowledge may be based on Kemmis and McTaggart's (1990) 'Action Research' model, where independent learning can be encouraged and students and teachers can work towards practical action for change.

Wassermann (1990) supports this view and suggests 'teachers can do a great deal to empower children' by providing them with learning opportunities which require them to 'engage in real activities that challenge their thinking' (p.14).

The value of critical knowledge is emphasised in the curriculum document 'Learning How to Learn' (Ministry of Education, Victoria, 1989b) which states:

"The objective of ‘improving’ learning and thinking in schools is concerned with moving students beyond those learning activities based on recall/memorisation and comprehension to those skills which are involved in more complex forms of reasoning and thinking such as problem-solving, decision making, invention and evaluation".

(Ministry of Education, Victoria, 1989b, p.11)

‘Learning How to Learn’ documents the use of metacognitive skills (the ability to control and reflect on one’s learning and thinking processes) in curriculum development. Baird and Mitchell (1989) recognised that a great deal of superficial learning was taking place in schools, with a lack of emphasis being placed on reflection. This lead to the development of the Project for Enhancing Effective Learning (PEEL) (Baird and Mitchell, 1989) which concentrated on training teachers and students in metacognition.
In an attempt to change teaching and learning in the classroom, teachers and students who participated in PEEL were asked to change their classroom strategies for learning. The following outcomes have been documented:

- often people's attitudes changed after they had changed their behaviour
- it was more profitable to allow teachers and students to try new strategies for themselves and see the results, then re-evaluate their own attitudes and values, rather than attempting to impose or coerce change.

(Ministry of Education, Victoria, 1989b, p.28)

It is only at Habermas' third critical (empancipatory) level of knowledge, that self-reflective understanding will allow teachers and students to explain the conditions under which they work, in their classroom and schools (Carr and Kemmis, 1986). Self-reflective understanding can provide the basis for a move towards action to improve one's situation.

According to Smith and Lovat:

"For Habermas, it is only when we have reached the third level (critical) that we are guaranteed true knowledge because true knowledge demands that we be free. At the first two levels, we are still liable to be controlled, to be insulated from critiques which are outside our immediate frame of reference. The so-called 'truths' which we receive at these levels can be the result of 'unreflective action'.

(Smith and Lovat, 1991, p.69)

Habermas' third level of self-reflective or critical knowledge, upon which reflective thought and action will occur, is essential if improved curriculum praxis and 'real' learning for students is expected.
In PEEL Habermas' third level of knowledge was aspired to, allowing students to become more willing and able to accept responsibility and control of their own learning (Baird and Mitchell, 1989). This required teachers to give up control and place their energy into listening to, and reflecting on, what was happening in their classrooms (Northfield, 1989).

The application of Habermas' 'Critical Theory' in reforming school health education has been advocated by Colquhoun and Robottom (1990). They argue that 'for both health and environmental education to be successful in the school context, we need a 'socially critical curriculum' (p.109). Colquhoun and Robottom (1990) advocate the adoption of a curriculum 'which stresses the political nature of knowledge and which recognises the vested interests inherent in curriculum (p.109)'.

According to Smith and Lovat (1991):

"Without the Critical Theory, the information which comes from any subject can become a means of bondage, rather than emancipation, a way of oppressing people or keeping them in straitjackets".

(Smith and Lovat, 1991, p.70)

Critical educators (Carr and Kemmis, 1986; Colquhoun and Robottom, 1990; Kemmis and McTaggart, 1990) who draw on the works of Habermas, endorse theories that are dialectical and view problems in society as 'interactive' between the individual and society. If we apply a dialectical understanding in the school situation we can view schools as arenas of 'domination and liberation' that may challenge the theory of social reproduction.
The theory of social reproduction and schooling is discussed by Apple (1979) who describes schools as:

"...a rather significant agent of cultural and economic reproduction. (After all, every child goes to it and it has important effects as both a credentialing and socialising institution)".

(Apple, 1979, p.31)

Apple (1979) and Giroux (1981) developed the concept of critical education which seeks to limit the economic domination perpetuated through education. The form of domination suggested is explained by Giroux (1981) through his description of the 'hidden curriculum' in schools forcing students to 'learn roles, feelings, norms, attitudes and organisational structures of the classroom' (p.83).

Critical theory allows us to rethink schooling in relation to existing inequalities (class, race and gender), and explore the potential to transform society through social reconstruction (McLaren, 1989).

McLaren (1989) believes:

"A dialectical view of schooling also questions the mainstream education theory, which conceives of schools as mainly providing students with the skills and attitudes necessary for patriotic, industrious, and responsible citizens. Critical educators argue that any worthwhile theory of schooling 'must be partisan' that is, must be fundamentally tied to a struggle for qualitatively better life for all through the construction of a 'society based on non-exploitive relations and social justice'.

(McLaren, 1989, p.167)

While one may recognise that cultural reproduction described by Apple (1979) is embedded in the model of transmission
perpetuated in schools, many attempts at any significant forms of intervention have had limited impact. According to a study by Broom, Jones, McDonell and Williams and reported by Keeves (1987), social inequality in Australian society is transmitted from one generation to the next through out school system, and little has changed over the past fifty years. In his review of social justice policy in Australian education, Smith (1991) states:

"The overall intention of social justice policy is to make the outcomes of schooling ‘fairer’ for all Australians. The educational treatment of social justice indicates that they have been absorbed into, or in Bernstein’s (1990) terms, recontextualised in existing educational ideology”.

(Smith, 1991, p.7)

This suggests policy development at the national and state level has had limited impact on producing equal opportunities in schools for all students regardless of class, race or gender. Perhaps it is time to look more closely at improvements that can be achieved at the school and classroom level to address social justice issues and support intervention into the cycle of cultural reproduction. If we, as teachers, expect to dissolve existing contradictions between promise and reality in education, it will be necessary for us to participate in critical reflection upon both our situation in our schools and our individual teaching practices.

McLaren (1989) has recognised this contradiction and suggests that if critical pedagogy is to become ‘viable’ in our schools, ‘teachers must learn to employ critical analysis and utopian thinking’.

Aoki (1989) from the University of Alberta, Canada has reinterpreted Habermas’ work and demonstrated its application in
the field of curriculum theory. He has done this through contrasting the technical, practical and emancipatory interests of curriculum inquirers. While a technical interest is predominant in the curriculum field (Carson, 1985), Aoki’s work concentrates on the interrelationship of the interpretive (practical) and the critical (emancipatory) paradigms, to maintain and restore human action in educational settings (Aoki, 1989).

Aoki developed the contrasting concepts of the curriculum-as-lived and the curriculum-as-plan (Aoki, 1977, 1985, 1991). The curriculum-as-plan refers to programs of study, curriculum guides, lesson plans and unit plans usually presented in a linear fashion prescribed in time allotments. This raises the question, “does learning happen in such an organised way?” Where is the space for curiosity, questioning and discussion without the extreme pressure to cover the material?

The curriculum-as-lived is an attempt to consider the presence of people and their meaning, where interest, motivation and other human qualities of education are of primary concern. Aoki (1991) uses the example of Miss O and her students to highlight his concerns for the imbalance between the two curriculum worlds as he perceives them:

"Miss O’s pedagogic situation is a world of students with proper names - like Andrew, Sara, Margaret and Tom - who are, for Miss O, very human unique beings. Miss O knows their uniqueness from having lived daily with them. And she knows that their uniqueness disappears into the shadow when they are spoken of in the prosaically abstract language of external curriculum planners who are, in a sense, condemned to plan for faceless people, students shorn of their uniqueness or for all teachers, who become generalised entities often defined in terms of performance roles”.

(Aoki, 1991, p.7)
Aoki used the two terms, curriculum-as-plan and curriculum-as-lived to explain his theory of how the prescribed curriculum, or the curriculum-as-plan denies the 'humanness that lies at the core of what education is' (Aoki, 1991, p.1).

From a curriculum theorist's perspective Aoki believes,

"...to many school curricula are neglectful and forgetful of the quality of the lived experience of students for whom curricula exists". (Aoki, 1985, p.1)

Aoki’s contrasting curriculum definitions are useful in considering school health education. The concept can make a significant contribution in facilitating educational transformation in improving health education in schools. The curriculum-as-plan may provide limited scope for schools and teachers to present learning opportunities for their students, which accommodate their 'lived experiences'. The curriculum-as-plan may be problematic in providing relevance to the diversity, complexity and uniqueness of individual school communities.

McLaren (1989) also recognises the importance of considering the 'lived experience' of students in the school curriculum. He states:

"Teachers must understand that student experiences arise from multiple discourses and subjectivities, some of which must be questioned more critically than others. It is crucial, therefore, that educators address the questions of how the social world is experienced, mediated and produced by students. Failure in this will not only prevent teachers from tapping into the drives, emotions, and interests that give students their own unique voice, but will also make it difficult to provide the momentum for 'learning itself'.

(McLaren, 1989, p.227)
The provision of quality health education requires that the curriculum-as-plan and the curriculum-as-lived find the space and the acceptance to co-exist in the school-community environment. Ideally the curriculum-as-lived should hold the dominant position if the current and continuing problem of 'cultural reproduction' in schools is to be addressed. This is only possible if teachers begin to employ 'critical analysis and utopian thinking' in their work as suggested by McLaren (1989) and Northfield (1989).

The critical framework illustrated in figure 3.1, which acknowledges the need to consider political, social, economic and cultural influences on school communities, emphasises the work of Aoki (1989) and Colquhoun and Robottom (1990). Aoki (1989) rejects the notion of 'teacher-centred', 'child-centred', discipline-centred' or 'society-centred' curriculum.

Aoki believes:

"...it (is) important to centre curriculum thought on a broader frame, that of "man/world relationships", for it permits probing of the deeper meaning of what it is for persons (teachers and students) to be human, to become more human, and act humanly in educational situations".

(Aoki, 1989, p.6)

Colquhoun and Robottom (1991) have extended Aoki's view in their discussion of a 'socially critical curriculum'. Such a curriculum must be approached from a broad framework of 'man/world' relationships if social, environmental, economic and political issues are to be encountered in a curriculum that focuses on a 'multi-sectoral' outlook.

A curriculum which focuses on man/world relationships cannot be
Figure 3.1  A Critical Framework for Considering the School Health Education Curriculum

(Source: Developed by the author for the purpose of this thesis)

The critical framework for considering the school health education curriculum, in its diagrammatical form, can only provide a fundamental representation of the aspects influencing the school curriculum and consequently students and teachers. The relative size of each sphere vary depending on the degree of influence exerted at different times on the 'lived experiences' of participants. The presence of class, race and gender have been subsumed into each sphere.
3.3 Educational Change in Australia

The state schools of Victoria prior to 1900 regarded the students as passive recipients of knowledge. In 1902 the Director of Education, Frank Tate, introduced a 'revolutionary course of study' based on John Dewey's theory of experimentalism (or learning by doing), which emphasised the pupil as an active participant who required school work related to his or her 'life interests'. His futuristic view of student empowerment was related in the following statement:

"Knowledge which is merely a memorising of more or less useful facts is not power: it is in the application of knowledge to the practical problems of everyday life that genuine power is most rightly shown".

(Education Department Victoria, 1954, p.3)

Despite Tate's recognition of the restrictions centrally developed curriculum had on teaching and learning, traditional teacher-directed methods continued to dominate Victorian primary school education during the first half of the century and into the sixties.

The Plowden Report (1967) was undertaken by the British government during the sixties to look at primary schooling in England and Wales. The report recommended changes to primary schooling which supported 'progressive' education initiatives. The influence of the report was felt in Australian schools. An example was the shift towards open-plan primary schools in the late sixties and early seventies, to accommodate inquiry learning advocated by Bruner (1960) and Taba (1962).

However, this innovation was short lived with pressure from employer groups to return to conventional structures, to
accommodate conservative education principles (Marsh and Stafford, 1990).

A major shift in education in Australia at a federal level came with the completion of the 'Report of the Interim Committee for the Australian Schools Commission' in 1973 (Karmel Report). The report recommended the devolution of responsibility from the central authority to schools themselves. This focus on school-based decision making was accompanied by recommendations for substantial increases in funding. Grants were provided to support teacher development and establish education centres, in an attempt to achieve equality of opportunity for all students. Australia experienced a period of economic prosperity and stability in the seventies and early eighties. The flourishing economy was reflected through the injection of funds to improve educational opportunity.

Educational change in the seventies and eighties reflected progress in relation to state and federal policies of devolution and decentralisation. Schools were beginning to be given greater autonomy in the decision making process. This was evident in Victoria where school councils participated in policy development guided by Ministerial Paper No.6, Curriculum Development and Planning in Victoria (Fordham, 1984).

Education in the late eighties and into the nineties was effected by a depressed economy, highlighted by climbing interest rates and high unemployment. During these times of economic uncertainty state education policy and consequently curriculum may be influenced by social and politico-economic philosophies (Smith and Lovat, 1991).
Economic instability may create concerns regarding a country's ability to compete internationally and employment prospects for the new generation. This was reflected in the federal government's paper 'Strengthening Australia's Schools' (Dawkins, 1988). The paper recommended the development of a National curriculum:

"A major feature of a common curriculum framework should be criteria for determining content in major subject areas. Criteria for methods of assessing the achievement of curriculum objectives should be outlined. The framework should provide a guide to the best curriculum design and teaching practices". (Dawkins, 1988, p.4)

'Strengthening Australia's Schools' advocates a curriculum which emphasises a technocratic view of teaching and learning.

In Victoria, the election of the state liberal government in 1992, produced radical changes to education. In 1993 the devolution of autonomy for Victorian state schools moved towards completion with the introduction of 'Schools of the Future' (Directorate of School Education, 1993a) emphasising self-managing schools, based on corporate management principles. Schools were given greater autonomy with the expectation of more effective, efficient and economical management.

Business practices based on economic rationalism may be inappropriate for the operation of primary schools, where personal growth and empowerment of students could be regarded as the major focus. Schools which are provided with the responsibility of developing human potential should not be expected to operate under the same economic framework as businesses aimed at making a profit through providing a service or producing a product. The intellectual, physical, personal and emotional development of each individual child needs to be given the highest priority if
equality and social justice issues are to be addressed. Self-managing schools governed by principles based on economic rationalism may be expected to operate with diminished resources causing schools to disregard this 'human aspect' of education.

Smith and Lovat (1991) believe an education system that is based on 'economic impulse' will ultimately return to technical efficiency and control where outcomes will be measured using pre-specified objectives and statistical methods. This form of education reinforces disadvantage due to an inability to cater to issues of gender, cultural, social and geographical constraints. Smith and Lovat (1991) suggest, '...education sits very uneasily in such an economistic framework' (p.199).

In contrast, principles which promote communication, negotiation of meaning and co-operative work, underpin emancipation, which strives to decompose inequality in education and society. While external forces continue to control curriculum development, changes at the classroom level will be minimal. Only true 'ownership' of the curriculum, which enhances commitment, will contribute to the success of any change process (Smith and Lovat, 1991).

This point is supported by Smith and Lovat (1991) who argue that:

"Ultimately, however, it is the teacher in his or her own classroom who must implement change...if the teacher is not committed to the change then there is little chance it will be implemented".

(Smith and Lovat, 1991, p.198)
McLaren's (1989) thoughts on contemporary education provides an interesting summary to the issues raised in this section of the thesis regarding educational change in Australia. McLaren suggests:

"The reactionary nature of present day educational policy-making and the essential conservative ethos that infuses much of contemporary school instruction should in no way be interpreted as a failure of Dewey's impact on our schools; rather it underscores the pervasive and remitting stranglehold that social, political and economic constraints have always placed on the educative process, especially during times of falling profitability and corporate malaise".

(McLaren, 1989, p.198)

3.4 Professional Development and In-service Education

Rowland and Patterson (1993) suggest that over the past ten years 'education systems' have realised the need to support new educational policy and curriculum initiatives with professional development strategies, if effective classroom implementation is to be attained.

Despite the findings in a number of reports on professional development and inservice education, including the In-service Teacher Education Project (Department of Employment, Education and Training, 1988), the Joint Review of Teacher Education (1986) and the Quality Education Review Committee (Karmel, 1985), recommending the need for quality teacher professional development, funding in the area has been erratic (Rowland and Patterson 1993).
However, if we review the effect of teacher in-service education on classroom implementation, we may need to consider new professional development initiatives. In his research into teacher in-service education in primary school science, John Henry states:

"If teachers’ curriculum philosophies and theories in teaching are at odds with the process/inquiry curriculum position, or have been unaffected by the in-service program, the modification of suggested strategies and activities will favour established teaching practice resulting in minimal curriculum change being obvious at the classroom level."

(Henry, 1990, p.25)

Henry (1990) goes further to suggest that the theories behind ‘external’ curriculum development put forward by experts outside the classroom, have missed the ‘fundamental point’. Henry argues that theories of those outside the classroom differ dramatically to those of practicing teachers. Northfield (1989) supports this view in suggesting:

"...ideas about teaching and learning can only have meaning in the context of classroom implementation, and it follows that teachers are crucial participants in any research process".

(Northfield, 1989, p.274)

Doyle and Ponder (1977-78) developed the concept of the practicality ethic in teacher decision-making in the context of curriculum change. They reported teachers’ frequent use of the word ‘practical’ when responding to statements regarding proposed classroom practices. They used this concept to analyse teacher’s responses to innovations. Doyle and Ponder (1977-78) suggest that most teachers react as ‘pragmatic sceptics’ to new curriculum proposals.
I would argue that while some teachers may be sceptical of curriculum innovations, in-service education as a means of dissemination provides limited (if any) ongoing support for these teachers in adopting new practices in the classroom situation. Alternative approaches need to be considered.

The School Development in Health Education (SDHE) projects (Irwin et al. 1990; Kennett, 1990; Little, 1990; Irwin et al. 1991b) identified teachers as 'critical to the process of school based change'. The success of the projects was facilitated by a supportive approach to program implementation. A collaborative approach to the professional development of teachers in the pilot schools led to the implementation of health/drug education in schools (Irwin, 1993). We can learn from this experience the value of collegial support in implementing curriculum change.

Fullan (1985) supports this view and suggests that professional development programs may be more successful if the emphasis was on small groups of participants, who were genuinely willing to work collaboratively towards improvements in teaching and learning.

The recent restructuring of the state education system in Victoria, towards self managing schools, has broad implications in many areas, in particular curriculum and professional development. The introduction of the AST (Advanced Skills Teacher) positions has changed teachers' career paths and influenced hierarchical structures within schools. Declining government funding has resulted in reduced staffing and the closure of school support centres. Professional development initiatives are becoming the financial and organisational responsibility of the schools or individual teachers, with assistance from colleagues in AST roles.
The AST career structure (Federated Teachers Union of Victoria, 1992) may potentially provide schools with the internal structure required to support and arrange curriculum and professional development activities. However, any 'real' options for teachers to critically review their practice and improve learning opportunities for their students can only come through self-reflective enquiry promoted through 'authentic' action research (Brown, 1987; Kemmis and McTaggart, 1990).

3.5 School Based Curriculum Development

The report to the Australian Schools Commission (Interim Committee for Australian Schools Commission, 1973) provided the scope for the official shift from centrally developed curriculum towards School Based Curriculum Development (SBCD), supposedly providing teachers with a greater degree of autonomy and professionalism. It has been suggested (Davis, 1979; Brady, 1990; Prideaux, 1993) that in fact SBCD has not been fully participatory in many cases, simply shifting the power for curriculum decision making from the central authority to the hierarchical structure within the school.

In Victoria, official policy regarding SBCD, as outlined in 'Decision Making in Victorian Education', states the governments policy is:

"...to encourage and extend decision making relating to school level choice, content and methods in order to involve parents, teachers and other community members".

(Fordham, 1983, p.6)

The Victorian State Governments' recent move towards 'Schools of the Future' (Directorate of School Education, 1993a) suggests
SBCD may be under threat. The Schools of the Future working document which outlines ‘Guiding Principles for Charter Development’ states that the school curriculum should ‘conform with Board of Studies guidelines’ (p.5).

Davis (1979) has suggested, in its pure form, SBCD has the potential to reconstruct Australian society through local community influence where teachers and parents are seen as the main participants in curriculum development. Here the interests of central authorities and ‘experts’ is removed, allowing the true relevance to the school community to be explored.

The problematic nature of evaluation and health education which have already been discussed (Cribb, 1986; Kirk and Gray, 1990; Naidoo, 1986) are identified by Davis (1979) in his comparison of prescribed curriculum and broad guideline curriculum.

<table>
<thead>
<tr>
<th>Outcomes and Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescribed</td>
</tr>
<tr>
<td>Usually restricted to short term, ‘objective’ measures of student performance at age or stage levels.</td>
</tr>
<tr>
<td>Broad Guidelines</td>
</tr>
<tr>
<td>Usually an acceptance of the importance of broad, long term and diffuse qualities - making evaluation more difficult.</td>
</tr>
</tbody>
</table>

(Adapted from Davis 1979)

In any analysis of education for social change we need to consider the fact that traditional teaching methods and evaluation may contribute to the reproduction of social inequality.
Bartlett (1981) suggests that the emphasis on traditional content approaches to health education can be attributed to teachers being trained in other disciplines in the use of cognitive and educational psychology.

During times of economic difficulty, the unfortunate return to quantifiable measurements of the outcomes of education, as outlined in the ‘Schools of the Future’ pilot program (Directorate of School Education, 1993a), limits a teacher’s ability to develop a curriculum which is perhaps most relevant to the needs of his or her students, but not as easily measured. This is particularly relevant in health education where a great deal of the curriculum may relate to the ‘lived experiences’ of the students.

Marsh and his colleagues suggest:

"School-based curriculum development is essentially a teacher-initiated grass roots phenomenon, and is likely to survive in this pure form regardless of political and economic contexts".

(Marsh et al., 1990, p.3)

Prideaux (1993) believes that in the 1990’s teachers will continue to be involved in ‘active’ curriculum development. He suggests teachers will be able to move beyond the school to contribute to and participate in external activities ‘aimed at wider curriculum and educational reform’ (p.176).

3.6 Facilitating Change in the School Environment

It has been highlighted throughout this thesis that teachers are central to any change process at the classroom level. It is therefore essential that teachers, who are responsible for
implementing curriculum change, must participate in deciding the nature and extent of the changes to be undertaken (Miles and Seashore-Louis, 1990). Cummings (1985) has explored the change process in her own pedagogic practices by implementing individual self-reflective enquiry. However, the absence of peer support and the ability to participate in critical discourse with colleagues may restrict the extent of change possible. McTaggart (1989) has explored the conditions which promote 'privatism' amongst teachers in the school environment and suggests support structures which promote a sense of community are 'necessary to nurture action research' (p.360).

Fullan (1986) suggests for effective classroom implementation to occur 'a new culture of the school' which is organised to encourage and support interaction between teachers, and accommodates shared activities, is necessary. Fullan (1986) goes further to suggest that changes in teaching practice precede changes in pedagogical philosophies.

The Ministry of Education, Victoria (1989b) advocates the development of action research projects undertaken by teachers with their colleagues as a means of participating in the decision making process to promote change in the school and classroom environment. It is suggested that this can provide the critical perspective required to improve teaching and learning.

Proponents of action research (Kemmis, 1984; McTaggart, 1991) would argue that the commitment to organisation required in the school environment, to improve teaching and consequently learning, will come from 'within' if schools are given the latitude to identify and solve their own curriculum problems. This view may explain the difficulties encountered when interested 'outsiders'
attempt to implement the action research process in school situations.

This point can be further explored by considering the successes and failures of recent curricula research, in the school context, employing the action research model. Three recent research projects displaying the above criteria have been 'The Project for Enhancing Effective Learning' (PEEL) (Baird and Mitchell, 1989), the 'Health in Primary Schools' (HIPS) project (Went, 1991) and the 'School Development in Health Education' (SDHE) projects (Kennett, 1990; Little, 1990; Irwin et al. 1990, 1991a, 1991b; Irwin, 1991a, 1991b, 1993; James, Carruthers and Cameron, 1992). Common elements in the three projects were that they were all longer term projects which received comparatively extensive funding and resourcing, and the initial ideas were born outside the schools. Voluntary participation of schools and teachers were accommodated through school submissions or individual expressions of interest.

In 'The Peel Project' Baird and Mitchell (1989) formulated the following conclusions regarding project implementation:

"Conclusion 9: Developing and researching an innovation demands a high level of personal commitment from teachers.

The project has been emotionally very draining, with a great deal of time and energy having been expended.

Conclusion 12: The opportunity for professional development was a major incentive for teacher's participation in the project.

It was this benefit which also sustained interest and motivation during the difficult early classroom experiences; it continued to be a most significant issue for teachers throughout the year".

(Baird and Mitchell, 1989, pp.288-289)
The experiences documented in the PEEL project demonstrate the difficulties of continued commitment and motivation by participants during the research. The ability of 'The Peel Project' to offer in-service opportunities for participants enabled the project team to address the problems of the continual commitment and the motivation required. Timetabling arrangements were extensively adjusted to accommodate the project. This suggests commitment to the project from inside the school can overcome the problem of logistics. The PEEL project recognised the need for participating teachers to have regular meeting times, and additional time for more intensive research reviews, as a potential timetabling problem in the school context.

Participants in the PEEL project have questioned the ability for the outcomes of the project to transfer to other school settings without the high degree of resourcing provided in the PEEL project (Baird and Mitchell, 1989). This raises the question of the viability of undertaking education research using the action research model, without adequate funding which can assist in the provision of time and resources. Additional time and resource allocation may enhance commitment by participants, which was the case in the Peel project.

McTaggart (1991) recognises the difficulty of using action research to improve education. McTaggart suggests:

"Even when the tasks seem clear and support obsensibly available, the work of action researchers in the development of authentic education is likely to encounter confusion and resistance...action researchers need to understand that their efforts do present alternative ways of thinking about and organising education which confront bureaucratic values by calling habit, custom, tradition and especially hierarchy into question".

(McTaggart, 1991, p.93)
Smith and Lovat (1991) report, that in the school context where time and resources have been made available, action research has proved to be effective for curricular and educational change. Fullan (1986) concludes that change is an inert process which takes place sequentially and is dependent on the necessary provision of assistance and support. He recommends that ‘organisational conditions at the school’ are of primary importance for the successful implementation of the change process. This has been supported by the School Development in Health Education (SDHE) projects where critical factors have been identified as crucial to the success of the projects. The critical factors involve organisational conditions at the school level including participation of the Principal, a collaborative group planning and leading the change process, and adequate resources in terms of people, materials, time and money (Irwin, 1991a; Kennett, 1990; Little, 1990).

3.7 Summary

In this chapter I have discussed Habermas’ ‘tri-paradigmatic framework’ in relation to curriculum development in school health education. I have explored Habermas’ critical theory and its application in curriculum development and implementation through the review of the Ministry of Education’s document ‘Learn How to Learn’ (1989b) and the PEEL project (Baird and Mitchell, 1989).

I have suggested Aoki’s (1977, 1985, 1991) two curriculum perspectives, the ‘curriculum-as-plan’ and the ‘curriculum-as-lived’, may be useful in considering school health education and any imbalance that may exist at the school level. I have used Aoki’s man/world view of the curriculum to generate a diagrammatic representation (Figure 3.1) of the external and internal influences operating on the school environment and consequently on the
'lived experiences' of students and teachers inside the school.

The inequality which continues to exist in, and be reproduced by, the institutionalised social settings schools represent, have been explored. I have documented the political, economic and social influences that have created educational change over the past ninety years in Australia.

I have explored current political, economic and social influences on schools through the Victorian governments 'Schools of the Future' (1993) working documents.

Professional development and in-service education have been considered and literature which questions the effectiveness of external professional development and in-service activities has been presented. It has been suggested that externally developed initiatives neglect the teachers' personal philosophies and classroom situation. I have considered the new Advance Skills Teacher (AST) structure and the potential it presents for internal professional development initiatives.

School based curriculum development (SBCD) has been considered in relation to the needs and interest of students, and the role it can play in reconstructing society through local community involvement. Teacher professionalism can be strengthened through opportunities to participate in school based curriculum development.

I have suggested that the application of critical theory, through self-reflective enquiry, can assist teachers to critically reflect upon their situations in schools and their pedagogic practice. I have considered action research as a means to promote self-reflective
enquiry and critical discourse between colleagues. The literature suggests that action research can be successful in facilitating change if organisational support is provided at the school level. Organisational factors which facilitate change have been considered.

In my attempt to address the problematic nature of curriculum change in health education at the classroom level, I will advocate the development of strategies to promote self-reflective enquiry and critical discourse amongst teachers in the primary school environment. This approach has the potential to increase awareness and promote critical reflection, which may influence choices in pedagogic situations. It is based on the premise, already explored in part one and two of this review, that emphasises the classroom teacher as a ‘key agent’ in creating change (Aoki, 1977; Smith and Lovat, 1991; Stenhouse, 1975) to improve school health education (Irwin, 1993).
CHAPTER FOUR

4.0 METHODS

4.1 Introduction

At the end of the previous chapter, this study was located within the wider context of concerns involving the theory and practice of school health education. This raises questions about curriculum development in schools. Classroom teachers are seen as the central element in the improvement of teaching and learning (Fullan, 1986; Fullan, Bennett and Rolheiser-Bennett, 1990; Irwin, 1993).

The literature in the area of school health education has been dominated by epidemiological studies focusing on smoking (Reid, 1985) nutrition (Gliksman, Dwyer and Boulton, 1987; Perry and Mullis, 1985; Hetzel and McMichael, 1989) and exercise (Dwyer, et al. 1983; Worsley and Coonan, 1984). This highlights the presence of Western diseases such as cancer and heart disease, and provides an empirical foundation for the promotion of school health education based on disease prevention strategies (Botvin, 1985; Temple, and Burkitt, 1993).

Limited research literature is available which explores school health education from the micro level of classroom application. This study attempts to fill a gap in current education research by examining and improving the health education curriculum of a Victorian primary school, from the perspective of a participant in the classroom environment. The research project was conducted during the 1993 school year. It commenced with official approval from the Directorate of School Education in February to contact school principals, in the Eastern Region, regarding their school’s
participation in the project. The data collection phase of the project was completed in December 1993.

The success of School Based Curriculum Development (SBCD) in health education relies heavily upon the collaboration and cooperation of teachers at the school and classroom levels. Action research projects have the potential to improve teaching and learning at the 'grass roots' level of the school and the classroom. However, a number of constraining factors need to be addressed if school communities are to benefit fully from professional development based on an action research approach.

In this chapter, I will outline the reasons for selecting action research and ethnography, and describe the specific methods and processes used in the collection and analysis of data. Methodological issues will be presented which address areas of the research that became problematic for the teacher-researcher and research participants during the course of the research project.

4.2 Origins

My interest in the area of school health education comes from my own experience as a primary school teacher with additional qualifications in health education. I am concerned with the current practices in Health education, specifically the methods used with students in upper grades. In my own experience I have seen traditional programs which emphasise the transmission of knowledge and have a limited view of health. These programs have focused largely on the physical and biological aspects. I believe alternative approaches in curriculum development and implementation must be considered if improvement in school health education is to be realised.
This research project investigates influences on, and barriers to, curriculum change in health education from the classroom and school levels.

4.3 Purpose of the Study

This study set out to explore:

- the school community’s perceptions of health education

- the current content and strategies employed in teaching health education to students in the upper primary grades

- changes in curriculum practice to improve health education

The following focus questions emerged as the study evolved:

a) What initiatives facilitated the improvement of the school’s health education curriculum?

b) What limiting factors inhibited the improvement of the school’s health education curriculum?

4.4 Research Paradigms

My initial introduction to action research was in 1991 during post graduate study in Health Education at Victoria College, Burwood. Students were asked to prepare a brief paper outlining the action research process and its application in their own area of Health Education. I remember thinking to myself, good teachers use informal action research methods in their classrooms every day to plan, implement, evaluate and modify or extend the curriculum to
suit the needs of their students and the school environment.

After wading through numerous papers on the subject I realised the process used by individual teachers basically followed the action research cycle, but two important aspects were omitted.

Firstly, in the classroom situation described, the cycle is most often performed in isolation without the collaboration of other practitioners. The second distinction was that the action research process is used in an attempt to make changes to improve a mutually agreed problem. In individual classroom practice a problem may become evident during any stage of the cycle. The action research cycle used by individual teachers is not consciously initiated in a deliberate attempt to treat or solve a preconceived problem.

When I began to consider an appropriate proposal for my Master of Education by research, I realised action research (Kemmis and McTaggart, 1990; Kemmis et al. 1988; Brown, 1987) would provide the ideal method to investigate and improve the health education curriculum in the primary school.

Historically the concept of action research was developed by social psychologist Kurt Lewin (1946). He used action research in the context of post-war community projects where group decision making and commitment to improvement were key features. Action research is a group activity with the collaborative process being an essential feature.

In more recent times action research has been used by school communities in educational settings to review and improve curriculum development through critically informed action and
reflection. Kemmis and McTaggart (1990) believe action research is suited to the 'real, complex and often confusing circumstances and constraints of the modern school' (p.7). They believe the critically informed action developed through action research has the potential to transform 'educational ideas' into 'educational action' (Kemmis and McTaggart, 1990).

While advocates of action research (Kemmis and McTaggart, 1990; Lewin, 1946; Brown, 1987) differ in their diagrammatic interpretations of the action research cycle, all include the main steps as plan, act, observe and reflect. The disagreement comes from the movement within the cycle and from one cycle to the next. It has been recognised that a great deal of intersecting between steps is naturally occurring and the move from one complete cycle to the next is not as definitive as the diagrammatic representations would suggest.

The School Development in Health Education (SDHE) project in the Northern Territory (O’Sullivan, 1993) developed a diagrammatic interpretation of the action research cycle appropriate to the primary school context. This is presented in Figure 4.1. The action research project at Smithfield primary school was based on the Northern Territory SDHE example.
Figure 4.1 School Development in Health Education Project -
The Action Research Model

(Source: O’Sullivan, 1993: School Development in Health Education Project, Northern Territory)
After my attendance at the Australian Council for Health, Physical Education and Recreation Conference in Darwin between July 5th and 9th, 1993, where a great deal of the research presented was based on a positivistic paradigm, I quickly became entangled in the quantitative versus qualitative research issue. I began to question the suitability of the action research method, consuming the literature to assure myself that the method I had selected was appropriate.

Both qualitative and quantitative research methods have relevance for improving education and can be used supportively. However, qualitative research methods are implemented in an attempt to ‘better understand social phenomena’ (Wiersma, 1991). Research in education should contribute to educational practice through improvement in classroom practice, improvement of teachers’ understanding the practices they undertake, and improvement in the physical and organisational aspects of schools (Kemmis, 1984). Qualitative methods based on the induction model (Wiersma, 1991) can best address these aspects.

According to Hustler and his colleagues, traditional education research is seen as irrelevant and impractical by classroom teachers. They believe the relevance of education research should be judged on its application in helping teachers improve the learning experiences of children in their classrooms (Hustler, Cassidy and Cuff, 1986). This view is supported by the Australian Research Council (National Board of Employment Education and Training, 1992) who suggest the priority of educational research should be in its application to improve Australian education.

Threadgold (1985) supports the view that a great deal of research does not meet the needs of teachers and therefore does not filter
through into the school situation and consequently classroom applications. She believes teachers often refer to researchers as those who live in ‘ivory towers, discussing theory detached from reality in a language understood only by themselves’ (Threadgold, 1985, p.253). Threadgold argues that research activities where teacher and researcher work side by side on school-based projects may help overcome this problem.

The collaborative and participatory nature of action research (Kommis and McTaggart, 1990; Brown, 1987) may provide teachers with a 'legitimate and more appropriate alternative to traditional research designs’ (Hopkins, 1985, p.43).

This research project attempts to address teachers’ negative perceptions of researchers and their findings. It takes a realistic, classroom-based, practical approach to a curriculum problem recognised by teachers at the school, including the classroom teacher and the teacher-researcher (Stenhouse, 1975). It is considered that this approach will overcome the perceived problem of a researcher investigating the curriculum in isolation from the institutionalised character of the school. This will allow for the real constrains on classroom settings, teachers and students to be addressed. It will provide the opportunity for the teacher-researcher and the classroom teachers to participate in critically informed discourse to improve health education practices at the school.

Stenhouse (1980) believes one of the most important things about curriculum research by teachers is that it invites the teacher to 'improve his (sic) art' through participation. Students will benefit more from improved teaching practice realised through self-reflective enquiry, rather than attempts to change teaching by
others outside the situation (Adelman, 1989; McTaggart, 1991; Stenhouse, 1980).

Adelman (1989) believes self-reflective enquiry can promote what he terms the 'practical reasoning' necessary to improve practice.

It has been suggested by Carr and Kemmis (1986) the way teachers act is generally produced through 'custom, habit, coercion and ideology which constrain action in ways which teachers themselves do not recognise....' (Carr and Kemmis, 1986, p.189). Self-reflective enquiry promoted through action research may challenge teachers' existing philosophies, attitudes and beliefs in teaching health education. An understanding of what the school and the teachers provide and intend, and what students experience and gain may provide the basis for changes to the school's existing health education curriculum.

Initially the research was to be confined to the classroom using the action research process in a 'critical friend' relationship (Kemmis and McTaggart, 1990) with the classroom teacher. Kemmis and McTaggart define action research as:

"...a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of these practices and the situations in which these practices are carried out." (Kemmis and McTaggart, 1990, p.5)
In this study the action research process was implemented using the following ongoing steps outlined by Kemmis and McTaggart:

- a review of the situation (reconnaissance)
- developing a plan of critically informed action
- acting to implement the plan
- observing the effects of the critically informed action in the context in which it occurred
- reflecting on these effects as a basis for further planning and subsequent critically informed action

(Adapted from Kemmis and McTaggart, 1990)

As the research evolved, units of work in health education were developed and piloted with upper school students. This extended the research to include others in the school community, and the complexity of the situation began to emerge. An ‘action research group’ (referred to hereafter as such) was formed to allow teachers involved in the units of work to contribute to the research effort. This group was fluid, allowing movement for teachers to be involved during particular stages of the research which attracted their specific curriculum interests.

However, it became evident that greater scope for collection of data was required. This was to accommodate issues outside the classroom which contributed to the understanding and critical analysis of the school’s health education curriculum as it existed, implementation of the five units piloted and the scope for and factors limiting change. Lack of time to complete the research in a completely collaborative manner led me to search for a second research method which could be used in conjunction with the action research process already underway.

My supervisor led me to the work of Hammersley and Atkinson (1983). I decided ethnography or participant observation was an
appropriate secondary method. The ethnographic researcher attempts to uncover how people behave, act and think in a particular social setting (Wiersma, 1991). Ethnography allows the researcher to examine social and political constraints that operate in the larger context of the school and society, influencing life in the classroom. According to Hammersley and Atkinson:

"The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned".

(Hammersley and Atkinson, 1983, p.2)

During the project I spent extended periods of time between March and October in the school situation. My role provided three focuses to the research project. Firstly, as a qualified teacher acting in a voluntary capacity, I implemented many of the sessions in the units piloted. Secondly, as a facilitator I provided knowledge of current theory and practice used in school-community approaches to health education. I also located and introduced appropriate resources to students and teachers. My role as a researcher has been described elsewhere in this chapter.

The three roles described provided me with the opportunity to participate overtly in the social situation asking, listening, watching and questioning in an effort to understand the influences and constraints on the health education curriculum within the school.
Werner and Rothe (198) describe ethnographic research in the school context as follows:

"Rather than reducing their commonsense comments into rigid, predefined categories, ethnographers allow categories relevant to that particular community-school situation to arise from observations and discussions. These categories which reflect the 'insider' interests (concerns, desires, expectations, and beliefs) are in themselves descriptions of the school-community context. To describe their interpretive procedures people use to define what is important to them and make sense of their situation, a multiperspective approach towards data gathering must be employed".

(Werner, and Rothe, 198, p.11)

In the school context the ethnographer’s descriptions about teaching can provide increased awareness and reflection which may influence choices in pedagogic situations. Werner and Rothe suggest ethnographic research has limited application if the curriculum is viewed as the relationship between learning objectives and methods of attainment. They recommend the curriculum be viewed from a broader perspective of the everyday activities in the classroom which encompasses the process of constant interaction between teachers and students. According to Werner and Rothe (198) ethnographic methods ‘get at this aspect of curriculum planning and teaching’.

Action research and ethnography are compatible methods in the sense that both subscribe to the concept of context-specific findings that can make a practical contribution to school improvement. This research project is best described as a case study of the health education curriculum in the upper grades of a Victorian state primary school. The study employs both ethnographic and action research methods to investigate the current state of, and improvement to, the health education
curriculum at the school. The study required the teacher-researcher to work in the school environment at least two afternoons each week (often more) in terms two and three of the 1993 school year to implement sessions and collect data. Ethnography and action research methods accommodated the inquiry to improve teaching and learning in school health education.

4.5 The Contextual Setting

4.5.1 The School

This research project was conducted in a state primary school located in the outer eastern suburbs of Melbourne. The school was established in 1973 with 365 enrolments. This had grown to approximately 510 students and 26.6 staff members in 1993. The school consisted of two main buildings and four smaller structures. One building accommodated the lower grades (P-3) and the Vice Principal's office. The Vice Principal's role included the coordination of grades prep to three.

The second main building housed the art room, library, general purpose room, staffroom and administration area and accommodated students in grades four and five. The two grade sixes were accommodated in portable classrooms outside the main building. Other buildings included the free standing music room and canteen. The school grounds were spacious and additional features included a large oval, outdoor amphitheatre and fun and fitness track. The school was within walking distance of the town centre, making community resources easily accessible.
4.5.2 The School Climate

A change in state government in 1992 brought radical changes to education policies. Consequently 1993 was a very unstable year for many school communities.

The following initial entries recorded in the teacher-researcher's journal describe the initial climate during the research project at Smithfield primary school.

"Phoned Mr K. (Principal) about proposal. A lot going on in schools. Negative feelings coming through. Possibility of STRT's (Short Term Relieving Teachers) being dismissed. Rumours circulating. Explained I understood he was busy due to upheaval schools faced".

(Personal Journal, 2/4/93)

"Despite economic (cuts) and political problems effecting schools at present, Smithfield 'appears' to be functioning in positive way. Not like others".

(Personal Journal, 6/4/93)

As the year progressed and the possibility of cuts to student/staff ratios became evident, a degree of nervousness and uncertainty was detected amongst staff. Two staff members who had been placed in the excess teaching pool in 1992 had been recalled to the school in 1993 due to teachers taking voluntary redundancy packages. The Principal and the Advanced Skills Teacher Grade 3 (AST3) both expressed the low morale of staff, and teachers experiencing high levels of stress due to their uncertain futures. Although these problems had been identified, no specific staff or student welfare frameworks were operating in the school.

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To maintain confidentiality and anonymity, pseudonyms have been used for the school and all participants in the research project.
The Principal and the AST3 both indicated to me individually that 1993 was an exceptional year for Smithfield Primary School politically and with curriculum commitments. The Principal suggested to me quite late in the project (meeting 25/8/93) that had he given greater consideration to the events which had taken place during the year, he would not have approved the project. However, it was impossible to anticipate the effect the government’s decisions would have on the school community as the year progressed.

4.5.3 **The School Community**

The school community displayed no distinctive characteristics. Parental employment covered a diverse range of occupations from professional through to skilled trades, with a minority unemployed. Single parent and mixed families contributed to about one third of the school’s population. Of the three hundred families with students attending the school in 1993, seventy-five families applied for the Educational Allowance. This required the production of a health care card or other evidence of reliance on the government for financial support. The school has never received any Disadvantaged Schools funding. It would appear that while many families at the school could be described as ‘middle class’ some could certainly be seen to be socially or economically disadvantaged. Considering the size of the student population, parental participation in school activities was not high. The Canteen Committee struggled to run the canteen with a consistently small number of parent volunteers.
4.5.4 The School Curriculum

The Principal and other senior staff indicated that the school had a reputation for offering relatively traditional approaches to the curriculum. It was also implied that the traditional emphasis on the curriculum reflected the expectations of the parent community.

Curriculum initiatives at the school were broad with specialist teachers in the areas of art, physical education, library and music. An extension program was offered to students with above average ability in maths in the upper grades and the Vice Principal provided support with computer studies. Excursions into the local community and beyond were used frequently by teachers to extend curriculum activities outside the classroom. Extra curricula activities available out of school hours for students in upper grades included participation in music lessons, choir, basketball or netball.

Curriculum resources appeared to be abundant in some areas and not in others. The music room was extremely well equipped with a large range of instruments, a sound system and tape recorders. Sports equipment was adequate for grade use. Restrictions on individual borrowing applied, perhaps as a cost conserving effort. The library was fully automated and stocks for student use appeared ample. Teachers' references were less substantial particularly in the area of health education. The professional library contained less than ten books on the subject, many of which were outdated. While specialist programs appeared to enjoy adequate resource provision, classroom supplies were not as extensive. In fact, extremely limited access and funding in some instances contributed to restricting curriculum activities.
The overseeing of the curriculum was arranged through co-ordinators at each grade level and in each curriculum area. The AST3 appointed in 1993 was given the responsibility of monitoring curriculum development throughout the school. The position was recognised as that of 'internal' curriculum adviser. While the schools health education policy recommended teachers spend 'at least one hour per week on health topics', it was suggested that health be 'integrated' with other subjects where appropriate, making it difficult to determine the actual amount of time spent on health education.

On the many occasions I entered the school, it was not unusual to hear minimal noise. Generally students were seated, listening to the teacher, providing the occasional required response, or working at their tables individually. My own observations confirmed that traditional approaches to curriculum implementation were the dominant form of transmission.

4.5.5 Curriculum Development

Curriculum documents to be used in specific subject areas were outlined in the implementation sections of the various subject related school policies. In the language area the school had developed its own course, the 'Smithfield Primary School Language Program'. The course adopted for use in Social Education was developed by a neighbouring school. The course which provided the basis for Health Education was a commercially produced publication titled, 'Health Education Program'.

School-based curriculum development had been in place in the past as is evident with the school's language document. In 1993 the school had allocated a curriculum day to explore school-based
curriculum development (SBCD) to develop integrated units of work. A visiting speaker was invited to address the topic and provide teachers with a framework to use in developing integrated units. The AST3 received encouraging feedback from most teachers who saw the day as successful and informative. However, one particular teacher expressed his dissatisfaction with the day. He suggested he had heard it all before and saw the day as a complete waste of time. Despite the difficulty of pleasing everyone, it would appear school-based curriculum development was supported by most of the staff at the school.

4.5.6 Professional Development

A reduction in funding for professional development activities was experienced at the school level in 1993. The delegation of responsibility for professional development of staff to the school level, had changed the structure of the school’s participation in in-service education programs. Professional development activities were generally school-based, taking place on curriculum days or during after school staff meetings, specifically allocated for professional development activities. Attendance at in-service education programs were difficult to accommodate, if leave during school hours was required. This became apparent when the teacher-researcher and teachers prepared to pilot a unit on nutrition had difficulty being released one hour before school officially finished to attend a ‘Food Smart’ in-service session.

Participation in professional development activities was, to some extent, the responsibility of individual teachers, with an increase in the availability of after school and weekend in-service education programs.
4.6 Research Process

4.6.1 Selection of the School

My own interest and background in health education, and commitment as a primary teacher to curriculum improvement in the area, led me to explore the possibility of working in a number of state primary schools in the Eastern metropolitan region. The non-random method of selection required the school to fulfil three specific criteria. Firstly the school’s health education curriculum needed to be seen, by teachers at the school involved in the area, to require review or improvement.

The second criteria I had included for selection was to work with a colleague I had taught with previously, making access to the school and classroom easier, and assisting the establishment of a harmonious working relationship. Primary teachers usually work in the isolation of their own classroom and rarely have the opportunity to work with and observe colleagues (Hopkins, 1985; Threadgold, 1985). The nature of this research project provided opportunities for the teacher and the teacher-researcher to work together and observe one another. It required a teacher who felt comfortable working with and observing the teacher-researcher. The essential elements of action research as outlined by Brown (1987) were seen as crucial factors for consideration in light of the success or failure of the project.

Brown’s essential elements of action research are:

a) A preparedness to search for an understanding of issues affecting one’s own situation.

b) A structure providing a means to obtaining meaningful answers.
c) An environment of supportive criticism in which to ask real questions about one’s own practice.
(Brown, 1987, p.11)

The third criteria for selection of the school was the location. It was considered being within close proximity to the researcher’s home may make access negotiation more flexible, if travel to and from the school was not excessive. Smithfield primary school fulfilled the three criteria. An action plan and timeline had been developed by staff to review the school’s health education policies and programs. The school was one of the largest in the area providing the potential advantage of involving more teachers in the action research project.

4.6.2 Participants

I was fortunate to be able to work with the newly appointed Advanced Skills Teacher Grade 3 (AST3). Not only did she fulfil the ‘essential elements’ described by Brown (1987) but her roles as AST3 included overseeing curriculum development in the school, delegated to specific curriculum co-ordinators in each subject area. Initially we worked together in a ‘critical friend’ relationship. However, as the research progressed and time constraints and other aspects diverted the methods used towards ethnography, she became my primary informant.

Her class of twenty-seven grade five students participated in the research by completing initial questionnaires. They also participated in the five units of work piloted and contributed through comments and written work to assist in the data collection process. Parents of these grade five students participated in the research by completing initial questionnaires and final evaluation surveys.
Action research requires that participation is voluntary and participants have the option to become involved or withdraw at any time (Brown, 1987). The progression of the research saw the inclusion of the other grade five teacher and her grade, the Physical Education teacher and all upper school students. Table 1 outlines the units of work piloted and participation by the teachers.

Table 1. Participants in Units Piloted in Health Education Research Project

<table>
<thead>
<tr>
<th>UNIT</th>
<th>TEACHERS</th>
<th>GRADES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Senior Citizens</td>
<td>AST3</td>
<td>5A</td>
</tr>
<tr>
<td>Our Emotions</td>
<td>AST3</td>
<td>5A</td>
</tr>
<tr>
<td>Fitness Fun</td>
<td>AST3 Grade 5</td>
<td>5A 5B 5/6</td>
</tr>
<tr>
<td></td>
<td>PE Specialist</td>
<td>6A 6B</td>
</tr>
<tr>
<td>Nutrition</td>
<td>AST3 Grade 5</td>
<td>5A 5B</td>
</tr>
<tr>
<td>Consumer Education</td>
<td>AST3</td>
<td>5A</td>
</tr>
</tbody>
</table>

The teachers who participated did so on a voluntary basis. This was indicated either on the teacher questionnaire or verbally through the AST3. Teachers and students were observed as they worked through the units of work developed. Conversations and discussions regarding strategies and content, teachers and students beliefs, ideas and attitudes provided a rich source of data.

The Principal’s contribution to the research included formal discussions on four occasions and the completion of a research evaluation survey. Evaluation surveys were completed by the three teachers who had volunteered to participate in the project.
4.7 Research Procedures

Part one of this section has been developed around the action research process implemented in the school environment. It includes the purposes, techniques and routines of data collection as they occurred through the interrelated phases of the cycle. In action research each phase is not seen as distinct 'but rather as moments in the action research spiral of planning, action, observation and reflection' (Kemmis and McTaggart, 1990, p.15). While the stages of the action research cycle are not seen as distinct steps, data collection and analysis techniques will be described using the progressive elements of the cycle, to place them in the context of the action research process.

Part two of this section describes the data collection and analysis techniques used for the more ethnographic areas of the research project.

4.7.1 PART ONE - Action Research

4.7.1.1 Reconnaissance

Document Analysis

The initial reconnaissance (Kemmis and McTaggart, 1990; Brown, 1987) involved the collection, examination and analysis of available documents within the school, concentrating on existing health education and related curriculum documents. This included the school’s Health Education (see appendix 1) and Smoking policies (see appendix 2) and the current program titled ‘Health Education Program’. A physical review of, and comparison between documents at the school level and the state level, ‘The Personal Development Framework: P-10’ (1989), assisted the teacher-researcher in establishing the current state of the school’s
formal health education curriculum. The schools 'Action Plan for Personal Development 1993' was made available. The plan provided the outline of an intended timeline for the review of the school's Health Education policy and program.

Interviews

Informal interviews were held with the AST3 and the Principal regarding the school's existing health education curriculum. Formal appointments were made with the Principal and interviews were conducted in his office. Interviews with the AST3 were held at the school in her classroom or in the staffroom during recess times. Alternatively interviews were conducted with the AST3 at my home after school hours.

Questionnaires

Student, teacher and parent questionnaires were piloted with corresponding populations and minor changes were made as a result.

The questionnaires distributed during the reconnaissance stage of the research, were developed to assist in providing a better picture of parent, student and teacher perceptions of the school's existing health education curriculum. Parent, student and teacher views on improving the health education curriculum at the school were also requested through the questionnaires.

Twenty-seven parent questionnaires (see appendix 3) were distributed to the AST3's grade five students, with the school newsletter, to be completed by either parent (eg. mother or father).
The questionnaires were returned to school with students and returned to the teacher-researcher via the classroom teacher. An 89% response rate was obtained.

Teacher questionnaires (see appendix 4) were distributed to the eight teachers in the upper school (Grades 4, 5, 6) by the AST3. A letter of introduction and explanation was included (see appendix 5). Teachers were requested to complete and return the questionnaires to the AST3 as promptly as possible. Questionnaires were then forwarded to the teacher-researcher. This process provided the AST3 and the teacher-researcher with the opportunity to review the questionnaires individually and discuss the results collaboratively. Seven of the eight teachers returned their questionnaires.

Student questionnaires (see appendix 6) were completed by twenty-seven grade five students during class time, with the teacher-researcher and the grade teacher present. Assistance was provided if required in understanding questions but no suggested answers were given. Supervision and collection methods ensured a 100% response rate.

Teachers and students questionnaires provided an additional source of information concerning the current content and practices in teaching health education to upper school students. The small amount of quantitative data provided on questionnaires was analysed using simple statistical procedures, based on "means" and expressed in percentages to the nearest whole number, or has been reported in the body of the results and discussion chapters of the thesis using raw numbers.
4.7.1.2 Planning

The analysis of documentary evidence and questionnaires confirmed the initial concern that the Health Education program was extremely traditional and content based. A reflective journal was kept by the researcher to record descriptions of incidents and activities, conversations and discussions, impressions and interpretations throughout the course of the research project. Initially, recording was done at home directly after time spent at the school. The difficulty of remembering information on returning home became apparent early in the research. It became increasingly necessary, as the research progressed, to record directly after conversations and discussions held with staff members, or teaching sessions with the children. Early discussions with the classroom teacher led to the following journal entry:

"Initial discussions with Mrs J (AST3) revealed the need for a full review of the Health Education policy and program and its implementation at Smithfield Primary School to address what is being taught, how it is being taught and how improvement can be made."

(Personal Journal, 12/3/93)

A critically informed plan to improve the content and strategies offered to upper school students was developed. This involved the development of units of work to be piloted with upper school students. The interaction model of curriculum development advocated by Taba (1962) was used in the development of the units. This was done collaboratively between the teacher-researcher, the AST3, one grade five teacher and the physical education teacher. The degree of involvement by participating teachers depended on the particular unit of work being developed. The teacher-researcher’s access to the AST3 allowed for continual
collaboration during the development and implementation of the units piloted. An after school meeting was held with the grade five teacher and the AST3 to discuss and develop the Nutrition unit. Discussions regarding the progress of the unit were more informal, taking place in the staffroom at lunchtimes or in the classroom after school. A meeting was held during the physical education teacher’s time release to discuss and develop the Fitness unit. Teaching with the physical education teacher provided the opportunity for continual informal discussions regarding the progress and outcomes of the unit.

A modified version of Tannahill’s Health-orientated health education model (Tannahill, 1990) was adopted. The model focused on people and places, and the positive aspects of health, with a strong emphasis on participation.

The AST3 and the teacher-researcher reviewed the information collected during the reconnaissance and established that the upper school Health Education curriculum could be improved by:

1. providing content more relevant to children’s lives
2. providing students with real life experiences
3. broadening parents, students, and teachers’ current perceptions of health education
4. developing an environment where supportive criticism about one’s own individual teaching practice could be discussed
The collaborative process was used with the action research group to define appropriate criteria for the development of unit content and strategies:

Criteria for selection of Unit Content:

- relevant to children’s lives and reflects individual, family and community health
- draws on recent literature in the area
- focuses on aspects of social, emotional, personal and physical health
- presented using a cross-curricular approach to health education

Criteria for selection of strategies:

- emphasises skills rather than knowledge although knowledge is recognised as an important base for skill development
- aims to explore children’s prior knowledge at the earliest stage
- uses a school-community approach where possible
- informs parents of, and includes parents in activities where possible
- creates student interaction with peers, teachers, parents and others
- develops students’ life skills
- empowers students
- must be practically achievable in classroom, school, community environment
- each unit to include an action component

4.7.1.3 Acting

Five units of work were developed and piloted with upper school students over second and third terms at the school using a cross-curricular approach. The changes in content and teaching
strategies which took place were based on data gathered from within the school community. The data were referred back to the literature and experts in the field (Hopkins, 1985) before the units were developed and implemented collaboratively with the classroom teacher and others inside and outside the school community. The units provided further generation of data including student’s work, comments and perceptions of the content and strategies implemented. A brief description of the pilot units is provided in the appendices indicated in Table 2.

Table 2. A Cross-curricular Approach to Units Piloted

<table>
<thead>
<tr>
<th>UNIT TITLE</th>
<th>MAIN CURRICULUM AREAS</th>
<th>APPENDIX NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Our Senior Citizens</td>
<td>Social/Health Education</td>
<td>(7)</td>
</tr>
<tr>
<td>Our Emotions</td>
<td>Personal Development/Health Education</td>
<td>(8)</td>
</tr>
<tr>
<td>Fitness Fun</td>
<td>Physical/Health Education</td>
<td>(9)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>Health Education/Personal Development</td>
<td>(10)</td>
</tr>
<tr>
<td>Consumer Education</td>
<td>Social/Health Education</td>
<td>(11)</td>
</tr>
</tbody>
</table>

4.7.1.4 Observing

It has been suggested teachers can learn ‘best’ from the opportunity to participate in peer observation which allows teachers to act as observers for one another. This situation can create an environment of supportive and reflective criticism (Hopkins, 1985).

On three occasions during the research project, audio tape recordings were made of classroom sessions with the students.
The first two taped sessions involved the AST3 running a discussion with the grade five students, and the teacher-researcher leading a discussion with the students. The third recorded session was during a socio-drama activity, also with the AST’s grade 5 students and implemented jointly by the teacher and the teacher-researcher. The tape recordings provided the scope for the teacher and the teacher-researcher to listen to, and reflect more specifically on teaching strategies and student responses.

The reflective journal kept by the researcher provided accounts of the observations made during all phases of the cycle. The AST3, who acted as a reciprocal ‘critical friend’, also kept a diary which documented accounts of what the students and teacher-researcher did during each session taken with her grade five students. Some reflective comments were recorded.

Discussions and conversations with the AST3 were held continually throughout the research, including before and after the implementation of each session. Discussions and conversations were also held with other participating teachers and the Principal. These oral exchanges occurred in any number of locations, including the staffroom, classrooms, the Principal’s office, in cars travelling to in-service education sessions and in the schoolyard. Details of discussions and conversation were recorded in the researcher’s reflective journal. These discussions provided an opportunity for reflective critical discourse between the teachers and the teacher-researcher.

4.7.1.5 Reflecting

The reflection phase of the cycle involved the three teachers and the teacher-researcher participating in critical discourse concerning
problems with the action research process, and the issues and constraints reflected in the research. Data collection was increased in this area through written evaluative responses (see appendix 12). The Principal’s reflections on, and evaluation of the research project, was also requested, using an evaluative response sheet (see appendix 13). Evaluative response sheets were distributed to the individual teachers and the Principal by the teacher-researcher. Follow up requests for the return of responses were made orally in person and via the telephone.

4.7.2 **PART TWO - Ethnography**

Ethnographic research does not conform to most other methods where the research process works through a linear progression of procedures. In ethnographic research, procedures are conducted concurrently (Wiersma, 1991). Wiersma suggests analysis of qualitative research is ‘a process of successive approximations towards an accurate description and interpretation of the phenomenon’ (p.85).

4.7.2.1 **Data Collection and Analysis**

Data for analysis were gathered from various sources including parents, teachers, the Principal and students in the Smithfield Primary School community. The data were generated by the teacher-researcher observing teachers teaching, students under instruction and working in the school community environment. Descriptions and reflections generated from observation made by the teacher-researcher were recorded in the reflective journal as soon as practically possible after the period of observations.
Attendance by the teacher-researcher at a meeting of the school canteen committee provided the teacher-researcher with the opportunity to discuss health education issues with four parents. Details from the discussions were recorded in the teacher-researchers reflective journal.

The opportunity to participate in informal discussions with the students and teachers generated further data, which were again recorded in the teacher-researcher’s reflective journal. A collection of photographs and students’ work, provided data regarding student outcomes throughout the units piloted.

Tape recordings were made on five occasions. The three tapes giving details of particular class sessions have already been detailed. The fourth tape was used to record student responses to questions evaluating the project, including content and strategies used throughout the five units. These informal discussions between the teacher-researcher and students occurred in groups of three. The tape was transcribed and given to the AST3 for her reflection on student responses.

The fifth tape was used to record a reflective discussion between the teacher-researcher and the AST3 regarding student responses to the content and strategies used in the piloted units. The discussion included critical reflection of the possibility of changes in teaching strategies and course content to better meet students’ needs and have more relevance for them. This provided the teacher-researcher with an increased awareness of the AST3’s reflections on the research and any possible influences the research process may have had on choices in the pedagogic situation.

Action research and ethnography share common elements in
relation to the analysis of data generated. In ethnographic research data analysis is not seen as a distinct stage and informally begins to take shape in the form of ‘ideas, hunches and emerging concepts’. (Hammersley and Atkinson, 1983) The action research spiral described by Kemmis and McTaggart (1990) suggests data collection and analysis continues simultaneously.

A great deal of data were generated and initial analysis was undertaken in the search for dominant themes relating to the focus questions. This was done through the use of notations and highlighting in my journal and on other written material. This lead to further collection of data to validate or further investigate emerging concepts. Additional sorting and focusing lead to the development of themes where common relationships could be explored. Internal and external influences on improving the school’s health curriculum were explored, but in many cases it was difficult to make distinctions as a great deal of overlap occurred between what went on in the classroom (internal) and outside the school (external).

Wiersma (1991) outlines the need to fully discuss and describe data analysis processes to enable other ethnographers to replicate the study. However, since the circumstances, people, and events, do not remain consistent in the school environment, the exact replication of any ethnographic study would be difficult. Another consideration when using action research and ethnographic methods is that in the former the design is not rigid and the concerns and themes emerge throughout the research. Ethnography is responsive to change in events, analysis and interest during the course of the research. These factors will complicate, if not eliminate, the ability to fully replicate the study.
In an attempt to provide an outline for fellow researchers interested in the methodology used in this study, the following example and table have been included to illustrate the analysis procedures.

Example 1:
Teacher directed discussion (recitation) as a form of transmission.

The above theme emerged through sorting of the following data:

a) Teacher questionnaires indicated whole group discussions as the most used strategy in health education.

b) Observation of classroom teacher using whole group discussion.

c) Journal reflections concerning the teacher-researcher resorting to teacher directed discussions during teaching episodes.

This theme continually coming through the data led to discussions with the classroom teacher regarding the teacher-directed recitation as opposed to student-centred methods. No agreement on the issue was reached, therefore it was felt further investigation was required.

d) Small group discussion with students to get their perceptions of the strategy. (Tape recorded)

Outcome:
Student perceptions, personal reflections and observations, and questionnaire results were discussed between the teacher and the teacher-researcher. This promoted critical discourse concerning the use of the recitation (teacher directed discussion) as a strategy utilized in implementing the health education curriculum and provided data for considering alternative approaches to implementing the health education curriculum.
The themes, relationships and categories organised in the final stage of analysis were as follows:

**Table 3. Final Stage of Data Analysis**

<table>
<thead>
<tr>
<th>THEMES</th>
<th>RELATIONSHIPS</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Community Perceptions</td>
<td>Internal/External</td>
<td>Limiting/Promoting</td>
</tr>
<tr>
<td>Traditional Health Education</td>
<td>Internal/External</td>
<td>Limiting</td>
</tr>
<tr>
<td>The Recitation</td>
<td>Internal</td>
<td>Limiting</td>
</tr>
<tr>
<td>Practicality Ethic</td>
<td>Internal</td>
<td>Limiting</td>
</tr>
<tr>
<td>In-service Education and Teacher Innovation</td>
<td>Internal/External</td>
<td>Limiting/Promoting</td>
</tr>
<tr>
<td>Competing Interests</td>
<td>Internal/External</td>
<td>Limiting</td>
</tr>
<tr>
<td>The 'Planned' vs the 'Lived' Curriculum</td>
<td>Internal/External</td>
<td>Limiting</td>
</tr>
<tr>
<td>Facilitating Curriculum Change</td>
<td>Internal/External</td>
<td>Limiting/Promoting</td>
</tr>
</tbody>
</table>
4.8 Methodological Issues

4.8.1 Access

Official preliminary access was granted by the Directorate of School Education on February 12th, 1993 (see appendix 14). This provided the permission necessary to approach the Principal of Smithfield Primary School to gain access to the school and the teacher’s classroom. The problem of access is given a great deal of consideration by Hammersley and Atkinson (1983) who refer to those who hold the key to access at ‘gatekeepers’.

In this research project access was a re-occurring problem that required continual negotiation and patience. The Principal revealed that in retrospect 1993 was an exceptional year for the school in terms of commitments and perhaps not the ideal time for the school to gain the most benefit from the project as it had evolved.

Access to the classroom had to be negotiated around a string of grade and school commitments including a ‘no visitors to the school week’ and a call from the class teacher one evening saying she felt the children needed a ‘normal’ school day without any interruption and would I mind not coming tomorrow. Hammersley and Atkinson (1983) refer to these constraints on access as ‘sensitive periods’ and suggest negotiating access is a ‘balancing act’ with continual trade-offs necessary.

To be implemented correctly, action research requires a great deal of time due to the collaborative nature. Access limitations reduced the amount of time available for collaboration.
4.8.2 Acceptance

The grade teacher and myself were colleagues at a previous school and had established a mutual respect for one another professionally. However, as a teacher on leave I was not appointed to the school and initially had problems being accepted by other staff members. Kemmis (1984) suggests,

"...that 'outsiders' helping to establish processes of self-reflection in schools must become participants themselves (that is, become virtual 'members' of the school community they are engaging)...". (Kemmis, 1984, p.33)

As the research project progressed I gained greater acceptance by staff members but never felt totally accepted as a colleague. The issue of 'assertiveness' as a researcher while observing school protocol, if addressed initially may have alleviated initial problems. The Principal agreed on reflection that attendance at a staff meeting explaining my presence may have been beneficial and addressed the problems of acceptance that had occurred.

Hammersley and Atkinson (1983) discuss the issue of gender which is certainly a consideration in a situation where three of the four senior positions are held by males in an otherwise female dominated environment. Hammersley and Atkinson suggest,

"Not only will the female researcher find it difficult to be taken seriously by male hosts, but other females may also display suspicion and hostility in the face of her intrusion".

(Hammersley and Atkinson, 1983, p.85)

This may have contributed to initial 'suspicion' by some female staff members at the school.
The students I worked with accepted me immediately as another teacher. This provided positive and negative aspects to the research. Working with the students was enjoyable and rewarding. I found myself easily settling back into the role of teacher, despite my eighteen month break from the classroom. However, this placed me in a compromising situation which I had to deal with throughout the research. According to Hammersley and Atkinson (1983) it is to the ethnographer’s advantage to remain slightly removed from the situation. If, as a researcher, you begin to feel ‘at home’, a critical perspective is more difficult to maintain. It was sometimes difficult to accommodate the conflicting roles of teacher, facilitator and researcher.

At times the Principal and teachers involved in the research appear to view me in the role of the ‘expert’ rather than a facilitator or colleague. For example, the Principal asked my advice on resources concerning conflict resolution in the playground. In planning the units of work I felt teachers would often look to me for a great deal of direction or perhaps simply agree with my suggestions. The perception of me being the ‘expert’ probably inhibited true collaboration in the development and implementation of units to a degree.

As the research progressed I came to see myself more as an ‘outsider’. This was in part due to the difficulty of being accepted by staff at the school ‘as one of them’. In the final stages of the research I realised had I been working at the school in a permanent capacity, the role I had anticipated as teacher-researcher would have been very different. My sentiments on the matter were echoed by my ‘critical friend’ who reiterated ‘....things would have been different if you were working here’.
Kemmis (1984) acknowledges the difficulties faced by the 'outsider' attempting to transform educational practice:

"The 'outsider' researcher may interpret or inform these practices, but does not constitute them, has limited power to transform them, and rarely lives with the consequences of any actual transformations that occur".

(Kemmis, 1984, p.32)

4.8.3 Validating Data

The ability to validate data was possible using the methods of triangulation (Adelman, 1981; Elliott, 1977) and saturation (Glaser and Strauss, 1967). The versions of triangulation used involved contrasting the perceptions of one person with others in the same situation, or comparing data from three different methods of collection. Adelman (1981) suggests accounts from the teacher, the pupils and participant observer as suitable 'actors' in validating through triangulation which focuses on the actions of the 'actor' in a role rather than an evaluation of the person.

The second approach involving saturation occurs when a category generated from observation is repeatedly tested against the data. The diverse range of methods used to determine information made it possible to validate using saturation. Methods of data collection included questionnaires, unstructured interviews, a physical review of relevant literature (policies and programs), diary and journal entries, collaborative discussions and conversations, observations and written evaluations.

My own interest in the area as a primary teacher, committed to the improvement of health education in the school curriculum, certainly brought personal bias to the research situation.
Action research and ethnographic methods require the researcher to collaborate with others to share and validate data. This enabled me to recognise and reject personal bias in the interpretation of data through constant checking with other participants. At times, in the collection of data, I had to rely on accounts of events provided by other participants (informants) making validation more difficult. Due to the possible biased or inaccurate nature of such accounts, I attempted to cross-validate and triangulate data.

Due to time constraints and imposed restrictions on access to meetings and discussions of particular interest to the research problem, I have been unable to triangulate all data presented in this thesis. While I acknowledge this as a limitation of the study, I have presented the information I have obtained and where possible compared it with literature in the field.

4.8.4 Data Collection

Discussions and conversations played a large part in the informal collection of data. These methods presented a number of positive and negative considerations. One of the biggest problems was making the distinction between research information and information given in confidence, addressing situations and events taking place in the school. If I felt information given was pertinent to the research I would discuss it further with the provider to ascertain whether I would be breaking confidentiality by using the information as data. However, to provide further confidentiality and anonymity, it was made clear to the Principal and teachers involved that pseudonyms would be used in the preparation of the thesis.
Data collection had to involve time efficient methods where possible to avoid any major imposition on teachers professional and personal time. This proved to be very difficult because the action research process by very nature requires a great deal of time to be spent if full collaboration and participation is to be realised. Although an immense amount of time was spent discussing and evaluating the progress of the research, it never seemed to be enough. Discussions took place in the classroom, in the staffroom, in the Principal’s office, on yard duty and at my home. Written responses and evaluations were resorted to in an effort to overcome this problem which presented further problems. Return of written responses required continual follow up and despite rigorous efforts, return could not be guaranteed.

The climate in the school, due to changes in government policies, made data collection difficult. I made a concerted effort to work within teachers’ comfort zones which involved non-intrusive methods of data collection where possible. I avoided journal writing and taking notes at school initially but found recall of information once I returned home difficult. Although I found particular statements stayed with me, many details of conversations had to be re-checked with participants.

The AST3 and the grade five teacher were asked to develop a reflective diary on the units of work piloted with their students and the action research process. The grade five teacher chose not to develop a diary, although she was prepared to participate in lengthy discussions. The AST3 developed a diary which was more a record of events rather than a reflection on the research process and strategies used with students. The problem of persuading teachers to develop journals for reflection on their teaching strategies has been documented by other researchers (Burgess,
1985; James, Carruthers, and Cameron, 1992). Lack of time for recording was cited by Burgess (1985) as a difficulty faced by teachers. While time is certainly a valid problem in the busy primary school environment, James (1992) and his colleagues suggest in their evaluation of the SDHE project in Western Australia:

“To effectively conduct ‘action research’ on health education strategies, teachers need to keep records of teaching strategies introduced so they can analyse their effectiveness”.

(James, Carruthers and Cameron, 1992, p.11)

I would agree with James (1992) and his colleagues that the issues relating to the use of reflective journals needed to be addressed at an initial planning meeting. Follow up workshops on the content and procedures to use when developing a reflective journal may be beneficial to the participants including the teacher-researcher. This would provide a strategy for monitoring recording, and a venue for sharing and reflecting on the project and the action research process.

While I believe teachers are generally extremely skilled at evaluating program outcomes and student outcomes, we find it more difficult to participate in self-reflective enquiry of our own particular practices. While successful self-reflective enquiry by teachers has the potential to improve teaching and consequently learning in health education, support to develop skills in this area need to be provided.

Tape recording was used to tape evaluative discussions with students at the conclusion of the project. Students were interviewed in groups of three in an attempt to stimulate
discussion. On reflection it was felt, in some cases, students tended to reiterate what their peers had said, rather than voice their own opinions. Individual interviews would possibly have generated more accurate data, but again, time was an important aspect. Some students were intimidated by the tape recorder which restricted their participation in discussions. Despite these problems, some interesting and valuable data were generated which allowed for triangulation between student, teacher and researchers perceptions of content and strategies used.

4.8.5 Time

The action research process in this case required a great deal more time than I had anticipated. No additional time release was provided within the school for myself and the teachers to collaborate, and although available lunchtimes and after school discussions were held, I could see the action research process could not be implemented to my complete satisfaction. Consideration must be given to the degree of time the research conducted impinges upon the teachers teaching and personal time. Methods of data collection should not be overly demanding of teachers time (Hopkins, 1985; Cummings and Hustler, 1986). Cummings (1985) discusses the problems she faced as a teacher-researcher in her own classroom. She suggests a great deal that has been written about the role of teacher-researcher has not been written by practicing teachers. Cummings (1985) believes the pressures and time constraints faced by teachers has been underemphasised in the literature. She writes:

"Many days have I vowed to find time to observe, to talk more with individuals, to enter this experience that the children live through. It has not been possible - perhaps next time!" (Cummings, 1985, p.148)
In her discussion of the action research process involving the SDHE project in the Northern Territory, O’Sullivan (1993a) includes time for consultation, participation and congruence as key elements to consider.

4.8.6 Transferability

This thesis has been written documenting the experiences of research participants, and describing events in the specific context of a large primary school in the south-eastern suburbs of Melbourne. While this is a case study of one school, Smithfield Primary School would be seen to be representative of many large primary schools in the south-eastern region of Melbourne. It would therefore be acceptable to consider the transfer of some of the generalisations developed through the research project to other similar contextual settings.

4.9 Summary

In this chapter I have described the research methods used throughout the development of the project. Consideration has been given to methodological issues which have prevented the action research process from being completely implemented to the satisfaction of the researcher.

In the specific context of this research project, the researcher had not anticipated the difficulties the action research model would present in practice. The organisation of, and commitment to the project, required by all participants certainly surpassed the researchers initial expectation. The logistical arrangements, time commitments and limited resources allocated, restricted team collaboration, an essential element for successful action research.
The research project at Smithfield Primary School was virtually unfunded. This presented the teacher-researcher and participating teachers with limited support in terms of additional resources, including workshops and the time release necessary for group meetings. Funding available to support such measures has contributed to the success of other action research projects (Baird and Mitchell, 1989; Kennett, 1990; Little, 1990; Went, 1991; James, Carruthers and Cameron, 1992; Irwin, 1993), undertaken in school environments.

Where does this leave the action research model in the context of a state primary school where the health education curriculum has been identified as in need of review? Without adequate funding, time and resources, the difficulty of implementing the action research process in a completely collaborative manner is reduced. Unless team collaboration is achieved, commitment to improving the health education curriculum will become fragmented and have minimal impact on changes at the classroom level.

While an increased level of funding and resources can contribute to improving the potential for team collaboration, the essential elements of action research outlined by Brown (1987) are difficult to meet. In a large school where a diverse range of personalities are represented, curriculum theories and philosophies of teaching will differ dramatically, making voluntary participation essential. However, any change which might occur in the practices of participants cannot be imposed on others.

In chapter five I will discuss the persistence of traditional school health education. This will be developed by focusing on school community perceptions and the curriculum-as-plan (Aoki, 1977, 1993) or the prescribed curriculum. The prescribed curriculum will
include a discussion of the school's health education and related policies. The text 'Health Education Program' (Meadows and Haynes, 1989) will be discussed. Strategies used by teachers to implement the existing health program will be explored.

In chapter six I will discuss factors influencing change in health education within the school environment. This will involve considering the 'practicality ethic' (Doyle and Ponder, 1977-78), the persistence of the 'recitation' (Hoetker and Ahlbrand, 1969) and teachers' views of innovation. Competing interests within the school environment will be discussed.

In chapter seven, factors influencing change outside the school environment will be considered. The focus will be on teacher in-service education and the curriculum-as-lived.

In chapter eight I will focus on facilitating curriculum change in school health education. The importance of school based curriculum developed (SBCD) will be discussed. The impact of a school-community approach to health education will be considered. The role of action research in creating curriculum change in health education will be explored. Skills necessary to participate in self-reflective enquiry will be considered.
CHAPTER FIVE - RESULTS AND DISCUSSION (Part One)

5.0 THE PERSISTENCE OF TRADITIONAL SCHOOL HEALTH EDUCATION

5.1 Introduction

In this chapter I will argue that traditional school health education, which concentrates on providing facts and information to students about how to stay healthy, remains prevalent in Victorian primary schools. This approach to health education is based on the assumption that knowledge can influence behaviour, and modified behaviour is the responsibility of the individual who has the capacity to change his or her behaviour in order to enhance his or her own state of health.

Naidoo states:

"Three major criticism can be levelled against individualistic health education: first, it denies that health is a social product; second, it assumes free choice exists; third, it is not effective within its own terms of references".

(Naidoo, 1986, p.19)

While it has been acknowledged that providing information can improve health knowledge (Bartlett, 1981; Tones, 1981), knowledge alone does not necessarily influence behaviour and an individual is often limited in his or her ability to change behaviour (Jackson, 1985; Naidoo, 1986; Tones, 1986, 1990).

If traditional health education targeted at the individual does not serve the purpose for which it is intended, why then do schools persist with this form?
Educational institutions, it would seem, even at the primary level, are most interested in the transmission of a body of knowledge and student attainment in the form of measurable outcomes. This view is reflected in the Victorian 'Schools of the Future' (1993) document. The guiding principles for developing a 'School Charter', which covers the eight curriculum areas (including Health and Physical Education) states:

"The school curriculum should:
ensure at least a 90% student success rate with respect
to the educational goals in each curriculum area".
(Office of Schools Review, 1993, p.5)

While it has been argued (Carr and Kemmis, 1986) that today's teachers enjoy greater autonomy in curriculum decision making and are better prepared professionally, it has also been recognised that teachers remain 'conformists' in many ways. This is particularly true in their use of prepared and marketed curriculum materials (Anderson, 1985; Hawthorne, Garrard, Dunt, 1993).

Aoki (1991) believes mere rhetoric has been paid to teacher professionalism. He states:

"But still we see about us efforts to place teaching in a grey box, if not a black box, wherein teachers are mere facilitators to teaching built in programmed learning packages. These are teacher-proof packages wherein claiming purity, preference is for non-contamination by a teacher's presence. This is akin to a technological understanding of teaching whose logical outcome is the robotisation of teaching-schools in the image of Japanese automobile factories - heaven forbid!"
(Aoki, 1991, p.1)

While Aoki's view may be a little overstated, it helps us develop a greater understanding of why teaching continues to focus on the
transmission of a body of knowledge and the difficulty of breaking away from the dominance of conventionality.

In this chapter I will explore the reasons behind the persistence of traditional health education in the primary school environment. This will be done by focusing on parents, teachers and students and their influences on, and relationships with, the curriculum-as-plan (Aoki, 1991).

5.2 School Community Perceptions of School Health Education

5.2.1 Parents

Parent expectations and perceptions of a school’s curriculum can have significant effects on content and approaches to curriculum. This is particularly true in a climate where the decision making process, in many areas including curriculum, has been devolved to include the parent community (Ministry of Education, Victoria, 1983). Parent representatives are expected to participate in events such as the writing of the ‘School Charter’ which is a requirement for Victorian primary schools identified as ‘Schools of the Future’ (Directorate of School Education, 1993a).

Conservative parent bodies will elect to develop School Charters and policies based on conservative views of education. This has been demonstrated at Smithfield primary school where the Health Education policy states:

"Sessions related to sexuality will be the responsibility of the School Council and will be arranged as a non-compulsory option".

(Smithfield Primary School, 1993)
This fragmented approach to health education is problematic for many reasons which need to be addressed. How can a school implement comprehensive, holistic health education when sexuality education is not the responsibility of the classroom teacher? How can teachers cater for student’s own interests, that often arise during current affairs sessions, based on media viewing?

Bartlett (1981) suggests:

“Schools often have policies against teaching such controversial topics as sex education, which may be precisely the topics which students most want and need to learn about”.

(Bartlett, 1981, p.1387)

It is difficult for the teacher to provide a forum for discussion, open to the ‘lived experiences’ of students, in a classroom environment where limited power and support are given. Here teacher professionalism is being questioned.

An informal staffroom discussion (30/6/93) concerning the school’s health education policy with teachers’ of students in the upper grades, highlighted this problem. A teacher recalled being asked by a student during a class discussion, "What’s a lesbian?" The teacher felt unable to accommodate the student’s ‘lived experience’ due to the restrictions imposed by the ‘curriculum-as-plan’ (Aoki, 1977, 1985, 1991). During our collaborative discussion (30/6/93) regarding the school’s health education policy, the teacher stated that she felt ‘restricted’ by the school’s policy to answer the student’s question and suggested the student refer the question to her parents.

The twenty-four parents of students in grade five who responded
to the parent questionnaire (89% response rate), provided information concerning health topics, which they viewed as important for their grade five children. Parents were asked to 'list five health topics you see as most important for your child at this level'.

The following results were obtained:

Table 4. Health Categories Viewed by Parents As Most Important For Their Grade Five Children

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>NUMBER OF PARENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hygiene</td>
<td>13 (50%)</td>
</tr>
<tr>
<td>Nutrition</td>
<td>11</td>
</tr>
<tr>
<td>Exercise</td>
<td>6</td>
</tr>
<tr>
<td>Disease</td>
<td>6</td>
</tr>
<tr>
<td>Dental Health</td>
<td>6</td>
</tr>
<tr>
<td>Body Systems</td>
<td>4</td>
</tr>
</tbody>
</table>

The researcher organised topics listed by parents into the categories indicated in Table 4. For example, if the parent listed topics such as 'diet' or 'eating habits', the response was placed under nutrition. Responses such as 'general cleanliness' and 'clean toilet habits' were placed under hygiene.

These figures suggest that conservative parent communities will identify priority areas in health education for their children, based on traditional health education concepts where the major focus is hygiene and disease prevention (Owen, Coonan, Worsley, 1989). Here the physical and biological aspects of health are promoted neglecting the personal, social and emotional areas. Again a fragmented, rather than an holistic, view of health education is presented.

Parents' perceptions of what school health education should
include has the potential to restrict curriculum innovation. It is in the interest of the students that the school needs to develop and implement strategies to broaden parents' perceptions and raise the profile of school health education.

Community awareness was an important priority in the Health In Primary Schools projects. While all HIPS pilot schools managed to develop and implement strategies to raise the profile of health education in their schools, the sustainability of many programs came into question (Went, 1991). Community support and involvement, and active participation by parents were seen as essential to the success of the HIPS projects. However, in many cases, continued support and participation was not attained, compromising the success of some projects.

This raises questions about whether parents really want the responsibility of being involved in curriculum development and implementation. It is also arguable whether the government is actually moving the power over curriculum matters to school communities through 'Schools of the Future' (Directorate of School Education, 1993a), or whether this is simple a facade, while the true intention is to move towards centrally or nationally prepared curriculum, with its emphasis on quantifiable student outcomes.

A prescribed curriculum which focuses on measurable student outcomes gives teachers less control over curriculum matters, limiting their potential to cater to the diverse needs of individual school communities. This does not contribute to improved teaching and learning opportunities for students in health education. Aoki’s (1991) view of the curriculum-as-plan is again appropriate here and should be given consideration in discussing school health education. Aoki (1991) believes curriculum-as-plan
or prescribed curriculum denies ‘...the humanness that lies at the core of what education is’ (p.1) the ‘lived experience’ of the students for who education is intended.

5.2.2 Students

Student questionnaires (100% response rate) investigating students’ perceptions of what health education should be, reflects a narrow view of health, focusing on the physical and biological aspects of the body. The influence of ‘risk factor-orientated’ health education (Tannahill, 1990), is evident in students’ responses to what they perceive to be important health topics.

Table 5. Grade Five Students’ Views of Important Health Categories

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PERCENTAGE OF STUDENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Body/Body Systems</td>
<td>81%</td>
</tr>
<tr>
<td>Nutrition</td>
<td>41%</td>
</tr>
<tr>
<td>Fitness/Exercise</td>
<td>41%</td>
</tr>
<tr>
<td>Diseases</td>
<td>18.5%</td>
</tr>
</tbody>
</table>

The researcher organised topics listed by students into categories. For example students topics such as ‘keeping fit’ and ‘vegetables’ were listed under the categories fitness/exercise and nutrition respectively.

The inclusion of fitness, exercise and nutrition as priority areas reflects the traditional medical approach employed to teach health education to upper primary students at Smithfield primary school.

The fact that 18.5% of the students have actually listed diseases as an important health topic, emphasises the ‘risk factor-orientated’ approach to health education which Tannahill (1990) suggests focuses on the negative rather than positive dimensions of health.
Responses to student questionnaires supports the traditional behavioural approach to health education specified in Smithfield primary schools curriculum-as-plan.

5.2.3 Teachers

Teachers' philosophies, attitudes, values and beliefs about health education, what it should achieve and how children best learn, will significantly influence the way individual teachers approach the subject. Bartlett (1981) and Tones (1981) believe teachers view their task largely as providing knowledge and developing cognitive skills, and argue that changes are necessary if improvements in school health education are to be realised.

Evidence collected at Smithfield primary school on teacher questionnaires (88% response rate) suggested that teachers generally viewed content in health education in a more holistic sense than parents and students. Teachers' views included the physical and biological aspects, but also incorporated social and emotional areas of health. Two teachers' views of health education extended beyond a single discipline approach, recognising the link between health and the environment. The first teacher listed 'Healthy Environment - Pollution' as a topic area to be covered in health education during the year. The second teacher included 'Recycling and distribution of rubbish' as a topic to be covered with her students.
When teachers were asked to list health education topics they felt were important for the children in their grades, the following responses were provided:

*Grade 4 Teacher*

*Anything that may come up in discussions, eg. Birth, Death.*

*Grade 5 Teacher*

*Puberty - in particular mood swings and associated peer dynamics.*

*Advance Skill Teacher Level 3*

*Making sensible choices, Welfare and self-esteem;*

*Associating with other people, Community health - decision making - people who help us maintain good health.*

*Grade 5/6 Teacher*

*There may be needs that arise that may be appropriate to the grade, eg. diabetes/disability;*

*Sex education (policy has this covered with evening meetings of parents and children).*

Teachers’ responses indicate that their perceptions of health education extend beyond the curriculum-as-plan to the outside world and the ‘lived experiences’ of their students. This is further supported by teachers ranked order responses on the questionnaire, which asked them to, ‘indicate which factors have the greatest influence on your choice of content’ in teaching health education to upper school students.
The following results were obtained:

Table 6. Factors Having the Greatest Influence on Teachers’ Choice of Content in Health Education

<table>
<thead>
<tr>
<th>RESPONSES</th>
<th>PERCENTAGE</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevance to Students’ Life Situations</td>
<td>86%</td>
<td>1</td>
</tr>
<tr>
<td>Relevance to Students’ Stages of Development</td>
<td>100%</td>
<td>1, 2 or 3</td>
</tr>
<tr>
<td>School Policy and Course</td>
<td>71%</td>
<td>1, 2, 3 or 4</td>
</tr>
</tbody>
</table>

While teachers may recognise the need to incorporate the curriculum-as-lived (Aoki, 1991), to accommodate the 'lived experience' and needs of their students, they are obliged to comply with the curriculum-as-plan due to a commitment to their 'professional ethic' of teaching.

5.3 The Curriculum-As-Plan

The state’s curriculum guidelines, the school’s policy and programs and the teachers’ courses and lesson plans, constitute the curriculum-as-plan (Aoki, 1991). While the 'Personal Development Framework: P-10' (Ministry of Education, Victoria, 1989a) provides guidelines for Victorian state primary and secondary schools in health education, it is not a mandatory requirement for schools to adopt the use of the document. The 'Personal Development Framework: P-10' (Ministry of Education, Victoria, 1989a) in total was not part of the curriculum-as-plan at Smithfield primary school.

The curriculum-as-plan at Smithfield primary school did include ‘Guidelines for Health Education, Memorandum No.60’ (Office of Director-General, 1984). This memorandum advocates that the
Principal and staff will decide on program implementation in health education, and while all students should be provided with the opportunity to participate in comprehensive health education, it is a parents’ privilege to withdraw their child.

The school’s curriculum-as-plan has a huge influence on the teaching of school health education. The ‘professional ethic’ adopted by a teacher will dictate his or her decision to comply with the teaching of the curriculum-as-plan. This has been illustrated at Smithfield primary school with the Grade 5/6 teacher’s response to the teacher questionnaire, regarding health education topics. While the teacher felt ‘sex education’ was an important health topic for her students she added, ‘(policy has this covered with evening meetings of parents and their children)’. Her willingness to comply with the curriculum-as-plan has been indicated. This has been supported in Table 6 where 71% of teachers have indicated that the schools’ policy and courses will influence their choice of content in health education.

The collaborative review of Smithfield primary school’s curriculum-as-plan revealed a fragmented, traditional approach to health education based on Tannahill’s (1990) ‘risk factor-orientated’ model. For example, the school’s Smoking Policy (1991) states:

"All pupils will be involved in a Smoking Education program".

(Smithfield Primary School, 1993, p.33)

While the smoking program aims to ‘increase pupil awareness of the dangers of smoking to health’ it emphasises the negative aspects of smoking rather than the positive aspects of not smoking.
The Health Education Policy (1991) states:

"Sessions related to sexuality will be the responsibility of the School Council and will be arranged as a non-compulsory option".

(Smithfield Primary School, 1993, p.17)

These two policies support an isolated, fragmented approach to health education, rather than an holistic approach. Smithfield primary school's fragmented approach to health education may in fact be detrimental rather than beneficial to students' health.

Hawthorne, Garrard and Dunt (1993), in their research focusing on the evaluation of Life Education Victoria, acknowledged the problems associated with health education programs taught in isolation and out of context. Their research supported claims made by Hetzel and McMichael (1989) that a fragmented approach to health education, such as the 'curriculum-as-plan' implemented at Smithfield primary school, has the potential to 'arouse student curiosity' and may lead to the 'desire for experimentation' (Hetzel and McMichael, 1989, p.283).

A specific area of health education where the problems of fragmentation and experimentation have been given consideration, is drug education. This has been acknowledged in the 'Personal Development Framework P-10' (Ministry of Education, Victoria, 1989a), where inappropriate approaches to drug education are outlined:

"A number of approaches to drug education appear ineffective, and possibly counter productive, insofar as curiosity may be aroused to the point where risk taking may become attractive, especially in a drug-oriented society. These include information-only approaches, the
use of emotional scare tactics, the use of single session or a guest speaker, ex-addict testimonials and over-detailed descriptions of the use and effects of different drugs".

(Ministry of Education, Victoria, 1989a, p.83)

The lack of support structures in the school environment may limit an individual teacher’s ability to challenge the relevance and worth of the curriculum-as-plan in health education. Participation in ‘authentic’ action research, which encourages self-reflective enquiry and promotes critical discourse between colleagues, can provide the base to challenge existing practices in school health education. It can create an awareness of the possibility of moving away from the individualistic behavioural model, prominent in ‘risk-factor orientated’ (Tannahill 1990) approaches, towards more holistic, action orientated approaches as advocated in the ‘Personal Development Framework P-10’"

"....education programs should include the notion of social action. The individual, singly or in groups, can influence society and take action to change social values and expectations about relationships".

(Ministry of Education, Victoria, 1989a, p.83)

Teacher questionnaires and work programs documented teachers’ adherence to the school’s curriculum-as-plan. When teachers were asked to list topics to be covered in health education during the year, evidence of their compliance with the curriculum-as-plan was strong, based on the prepared text ‘Health Education Program’ (Meadows and Haynes, 1989). The text supports a traditional, medical approach to school health education with the emphasis on providing knowledge rather than a skill-based approach.

In the text ‘Health Education Program’ the unit on ‘My Body and How it Works’ centres around anatomy. Suggested activities
include visits to the school by a doctor or nurse and looking at the organs of animals. When asked to list additional strategies used to teach health education, one teacher’s responses included, ‘dissecting a lamb’s pluck (beast’s heart)’.

While the teacher is complying with the curriculum-as-plan and the students may find the activity interesting, it is questionable whether the learning opportunity has relevance for student or community health.

The emphasis on individual responsibility for health behaviour is evident throughout the text. For example, in the unit ‘Myself and Others’ a suggested activity for students states:

"Discuss feelings and emotions and ways to control these - reaction to pain and self-control".

(Meadows and Haynes, 1989, p.39)

The use of the word ‘control’, defined as the power of directing and restraining, suggests it is the individual’s responsibility to keep ones emotions in check. The ‘Health Education Program’ provides limited scope to cater for individual differences within a specific school community or classroom context. It therefore neglects to accommodate physical, socio-economic and family environmental influences (Jackson, 1985) which will affect an individual’s health status, and consequently his or her power over health decisions.

In some units the ‘Health Education Program’ approaches health education from an ‘illness’ perspective. An example of this is in the grade five unit ‘Sickness to Health’ which develops the topic ‘The Fight Against Disease’. Suggested activities include finding out about the history of particular medicines, different departments in the hospital and medical equipment. It even asks students to define the word ‘sterilised’ (Meadows and Haynes, 1989, p.44).
Bartlett (1981) acknowledges the difficulty of assessing students’ needs and interests in health education. He believes,

"...at best teachers glean an impression of pupils’ interests through chance comments and questions; at worst they utilise an outdated curriculum or textbook".

(Bartlett, 1981, p.1387)

Bartlett’s comments highlight the necessity for schools to implement a situational analysis (Irwin, 1993, Ministry of Education, Victoria, 1989a), which is aimed at not only assessing local needs, but also accommodates a planned evaluation of what students want to know regarding their own health and the health of their family and their community.

Aoki (1991) believes external planners of curriculum, as is the case with the school’s text, ‘Health Education Program’ are unable to consider the essential elements of learning as defined in the curriculum-as-lived. He suggests external planners ‘regard teachers essentially as installers of curriculum’ where ‘implementing assumes an instrumental flavour’ (p.7).

The implementation section of the Smithfield primary school’s Health Education policy (1991) states classroom programs should be based on ‘acquiring knowledge, exploring values and attitudes, and developing skills’ and suggests that ‘experts’ in the community be invited to the classroom to share their ‘knowledge’ (Smithfield Primary School, 1991, p.18). This again emphasises the traditional, knowledge based, medical approach to school health education which Tannahill (1990) suggests is ‘expert-dominated rather than properly participatory’.

Aoki (1991) believes the curriculum-as-plan with its expert
dominance is often 'forgetful that teaching is fundamentally a mode of being' (p.7). Aoki (1991) states:

"To raise curriculum planning from being mired in a technical view is a major challenge to curriculum developers of today".

(Aoki, 1991, p.10)

5.4 Teaching Strategies in Health Education

Tones (1981) has indicated the necessity for teachers to use strategies that differ dramatically from those used to provide knowledge and develop cognitive skills when dealing with the health education curriculum. He also suggests teachers are generally uncomfortable with innovation and prefer teacher-directed methods (Tones, 1981). Bartlett (1981) recognises 'that a lack of consensus regarding the desired outcomes of school health education' (p.1389) has obstructed the development of more appropriate teaching strategies.

Evidence collected at Smithfield primary school supports Tones' (1981) suggestion that teachers prefer to use traditional, teacher-directed methods when teaching health education. A modified version of the Semantic Differential Scale was used to ascertain teachers' approaches to teaching health education to students in the upper school. Most of the teachers indicated on their questionnaires that they used more traditional than progressive approaches in teaching health education to their students.
A combination of scaled items and rankings were used on teacher questionnaires to establish which teaching strategies were most used by teachers, when teaching health education to upper school students at Smithfield primary school. The following results were obtained:

**Table 7. Teaching Strategies Most Used in Teaching Health Education to Upper Primary Students**

<table>
<thead>
<tr>
<th>STRATEGY</th>
<th>PERCENTAGE</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Discussions</td>
<td>100%</td>
<td>1</td>
</tr>
<tr>
<td>Small Group Discussions and Brainstorms</td>
<td>86%</td>
<td>2</td>
</tr>
<tr>
<td>Illustrated Presentations, Group Work and Work Sheets</td>
<td>57%</td>
<td>3</td>
</tr>
<tr>
<td>Oral Presentations</td>
<td>43%</td>
<td>4</td>
</tr>
</tbody>
</table>

General discussions, illustrated presentations and oral presentations all subscribe to the didactic methods opposed by Tones (1981) and Bartlett (1981) in teaching school health education. Bartlett (1981) believes teachers choose to use ‘lecture-oriented’ teaching methods because they better suit class sizes of 25 or more students. He acknowledges that while ‘lectures, instructional media, and question-and-answer periods are the most common teaching methods used’ they are the least effective in promoting behavioural change (p.1387).

Teachers were asked on questionnaires to indicate rankings according to specified criteria, by considering ‘which factors had the greatest influence on their choice of teaching strategies’ in health education.
The following results were obtained:

Table 8. Factors Having the Greatest Influence on Teachers’ Choice of Strategies in Teaching Health Education

<table>
<thead>
<tr>
<th>RESPONSE</th>
<th>PERCENTAGE</th>
<th>RANKING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Group Dynamics Within the Grade</td>
<td>71%</td>
<td>1</td>
</tr>
<tr>
<td>Confidence In The Use of the Strategy</td>
<td>86%</td>
<td>1, 2 or 3</td>
</tr>
<tr>
<td>Resources Available in the School</td>
<td>57%</td>
<td>1, 2 or 3</td>
</tr>
<tr>
<td>Availability of Prepared Worksheets</td>
<td>57%</td>
<td>1, 2 or 3</td>
</tr>
</tbody>
</table>

Most teachers indicated that the greatest influences on their choice of teaching strategies were group dynamics within the grade, and their own confidence in using the strategy. Confidence in the use of strategies has implications for teacher innovation in health education, and in-service education which will be discussed in Chapters Six and Seven respectively.

Other influences on teachers’ choices of teaching strategies were, resources available in the school, and the availability of prepared worksheets. Both criteria suggest a lack of time available for teachers to locate and prepare work for their students, making school-based resources, such as the commercially marketed packages listed in Chapter Three, attractive to teachers. The access to and use of prepared worksheets by teachers in health education supports the view that a tangible product provides greater accountability and can fit neatly into the accommodation of measurable objectives and quantifiable outcomes preferred by some teachers and parents. This will be discussed further in Chapter Six.
My own observations of Mrs W's initial nutrition education session in progress with her grade five students, provided further evidence to support the preferred use of traditional approaches to health education which accommodate measurable outcomes. Mrs W had set her students a project to find and display for presentation to their peers, fifteen foods that were 'good' for you and fifteen foods that were 'bad' for you. Students had developed a number of colourful posters, generally displaying pictures of food cut out of magazines. Students took it in turns to present and explain their posters to the grade. During a discussion after the session Mrs W said how pleased she was with her grades knowledge of nutrition which she felt had been demonstrated through this exercise. This again demonstrates the desire for measurable objectives and quantifiable outcomes for students.

Teachers were asked, through the teacher questionnaires, to briefly outline their philosophies when selecting strategies to use with students. Teachers provided the following responses:

"What I feel will have most impact on the children".

"It depends on the grade - this year's group, for example, hold well informed discussions and really enjoy sharing their experiences and ideas. They are also very supportive when these discussions might get emotional".

"Tie in with Social Studies, but allow children's interests as a guide to the type of information discussed".

"I like to use a variety of strategies to encourage children to take ownership of their own learning. I believe a range of experiences is vital and that children need the chance to work alone, co-
operatively in groups and as part of a whole class”.

“- appropriate to children’s stage of development
- appropriate to behaviour/pressures of age”.

"Find out what children want/need to know (using brainstorm, flow charts) what they already know and work from the known-unknown".

"Relevance to current topics in room and those raised by the children determine topics, strategies are chosen according to how best to develop topic".

The information presented in Chapter Six concerning the ‘practicality ethic’, the ‘recitation’ and teacher innovation, challenges teachers perceptions as indicated above, and suggests there may be a gap which exists between teachers’ behaviours and what is actually intended. Hopkins (1985) refers to this as the ‘performance gap’ and suggests ‘there is often incongruence between a teacher’s publicly declared philosophy or beliefs about education and how he or she behaves in the classroom’ (p.48). The reality of the ‘performance gap’ is explored in Chapter Seven.

5.5 Summary

In this chapter I have presented evidence to support my view that traditional approaches in health education continue to be used with upper primary students. I have explored the persistence of traditional health education in relation to parents, students and teachers and the curriculum-as-plan.

Evidence has been presented which indicates that health education,
based on individualism, is presently the dominant form employed at the school. The dominance of primary school health education based on individualism has been documented by Colquhoun, Kelly and Stevens (1990) and a move towards alternative approaches has been suggested.

I have demonstrated that conservative parent communities will have a conservative influence on a school’s health education policy, and that this will in turn influence the school’s program and practice in the form of the curriculum-as-plan. I have shown that the school’s curriculum-as-plan emphasises Tannahill’s (1990) ‘risk-factor’ orientated model of health education.

While teachers demonstrate that they view health education more holistically than parents and students, and are aware of the need to accommodate the ‘lived experiences’ of their students, I have suggested they are constrained due to their ‘professional ethic’, by the curriculum-as-plan. Teachers’ adherence to the curriculum-as-plan has been demonstrated in students’ perceptions of health education prior to the implementation of the units piloted. I have considered the influence external curriculum developers have on the curriculum-as-plan and how this in turn is reflected in teachers approaches to curriculum implementation. I have considered the ‘performance gap’ in relation to teacher philosophies regarding selection of teaching strategies and actual classroom practice.

I have recommended that ‘authentic’ action research which encourages self-reflective enquiry and promotes critical discourse between colleagues, can provide a base to challenge existing practices in school health education. This process may support moves away from the individual behavioural model towards more holistic, action orientated approaches.
In Chapter Six I will focus more specifically on factors influencing change in the school environment, primarily in the classroom situation.
CHAPTER SIX - RESULTS AND DISCUSSION (Part Two)

6.0 FACTORS INFLUENCING CHANGE WITHIN THE SCHOOL ENVIRONMENT

6.1 Introduction

In this chapter I will discuss the problems that occurred in the school environment, when the action research group attempted to move away from the school’s traditional behavioural approach to health education. The units of work which were developed and piloted, were an attempt to accommodate a cross-curricular (Tomlinson, 1981; Cribb, 1986) approach to health education. This potentially provided a more broad and balanced view of health and health education which could allow issues to be dealt with in context (Ministry of Education, Victoria, 1989a). The units were based on Tannahill’s (1990) health-orientated model of health education. This model accepts the view that health is socially constructed and emphasises the development of comprehensive health education programs, in ‘key settings’ (schools) developed and co-ordinated by ‘relevant gatekeepers’ (teachers) to facilitate ‘multi-disciplinary and intersectoral collaboration’ (p.106). The health-orientated model accommodates the process of shaping and implementing ‘action’ for better health. This was the vision, not the reality at Smithfield primary school.

Despite calls from contemporary academics in the field (Howat and Fisher, 1984; Colquhoun, 1990) for broader approaches to health education, I will argue that teachers are often confined in the school environment, due to organisational, personal and other practical constraints, from developing broad curriculum in health
education, and adopting and implementing alternative teaching strategies.

The problematic nature of the ‘practicality ethic’ (Doyle, Ponder, 1977/78) will be discussed and the influence it has had on the implementation of school health education. This involves teachers’ attitudes towards what is practically achievable and acceptable in their individual teaching situations. The ‘practicality ethic’ has relevance to the ‘lived experience’ teachers bring to their pedagogic situations (Aoki, 1991).

The persistence of the ‘recitation’ (Hoetker and Ahlbrand, 1969) as a teaching strategy used in health education will be considered. The relevance of the recitation in relation to the ‘hidden curriculum’ and the ‘lived experience’ of the teacher will be briefly discussed.

I will consider other factors which contribute to limiting teacher innovation in school health education. These include a teacher’s knowledge of alternative strategies, and a teacher’s confidence in, approaching a sensitive area or using a different strategy, in school health education. The desire for measurable outcomes for students in health education, which was introduced in Chapter Five, will be expanded upon and considered in relation to restricting teacher innovation in health education.

6.2 The ‘Practicality Ethic’

The practicality ethic as discussed by Dolye and Ponder (1977/78) considers the influence of what classroom teachers perceive to be practically achievable in their school and classroom environments.
A huge consideration for teachers and researchers regarding the 'practicality ethic', is the time constraints they are expected to operate under. Teachers are further restricted by the additional workload they carry, often not directly related to teaching their students. These problems have been identified in the following personal journal entry:

"When removed from the school situation (on family leave) the physical, financial, organisational and other constraints placed upon classroom teachers are quickly forgotten. Fitting our cross-curricular units of work in around Artists in Schools program, administrative classroom tasks, Education week, a visiting Japanese student taking weekly sessions for a term, story telling at the local library, a bus trip to the high school for Science and Technology, the musical production rehearsals and practice and incidental arrangements such as Jarrod's forgotten lunch reminded me of a juggling act. These are not excuses, merely reality. Huge curriculum, administrative and organisational demands are being placed on classroom teachers".

(Personal Journal, 26/5/93)

This highlights the problem of finding the time to implement the project successfully on two counts. Firstly, the time for the development and implementation of alternative approaches to health education, and secondly the time for group reflection on practice, to accommodate self-reflective enquiry.

O'Sullivan (1993b) in her evaluation report of the School Development in Health Education (SDHE) in the Northern Territory documented insufficient time as a factor constraining achievement. The report outlines the problems of insufficient time to accommodate the following organisational aspects within the school environment:

- Time to consult with Principal, staff and parents to determine participation strategies and school health education priorities
. Time to complete the total process

. Time to allow for a certain degree of flexibility to avoid conflict with other school community commitments.

(Adapted from School Development in Health Education Report, 1993)

The problem of providing the time to accommodate the action research project in the busy school environment was documented in all teachers’ written evaluations. Teachers documented *lack of time together* as a disadvantage of the collaborative process. The Principal suggested through his written evaluation, that the problem of insufficient time outlined by O’Sullivan (1993b), could be overcome:

"I believe the project should be part of a whole school plan and that interaction is necessary between the researcher and the school up to a year before the activities are staged".

While ‘whole school planning’ has been advocated to overcome ‘fragmentation and confusion’ (Ministry of Education, Victoria, 1989b), and is supported by Fullan (1986) when he discusses a ‘new culture’ of schools, it would appear this concept is perhaps a vision of the future for Smithfield primary school and presents a degree of imposition (Prideaux, 1993) which can actually work against effective change. This will be discussed further in Chapter Eight.

The Principal’s comments suggest that he views the researcher as an external facilitator or an "outsider". The notion of the external facilitator has been viewed as problematic in terms of action research (Kemmis, 1984) in the school context. This has been discussed in Chapter Four.

The problems experienced by external facilitators raises the issue
of the advantages of an internal facilitator who is continually exposed to, and has an understanding of, their unique school community. An internal facilitator may have greater power to negotiate, and the flexibility to accommodate logistic arrangements, which may be outside the control of an external facilitator.

The logistic arrangements which became problematic in this action research project were documented as a potential problem in PEEL (Baird and Mitchell, 1989). Participants in PEEL were able to overcome the problems by a great deal of flexibility being provided in the school’s organisational arrangements to accommodate the project. This allowed for regular meetings of participants and specific time allocation for research reviews. An essential element of self-reflective enquiry to improve practice is critically informed collaborative discourse. Time to participate in such discourse is necessary if improved practice is expected to occur.

The ‘practicality ethic’ (Doyle and Ponder 1977/78) is a real concern for teachers, and needs to be considered when developing teaching strategies designed to challenge traditional approaches in health education. In developing criteria for the selection of teaching strategies to be used in the units to be piloted, Mrs J and myself, in my role as teacher-researcher, felt it was important to ensure that teaching strategies must be practically achievable in the classroom, school or community environment. However, this proved to be a more significant problem than had been initially anticipated. Mrs J’s following diary entries demonstrate this point:

"Denise has great knowledge of suitable resources and is prepared to hunt about to obtain them. This can be a problem when classroom teachers are too busy”.

(Mrs J’s Diary, 24/5/93)

"Great ideas - sometimes difficult to act upon, eg. Recipe
Book: (a) children didn’t bring along enough healthy recipes (children were asked to cook recipe at home and bring for grade to share, lack of funds and time allocated to cooking at school); (b) cost of photocopying; (c) interruptions such as Somers Camp; (d) Time, eg. manpower to collate, type up, prepare book. "Didn’t eventuate although planning and ideas were good".

(Mrs J’s Diary 31/8/93)

The problem of time has also been highlighted in Chapter Five where teachers have indicated that resources available within the school, and the availability of prepared worksheets, influenced their choice of teaching strategies in health education.

The problematic nature of time and resources has been identified by the School Development in Health Education (SDHE) projects as crucial to the successful implementation of drug/health education (Irwin, 1991b, 1993; Kennett, 1990; Little, 1990). They have identified adequate resources in terms of people, material, time and money as essential elements to support the success of programs.

The evidence documented during the research project has identified the lack of adequate resources as a constraining influence on the implementation of alternative approaches to the health education curriculum. In 1993 access to support, in terms of external consultants who could assist with resource location and professional development initiatives, was reduced with the closure of Smithfield primary school’s local school support centre. Alternative support structures need to be considered.

The advantages of an internal facilitator working inside the school, who has the knowledge and the time to assist with resource location outside the school environment, has been demonstrated in
this study. Location and use of appropriate resources from within the broader community, has the potential to raise the profile of school health education (Went, 1991). Adequate resource allocation, location and use can support teaching strategies and extend learning opportunities for students.

In Chapter Five teachers' responses to questionnaires regarding their selection of teaching strategies have been documented. Seventy-one percent of teachers identified group dynamics within their grade as having the greatest influence on their choice of teaching strategies in health education. This information points towards a concern for discipline and organisation of groups. For example if a teacher had a grade which consisted of some children who were disruptive or did not work well in group situations, he/she would probably avoid strategies that required group work and increased movement, working on the assumption that difficult students were more easily controlled using traditional instructional methods.

In his research concerning process/inquiry methods in teaching primary school science, Henry (1990) suggests teachers' anticipated problems with the method included space, noise, discipline, increased movement, organisation of groups and keeping the children on task.

The problems outlined by Henry (1990), became apparent as the action research group in the study attempted to move away from traditional teaching strategies, to implement the units of work piloted. Mrs W's evaluation of activities during the second week of the Fitness Fun unit, demonstrates her perception of the practical
problems concerning implementation, and concur with the problems anticipated by the teachers in Henry’s (1990) study:

"Circuit
- lots of noise due to canteen area echoing
- constant child complaints about others
- a solution could possibly be to have disruptive children run around asphalt area
- kids actually loved it once fully underway, usually after about four exercises (circuit consisted of eight stations)
- a few still have excuses to lessen their participation - stickers needed

1km Run (Power Walk)
- whinges initially - then happy.....picking up papers was a good way to ‘encourage’

Aerobics
- needs to ideally be one grade, twice a week in set routine to build up discipline and participation - as it is, anyone who fools around could be taken out for a run around the oval as time out with extra teacher
- there are quite a few kids who really love this and were truly inspired by gym visit”.

(Mrs W’s Written Evaluation, 11/8/93)

My own perceptions of the activities was dramatically different to Mrs W’s. It was hard to believe we were witnessing the same event:

"I felt the majority of children were participating well and disruptive behaviour was minimal. I certainly felt the disciplinary action was a bit over the top. Mrs J and I discussed Mrs W’s evaluation of the Fitness Fun activities. Mrs J didn’t criticise Mrs W’s recommended discipline, but said her own view of the way things were going was much more positive. I suggested to Mrs J that Mrs W’s comments may be because she hadn’t taken physical education before, and therefore had more of a classroom expectation of order and quietness”.

(Personal Journal, 11/8/93)
The emphasis on the 'practicality ethic' continually emerged during the implementation of units piloted with students. In my role as teacher-researcher I had to consistently modify teaching strategies to accommodate classroom expectations. At times this became extremely frustrating.

Comments in Mrs J's diary and my personal journal, concerning learning opportunities during the Consumer Education unit piloted, demonstrates the conflict between our differing perceptions regarding acceptable noise levels in the classroom:

"At times lessons have been too noisy and some children have been unproductive".

(Mrs J's Diary 13/10/93)

"During a session where the students were developing their own radio commercials in groups of three, Mrs J suggested the noise level was too high. I asked her if she felt the problem was that the students weren't on task. She said she felt the students were on task but she was worried about disturbing the teacher in the next room".

(Personal Journal, 18/10/93)

My own acceptance of noise levels when students are participating in activities, is higher than Mrs W's or Mrs J's. When children are working co-operatively rather than individually the noise level tends to rise. Co-operative, group work requires student movement around the room. This in itself can create noise and does not subscribe to the orderly classroom environment easily maintained using traditional teaching strategies. I believe a degree of noise is acceptable and essential if open communication between student and student, and student and teacher, is to be encouraged and accommodated. Wasserman (1990) suggests that a degree of noise is a 'normal by-product' of active learning.
The physical constraints imposed by the school building, provide another dimension relevant in considering any move away from traditional approaches to school health education. The two classrooms were joined by a movable door, constructed of very light material, providing a limited barrier to the noise level generated from either classroom.

The previous entries reflect the differing philosophies and expectations acceptable to different teachers and highlights the need to provide an 'environment of supportive criticism' (Brown, 1987) if self-reflective enquiry is to be established. A degree of sensitivity and acceptance is required to accommodate self-reflective enquiry and critical discourse amongst teachers, if improvement in practice is to be achieved. Teacher 'privatism' (McTaggart, 1989) where teachers are isolated to the confines of their own classrooms, has not required open accommodation of conflicting pedagogic practices. McTaggart (1989) has recognised this problem in regards to improving practice:

"Obviously, any reluctance to disclose and discuss the nature of educational work - a tendency to 'privatism' - among teachers must be alleviated to realise these longstanding aspirations for the profession of teaching".

(McTaggart, 1989, p.346)

Individual members of the action research group perceived the practical constraints of various strategies differently. This demonstrates the extreme differences in attitudes teachers experience in relation to the 'practicality ethic'. Any attempt to challenge traditional approaches in health education must accommodate diverse teacher philosophies and attitudes and provide the organisation and resourcing necessary within the
school environment.

Doyle and Ponder (1977/78) support this view:

"...if an effective change strategy is ever to be devised, it must be constructed on a more thorough understanding of the natural existing mechanisms which operate in the school environment". (Doyle, Ponder, 1977/78, p.1)

6.3 The Persistence of the Recitation

A second consideration which restricted the move away from traditional approaches to health education, during the units piloted at Smithfield primary school, related to Hoetker and Ahlbrand's (1969) review paper titled 'The Persistence of the Recitation'. In the following passage Hoetker and Ahlbrand (1969) define and question the effectiveness of what they refer to as the 'recitation':

"The studies that have been reviewed show a remarkable stability of classroom verbal behaviour patterns over the past half century, despite the fact that each successive generation of education thinkers, no matter how else they differ, have condemned the rapid-fire, question answer pattern of instruction. What is there about the recitation which makes it so singularly successful in the evolutionary struggle with other, more highly recommended methods? What 'survival needs' (my emphasis) of teachers are met uniquely by the recitation? If the recitation is a poor pedagogical method, as most teacher educators have long believed, why have they not been able to deter teachers from using it?"

(Hoetker and Ahlbrand, 1969, p.163)

After the reconnaissance stage of the research project, Mrs J and myself had agreed to try to move away from the traditional content based approach to health education used at Smithfield primary school. The idea was to move towards teaching strategies
which provided learning opportunities for students which focused more heavily on skill development, with an action orientation (Ministry of Education, Victoria, 1989b; Wassermann, 1990). A move towards more student control was anticipated.

The document 'Learning How to Learn' states:

"Without an emphasis on the increasing control a learner exerts over the learning process, students will remain relatively dependant on the teacher's role in evaluating their efforts and structuring their learning".

(Ministry of Education, Victoria, 1989b, p.12)

In my role as teacher-researcher I felt that many of the teaching strategies adopted continued to reflect the teacher-directed, instructional form, defined as the 'recitation'. On a number of occasions I wanted to start sessions with various brainstorming activities (not teacher-directed) but Mrs J was uncomfortable with this and asked me to give the children more direction. Often these discussions with students degenerated into what Hoetker and Ahlbrand (1969) refer to as the recitation. The following documentation supports this view:

My journal entry reads:

"Mrs J and I discussed the progress of the sessions so far.......Although I was a little concerned about our content and approach so far (too much teacher direction) we felt we had provided the opportunity for students to:

- think about their relationship to others
- explore problems faced by the elderly
- participate in activities to develop skills required to empower

I suggested to Mrs J that the senior citizens profile (seatwork) was a little conventional, but she reminded me
teachers "like that sort of thing" and you can't do whiz bang things all the time (due to time, energy and resources required)"

(Personal Journal, 28/5/92)

Mrs J's diary entry reads:

"Networking coming along well. Denise gave an example which I feel helped children know where to start. At times I would give the children more direction than Denise does. Do I lead the children too much? I feel children do need to have a clear understanding of the purpose for an activity and the means to achieve it".

(Mrs J’s Diary, 13/8/93)

My personal journal entry reads:

"Mrs J, Mrs W and myself met informally after school to discuss how the nutrition unit was going. Mrs W was happy with the way the topic was going with her students, (traditional approach) she was using whole group discussions and individual presentations. She did mention she as probably 'feeding' (providing information) her students too much. Mrs J and I felt things didn't go at all well today. We discussed the differences in our approaches. My lack of depth of questioning with students, keenness to get students interacting, Mrs J's preference for teacher directed discussion, giving students information they require".

(Personal Journal, 19/8/93)

Mrs J's comments regarding doing 'whiz bang things' reflects the concern for the 'survival needs' of teachers. Only practitioners in the classroom can understand the demands placed on contemporary teachers. Mrs J's reflections concerning whether 'she leads the students too much', Mrs W's reflections about 'feeding' (providing information) her students, and my own continual return throughout the units to teacher-directed, whole group discussions, has lead me to the following conclusion.
The ‘persistence of the recitation’ is closely related to the amount of time and energy a teacher can physically expend in his or her work. A teacher’s own philosophy of how children learn and his/her perceptions of his/her role in the classroom will promote or restrict the use of the recitation as a teaching strategy in health education. The ‘practicality ethic’ which considers classroom organisation, noise and discipline will influence a teacher’s choice of teaching strategies in health education. A teacher’s knowledge of, and confidence in, using alternative strategies has the potential to assist in a move away from the use of this traditional, instructional approach.

As time went on it became evident that Mrs J’s, Mrs W’s and my own teaching styles differed quite dramatically. Working with one another over time caused us to reflect on our own teaching styles and question the effectiveness for students. Despite the fact that I believe, in health education students need to be involved in their own learning through ‘doing’ and interacting as much as possible (Ministry of Education, Victoria, 1989b), I continually saw myself resorting to the use of instructional teaching strategies including the recitation, to accommodate practical, organisational constraints in the school environment.

An example of this was during the unit on Our Emotions. I wanted to initiate the unit with a session about stress and stress situations. I had planned to conduct a brainstorm where the children rotated in groups to discuss questions and list possibilities. A debriefing session would allow us as a group to accept or reject relevant suggestions. The following questions were to be posed.

- What is stress?
- What experiences/situations cause or add to stress?
. What feelings do we experience when we are stressed?
. What can we do to avoid feeling stressed?

Mrs J suggested I run a whole group discussion exploring definitions of stress before allowing students to rotate and write in smaller groups. I found myself expecting set answers and giving clues to entice students to guess what I was thinking. An example from the transcript (9/8/93) went as follows:

Teacher: What do you think this word means? (Word 'stress' written on chalkboard)
Student 1: Being unhappy.
Student 2: Frustrated.
Student 3: Angry.
Teacher: You can feel all of those things without feeling stressed. What do you think the difference might be?
Student 4: You feel.....over the top.
Teacher: Mmm...
Student 5: Everything gets you down.
Teacher: Mmm...
Student 5: It keeps going....
Teacher: Good.

Silence..................

Teacher: What do you mean it keeps going?
Silence..................

Teacher: Do you mean you can get angry or frustrated but you might only feel that way for a minute or an hour, but if you feel that way all day or all week then you can begin to feel stressed.
Student 6: Yeah.
Teacher: So feeling stressed is more long term.
Student 5: Yeah. When you feel like you can't cope.
Teacher: Tell me some other feelings you might experience if you're stressed.
Student 7: Sad.
Student 8: Horrible.
Student 9: Unloved.
Teacher: Mmm...Something I'm thinking of, it starts
Student 7: Dull.
Teacher: Mmm...
Student 4: Dreadful.
Teacher: Another word that starts with D and people feel this way when they are stressed.

Silence....................

Student 5: Depressed.
Teacher: Yes! Well done.

When we did allow students to rotate and record their responses on large sheets of butcher's paper, it was interesting to see students who did not participate in the whole group discussion, eager to write their responses. This may indicate either students felt less self conscious about writing their responses, or they had more opportunity to participate than they had in the teacher controlled question-answer discussion.

My own example of the teacher-directed discussion about stress demonstrates how my own ‘lived experience’ has influenced the meaning I have expected the students to assume. It may be inconsistent with the students’ ‘lived experiences’ and provides an example of how the ‘hidden curriculum’ (Giroux, 1981) can impose on student learning, through the teachers expectation of required responses.

Because Mrs J continued to direct me towards giving students more information, I suggested to her that perhaps my questioning technique was lacking and would she run the discussion on Nutrition. The following transcript consists of a segment of the discussion taken by Mrs J on 18/8/93:

Teacher: Who can tell me why we need good nutrition?
Student 1: To keep us healthy.
Teacher: Yes. What else?
Student 2: To help us grow?
Teacher: Good. Who can think of another important reason why we need good nutrition?
Student 3: To keep our bones and teeth strong?
Teacher: Yes. Remember our body is like a car and we need to put petrol in the car to make it go.
Student 4: We need good food to give us energy so we can walk and run and that...
Teacher: Who can think of another very important reason?

Silence........................

Teacher: You should know this. We talked about it at the Life Ed van.
Teacher: What happens when you get sick?

Silence........................

Teacher: Why do you need good nutrition when you are sick?
Student 5: To help fight germs.
Teacher: And?

Silence........................

Teacher: .....to repair your body.

Stenhouse (1969) suggests that even discussion initiated from enquiry-based learning can deteriorate into a 'guessing game' to determine the correct answer, according to what the teacher is thinking. Stenhouse (1969) regards this type of 'guessing game' as concealed instruction. It must be remembered that what the teacher is thinking reflects the teacher's 'lived experience', which may be outside or in conflict with the student's 'lived experience'.

This instructional approach concentrates on building technical knowledge, and restricts improved learning through higher order thinking which involves problem solving, decision making,
invention and evaluation, and is necessary if we expect students to critically reflect on their learning (Ministry of Education, Victoria, 1989b).

It is interesting to consider students’ views here which adds a further dimension to the study. Students were asked during taped interviews whether they preferred large or small group discussions during the health education units. Most students said they preferred small groups of between three and six students and many indicated they preferred to be in control of their own learning (Ministry of Education, Victoria, 1989b).

The following transcripts (29/10/93) describe student’s attitudes towards whole group discussions and illustrates their desire to have some control over their own learning (Baird and Mitchell, 1989; Ministry of Education, Victoria, 1989b) by being actively involved (Wassermann, 1990):

**Group One**

**Teacher:** Did you enjoy it when we had a whole group discussion, everyone together?

**Student 1:** Yeah oh…I like it better than when you’re on your own.

**Teacher:** Why?

**Student 1:** It’s better when you discuss it. There’s more ideas.

**Teacher:** You guys think its better in a large group?

**Student 2:** Not too large. Only about three.

**Teacher:** What about the whole group discussing, that’s OK?

**Student 2:** Not bad.

**Group Two**

**Teacher:** So when we were in the classroom did you like discussing in a large group or a small group or what?

**Student 1:** Umm. I liked discussing in a large group...
because the other people have got decisions and other comments to make.

**Teacher:** You like a large group?

**Student 2:** Yeah. Cause then you can think of more ideas and that. If you're in a small group like two or three, sometimes there could be arguments. In a bigger (five or six student) group it is easier to settle.

**Teacher:** When we do activities do you prefer it when I give you a lot of information or when you have to do something for yourself?

**Student 1:** Not all of it, just a bit of it then we do it.

**Teacher:** Like the research when you had to go and find out about a service. Did you enjoy that?

**Student 2:** Yeah, we liked that.

**Teacher:** What about when the lady came from the council? (She used a lecture-oriented approach)

(J's expression indicated he didn't really like it)

**Teacher:** Why didn't you like that J?

**Student 1:** Because really all she did was talk about the one subject.

**Teacher:** I could tell by your face you didn't like it. But she was giving you information.

**Student 1:** Um. I guess so but I just didn't really like it.

**Group Three**

**Teacher:** What did you like the best out of all of the things we did?

**Student 1:** Healthy lunch day.

**Teacher:** Why did you like the health lunch day the best?

**Student 1:** Because we sort of organised things ourselves.

**Teacher:** So what didn't you like? Remember when we talked about the health services, you said you liked researching the services but you didn't like the discussion about it. Why was that again N?

**Student 1:** Sort of like you.......it's a bit boring.

**Teacher:** What's boring?

**Student 1:** Talking.

**Teacher:** Oh yeah. What do you mean talking, in big groups?

**Student 1:** Yeah. Everyone's gotta have a turn in a big
group.

Teacher: Right. Is that a problem?
Student 1: Like if you’re in three groups or something that might be better, it’s not such a large group.
Teacher: Yeah, but you know how the teacher usually runs the discussion, if you do it in three groups who would run it then?
Student 1: Ah.....I don’t know. You’d choose a leader.
Teacher: You’d choose a leader to run it. So do you think it’s better when you have discussions like that?
Student 2: Because there’s not so many people you have to listen to and talk.

**Group Four**

Teacher: What’s wrong, why don’t you like the brainstorms, that sort of thing?
Student 1: I don’t like discussions.
Teacher: Why? Tell me why.
Student 1: They’re boring.
Teacher: Why are they boring?
Student 1: Too many people have to take turns and it’s always the same ones.
Teacher: What sort of work did you like?
Student 2: Creating the aerobic routines, that was fun.

**Group Five**

Teacher: When we discussed the picture story books, was the large group OK? (Meaning the whole grade as was the case with these discussions)
Student 1: I think we could discuss in small groups and then come back to the larger group. That way everyone gets their turn and the same people don’t always have all of the say.

Considering the students reflections, and Hoetker and Ahlbrand’s paper (1969), I can see minimal benefit for students (if any) in the continual use of the recitation (which promotes cultural reproduction) as a teaching strategy in school health education. While I am theoretically opposed to the use of the ‘recitation’ in
any form as a teaching strategy in health education, as a practicing teacher, I understand that until class sizes are reduced dramatically through the provision of more teachers in primary classrooms, and knowledge and ‘support’ in the use of alternative strategies is made accessible to teachers, the use of the recitation as a strategy in teaching health education will persist.

It has been suggested by Bartlett (1981), that large class sizes (25 plus), which require greater organisation if involvement teaching methods are adopted, may explain the persistence of question-and-answer periods and other lecture-orientated methods used in health education with children. He includes ‘Instructional media’ which would incorporate television, videos and slides as lecture-oriented methods.

In his paper titled ‘Conventional Classrooms, "Open" Classrooms and the Technology of Teaching’, Westbury (1973) explores the persistence of conventional classroom practice, in particular the ‘recitation’. He has recognised that if progress is to be made towards the adoption of alternative approaches, ‘classrooms (need to) be manned more intensively’ or that ‘teachers must expend greater than "normal" (my emphasis) energy on teaching’ (p.114).

Tones (1981) discusses affective education in relation to school health education. He suggests affective education should concern students with the exploration of values and questions of health and responsibility. He acknowledges the difficulty of implementing appropriate teaching strategies which promote affective education in the school environment:

"....for genuine understanding of issues of any kind, the evidence for the superiority of group discussion is overwhelmingly strong. The problem is that the technique
is costly in terms of time, especially since membership numbers of between twelve and sixteen are usually recommended".

(Tones, 1981, p. 29-30)

6.4 Teacher Innovation

While it has been demonstrated in this thesis that the ‘practicality ethic’, the ‘persistence of the recitation’ and the curriculum-as-plan have directly or indirectly restricted teacher innovation in health education at Smithfield primary school, further influences on teacher innovation, which became evident during the course of study, will be discussed in this section.

Bartlett (1981) suggests that research on using alternative methods in health education with children has demonstrated the effectiveness of small group discussions and problem solving strategies in ‘developing critical thinking, achieving values clarification, and promoting behavioural change’ (p. 1387).

Bartlett (1981) states:

"Although use of involvement teaching methods such as debates, demonstrations, projects, socio-drama, small group discussions, and team teaching are commonly advocated, these methods have not received widespread acceptance, perhaps because of teachers’ lack of confidence in using these methods and/or difficulties of using them in large classes”.

(Bartlett, 1981, p. 1387)

I would like to suggest further reasons for teachers not fully adopting the involvement methods specified by Bartlett (1981). A teacher’s lack of knowledge and understanding about how to implement a strategy in the classroom situation will reduce the
chance of the strategy being adopted. Lack of support in implementing the strategy, and a teacher's own perception of the worth of a strategy, will also influence the degree of adoption. I will use the following two examples, which came to light during this study, to expand on factors influencing teacher innovation suggested by Bartlett (1981) and myself.

**EXAMPLE ONE**

While attending the ACHPER conference in Darwin, during term two break (July 5-9, 1993), I went to a workshop titled, "The Power of Socio-drama and Action Methods in the Classroom", presented by Anna Shadbolt. Before attending the workshop I perceived the strategies to be role play orientated and felt I had probably used the methods before but decided I would go along anyway. During the workshop I realised socio-drama was far more powerful than the role play activities I had envisaged. I was excited about returning to school and having the opportunity to use the method with the children.

On my return to school I felt a little apprehensive about trying the method because I was not overly confident that I could implement the strategies as successfully as I had seen demonstrated in the workshop. The method was certainly appropriate for the unit we had planned on Our Emotions.

The children worked in small groups to select a stressful/conflict situation which might occur at home or school which they could act out. Children selected situations such as a conflict with parents over homework or bullying in the school ground. The socio-drama method allows the teacher to stop the drama at anytime, to ask questions, to reverse roles (e.g. the aggressor
becomes the victim), to change actors or to ask the players to act out an alternative to the situation.

Mrs J and I implemented the strategy jointly with the whole grade. While one group acted, the rest of the grade watched. Anna had suggested this was not the perfect situation and recommended that small groups of twelve students with one teacher would be appropriate. Tones (1981) has acknowledged the benefit of small groups in promoting affective education while recognising the restrictions in the school environment. The reality of working in the primary school situation, and teachers concerns regarding the 'practicality ethic', again became evident here. If I had removed small groups of children from the grade to work with them individually, the support provided to Mrs J through my modelling the strategy, would have been lost. I worked with the first two groups and Mrs J worked with the third and fourth groups.

My personal journal entry reads:

"Judy and I were really impressed with this strategy despite our inexperience with it. Students responded really well and even wanted to stay in over recess to have their turn. Judy was really impressed with this strategy and asked for Anna's notes - she wanted to use them to present the strategy to staff members reviewing strategies to address "Inclusive Schooling".

(Personal Journal, 11/8/93)

Mrs J's diary entry reads:

"Socio-drama activity worked really well. Teachers need to practice this though - new concept to develop and capitalise on. I am really pleased to get new ideas, input from Denise".

(Mrs J's Diary, 11/8/93)
During our informal discussion (16/8/93) Mrs J revealed her disappointment at the ‘Inclusive Schooling’ meeting, with the reaction of colleagues to her suggestion of using the socio-drama strategy with students. She felt her presentation of the strategy at the meeting was ‘a little lost’. The reaction of the Personal Development co-ordinator was “done that”. Mrs J and myself felt that the Health/Personal Development areas were where the method could be most useful. Perhaps the Personal Development co-ordinator perceived the method to be basic role play, reflecting my own initial perception.

It is interesting to note that the Personal Development co-ordinator indicated an interest initially in joining the action research group. However, restrictions placed on broadening the group prevented her inclusion.

**EXAMPLE TWO**

During an informal staffroom discussion (30/6/93) with teachers in the action research group, the week immediately before term break, we began chatting about what we were doing over the holidays. Mrs W asked me what I was doing and I mentioned I was going to Darwin to present a paper at the ACHPER conference. She asked me what the paper was about. I opened a can of worms when I told her the paper was concerning children’s sexual knowledge. She immediately suggested she would like me to come into her classroom and do some work with her children on the subject because she didn’t feel she could tackle the content area herself. I was really surprised at her lack of confidence. I discussed this later with Mrs J who had been present during the initial staffroom discussion. Mrs J was also surprised by Mrs W’s comments because she felt, as I did, that Mrs W was an
experienced, competent teacher who appeared confident in her own abilities to manage and teach her grade. The mention of my presentation led to further discussion regarding the school's policy on the teaching of sex education. This has been explored in Chapter Five.

The value of, and need for appropriate in-service education, followed by classroom support with implementation is emphasised in both of the above examples. Appropriate in-service education and peer support in the classroom can foster implementation making continued use of the strategy more likely. These examples indicate there is a need for the establishment of strategies which promote self-reflective enquiry and critical discourse amongst colleagues, if changes in school health education are expected to occur.

The final aspect I would like to consider in this section regarding limitations on teacher innovation was introduced in Chapter Five. This involves teachers' attitudes towards measurable outcomes in health education. Cribb (1986), and Kirk and Gray (1990) have recognised the difficulty of moving away from the objectives model advocated by Tyler (1949) with its emphasis on measurable outcomes, in a system where quantifiable results and credentials are highly valued.

The following personal journal entry demonstrates teachers' concerns about measurable outcomes in health education:

"Mrs J phoned to say not to come today. She seemed concerned about Mrs W's grade appearing to cope better with the nutrition unit. I explained the two approaches being used were completely different. Mrs W's traditional methods such as asking students to find 15 foods that are good for you and 15 foods that are bad for you are totally measurable. Mrs J and I discussed this issue. She
suggested teachers like measurable outcomes and parents want to know where their child ‘fits’ in traditional terms. Teaching for affective outcomes does not provide this”.
(Personal Journal, 20/8/93)

There can be a great deal of interaction going on in the classroom, for example, students bringing books and articles on nutrition to share with their peers, but unless you have that tangible proof of student’s mastery of knowledge, it would appear that as a teacher you have not completely accomplished your task (Naidoo, 1989; Cribb, 1986). The difficulty of measuring outcomes of health education such as attitude change, social skills or increased self esteem make alternative approaches to health education problematic. A teacher’s preference or perceived need for measurable outcomes supports traditional approaches to health education and discourages teacher innovation to address individual needs of specific school populations (Anderson, 1985; Sargent, 1983).

6.5 Competing Interests

The problematic nature of health education competing for space in an already crowded curriculum has been recognised (Cribb, 1986; Tones, 1981) and cross-curriculum approaches to health education have been advocated (Arnold, 1991; Sleap, 1992; Tomlinson, 1981).

In the study at Smithfield primary school a cross-curricula approach to teaching health education was used in implementing the units of work piloted. The evidence presented will demonstrate how this approach exacerbated rather than alleviated problems in regards to the sharing of curriculum space, time and resources.
This became evident with the implementation of the Fun and Fitness unit. The Fun and Fitness unit evolved to include all students in grade five and six with the collaboration and cooperation of the physical education specialist. The culmination of the unit was a dance/aerobics demonstration at the local youth club hall. The unit was perceived to be very successful by all involved but caused some controversy within the school. The controversial nature of sharing of resources, time and space is described in the following journal and diary entries:

"Aerobics Dance Comp Demo Day - end result was fantastic, needed a lot of work from a few teachers and dedication from chn. Again - need - experts, extra people to help, people prepared to put in a lot of extra time. Great that PE/Health program combined here - would like to see more of this. Great experience for children to get - performing in co-operation and in front of an audience".

(Mrs J's Diary, 16/9/93)

"Mrs J came up to talk about the success of the Dance/Aerobics. Accommodated inclusive school - gender inclusive boys groups, girls groups, mixed groups. Interestingly boys groups emphasised strength movements, strong arms, push-ups, tricep dips - girls emphasis on dance routine, leg kicks creative arm movements. She also mentioned: Leadership meeting - music specialist reaction to dance aerobics demonstration - indicated poor timing, he'd wished he'd been consulted. Mrs J pointed out: Artists in Schools (Music theme) - Term 2 Musical Auditions and Practice - Term 3 Miss N had planned gym/aerobics component in Term 3 due to expected poor weather conditions - the demonstration was a natural culmination of the children's work. We also discussed lack of recognition and support from Mr K. Local excursion issue. School climate is so political". (Personal Journal 18/9/93)

It is interesting to consider why the music specialist appeared upset with the Aerobics component when movement to music,
rhythm and beat were all aspects explored in the unit.

The evidence presented highlights the problems of competing curriculum interests in the school environment. An attempt to implement a cross-curricula approach to expand the subject bound view of health education and accommodate the problem of squeezing time from a school with a very full curriculum commitment, was met with opposition. Strong influences inside the school can determine the degree of time a curriculum area is given. This indicates the need for whole schooling planning, regarding curriculum activities, to equalise all interests and ensure a balanced curriculum is provided for students.

Little (1990), in her evaluation of the School Development in Health Education (SDHE) in Queensland, include the support of non participating colleagues in the school environment as critical to the success of the projects. Little (1990) recommends keeping all staff informed of the project and initiatives has the potential to reduce resistance from colleagues.

6.6 Summary

In this chapter I have demonstrated how the ‘practicality ethic’ as interpreted by individual teachers, can significantly influence the actual degree of change which can possibly take place in the school environment. I have suggested the ‘practicality ethic’ is a valid concern for individual teachers in specific teaching situations and therefore cannot be overlooked in curriculum development activities, if any progress towards change is expected to be made.

It has been suggested that further provision of resources are necessary in terms of time, money and additional personnel to
accommodate a move towards alternative approaches to health education. This would include internal facilitators who are participants in the teacher's world, and who can assist and support teachers with the implementation of alternative strategies. If a significant move away from traditional approaches to school health education is expected, then the provisions mentioned need to be activated.

The 'persistence of the recitation' in school health education has been explored and while I have argued that the method is certainly questionable, it continues to be used by teachers due to the influence of the 'practicality ethic' including class size, time, noise and classroom organisation. I have argued that the physical and mental energy teachers are capable of expanding in one school day, has accommodated the persistence of the recitation.

The influence of the 'practicality ethic' and the 'persistence of the recitation' in health education could be reduced if greater consideration was given to reduced class sizes, internal support structures for teachers, and the financial means required to support alternative approaches.

There are a number of constraints operating against teacher innovation in school health education which include lack of knowledge of alternative approaches, support with implementing alternative methods, a teacher's perception of the value of a strategy, class size and the expectation of measurable outcomes. A change in pedagogic practice is more likely to occur, if practical constraints operating within the school environment are accommodated.

I have argued that competing interest within the school
environment can create an imbalance in curriculum provision. I have suggested a whole school approach to curriculum activities may assist in ensuring adequate coverage is developed and maintained in all areas.

I would argue that opportunities for teachers to participate in self-reflective enquiry is necessary to allow teachers to reflect on their own philosophies and practices in teaching school health education. This will in turn allow them to consider possible changes to their current pedagogic practices.

Throughout this chapter the various constraints operating within the context of the school environment have been considered. This supports the view that while contemporary academics call for broader approaches to health education (Howat, Fisher, 1984; Colquhoun, 1990), limited change will occur unless strategies which can be accommodated in the school context are employed.
CHAPTER SEVEN - RESULTS AND DISCUSSION

(Part Three)

7.0 FACTORS INFLUENCING CHANGE OUTSIDE THE SCHOOL ENVIRONMENT

7.1 Introduction

In this chapter I will explore the problematic nature of current forms of in-service education available in health education for primary school teachers. Aoki's (1991) description of in-service education is considered:

"Within this scheme of things, teachers are asked to be doers, and often they are asked to participate in implementation workshops on "how to do this and that"........At times at such workshops, ignored are the teachers' own skills that emerge from the reflection upon their experiences of teaching and more seriously, there is a forgetfulness that what matters deeply in the situated world of the classroom is how the teachers' "doings" flow from who they are, their beings".

(Aoki, 1991, p.7)

I have referred to in-service education as an outside influence. While I recognise that in-service education is at times implemented on curriculum days in the school environment, the personnel are usually outsiders to the school, therefore having a limited understanding of the uniqueness of an individual school community and the 'lived experience' of the teacher. The uniqueness and 'lived experience' referred to here has been explored, described and highlighted throughout this thesis.

I will explain how those who create the 'lived experience' in the school environment have a better understanding of the diverse and complex needs of their individual school community.
I will argue that current forms of in-service education for teachers may be inappropriate and need review if there is any true intention of assisting practice and creating change in school health education.

I will discuss the curriculum-as-lived (Aoki, 1991) and the influence it generates in the school environment. While the curriculum-as-lived exists in the school environment, it is created through influences operating in the outside world of students and teachers. This is demonstrated in Chapter Three (See Figure 3.1). I will argue that the curriculum-as-lived needs to be given the recognition to develop and survive in the school environment, to accommodate the ‘lived experiences’ of students and teachers if it is to assist in the struggle against ‘domination’ and towards ‘liberation’.

7.2 In-service Education

Traditional approaches to in-service education, where teachers participate in a program in an artificial setting (without students), and are expected to return to their classroom and implement new or innovative strategies without support, are of limited value to teachers. This traditional approach to in-service education is unlikely to increase implementation of alternative teaching strategies back in the classroom situation (Fullan and Pomfret, 1977; Henry, 1990).

Henry (1990) in his discussion of in-service education states:

"By ignoring the theories of teaching practice held by teachers, innovative curriculum development based upon Research, Development and Dissemination approach and incorporating the theories of others (psychologists, scientists, educators, etc) becomes an exercise with very little classroom practitioner engagement".

(Henry, 1990, p.26)
During the course of the study Mrs J and myself were able to attend an in-service session developed and run by the National Heart Foundation. The decision to attend the ‘Food Smart’ (16/7/94) in-service offered, was based on the fact that Nutrition was a unit to be developed in the following weeks with students. The in-service turned out to be basically a promotion for the sale of the ‘Food Smart’ manual, which concentrated on students developing food preparation skills.

A lack of understanding of the importance of the ‘practicality ethic’ for teachers in regards to resources, time and organisation, and the ‘lived experience’ of the classroom became apparent. One participating teacher asked the workshop leader whether there was a large amount of food wasted by students during the pilot phase of the program. The leader suggested it was the teacher’s concern as to whether the students ate the food. They (curriculum developers) simply provided the activities.

Anderson (1985) questions the approach taken by external ‘curriculum salesmen (sic)’ and suggests:

"To be successful they (external curriculum developers) must involve themselves in the lesson and not restrict their advice to the first and last few minutes".

(Anderson, 1985, p.192)

If we look at the in-service education available through corporate organisations such as the National Heart Foundation, we see the presentation of expertly marketed packages developed for use by teachers, which concentrate on Tannahill’s (1990) ‘risk factor-orientated’ approach to health education. However, such packages are unable to tap the needs of individual school communities and to accommodate the true concerns of teachers (Anderson, 1985).
Appropriate professional development activities in health education, implemented within the reality of the school environment, should be a high priority in primary schools, if any change in practice in health education is expected. This has been accepted and supported in the School Development in Health Education (SDHE) projects where a supportive, collaborative approach to professional development activities was implemented (Irwin, 1993).

In Chapter Five and Six I have already presented results which indicated that teachers considered their confidence in the use of a teaching strategy as having a major influence on their adoption of the strategy. I will argue that a teacher is more likely to gain confidence in the use of a strategy by trying the strategy in their classroom with support from a credible, internal facilitator (a colleague).

The method of dissemination used in the "The Power of Sociodrama and Action Methods in the Classroom" workshop led by Anna Shadbolt at the ACHPER conference, where participant's active involvement was a priority, in conjunction with an opportunity to practice the new strategy in a supportive, realistic environment, proved essential for successful implementation. Evidence concerning the success of the strategy has been documented in Chapter Six. It is appropriate here to include students comments to further support the success of the strategy:

Teacher: What about when we had to make up problems from out in the playground or at home. Stress situations. How was that?
Student 1: Yeah I liked that.
Student 2: I liked doing that.
Student 3: I liked it, you can go to anyone, just about everybody's been in that situation.
Teacher: Did you feel when you were doing it that you were really in the situation?

Student 3: ...because you know that it could happen, it's not if..you..like..something that's just about impossible, you know that wouldn't happen, you know, but these things are things that could have happened.

Teacher: Umm.

Student 3: That also helps.

Teacher: So because it was real situations that you really do come across, so that next time you come across it you might think this is a way of getting around it, rather than having a conflict.

Student 3: Yeah.

Mrs J’s diary indicates that teachers need to have the opportunity to practice an alternative strategy, and supports the notion that self-reflective enquiry may provide the foundation for a move towards action to improve one’s own practice.

"Teachers need to practice this though - new concept to develop and capitalise on".

(Mrs J’s Diary, 11/8/93)

The rejection by her colleagues towards the proposed introduction of the strategy to other staff members outlined in Chapter Six, highlights how differences in teachers’ philosophies, beliefs and attitudes will effect their lived experience and classroom practice, and influence their rejection or acceptance of proposed changes to practice.

Research conducted during PEEL indicated that attempting to impose or coerce change on teachers and students was of limited value in terms of improved practice. They found it was more beneficial to allow teachers and students to try new strategies for themselves, see the results and re-evaluate their own attitudes and
values (Baird and Mitchell, 1989; Ministry of Education, Victoria, 1989b). This highlights the value of voluntary participation in any strategy developed to assist changes in pedagogic practice. Action research accommodates the voluntary aspect of participation.

The fact that teachers' attitudes often change after they have changed their behaviour (Fullan, 1986; Ministry of Education, Victoria, 1989b) suggests that time and opportunities must be made available for participation, reflection, practice and critical discourse with colleagues if alternative strategies are to be considered by teachers.

Henry (1990) in his discussion of teacher implementation of the process/inquiry method in primary school science states:

"If teachers' curriculum philosophies and theories of teaching are at odds with the process/inquiry curriculum position, or have been unaffected by the in-service program.....then the modification of suggested strategies and activities will favour established teaching practice resulting in minimal curriculum change being obvious at the classroom level".

(Henry, 1990, p.25)

This highlights the need for support with classroom implementation following in-service education.

An appropriate option for professional development strategies in health education, to promote the use of alternative teaching strategies, would be the appointment of a facilitator in the school environment. The facilitator could provide in-service education and classroom support, through paired teaching situations. The adoption of alternative teaching strategies would become more
likely under the conditions described, as was the case in this study.

A move towards the type of internal facilitator I have described is currently taking effect in Victorian schools through the AST career structure. A number of positions have been delegated specific titles which could prove relevant in creating changes to health education practice in schools. These titles include Professional Development, Personal Development and Curriculum General. The existing problem with this structure is that while the AST’s may have the expertise to provide the service required, they are currently expected to fill a full-time classroom role, along with additional designated tasks.

Mrs J, who held the position of AST3 at Smithfield primary school, was allowed the same allocation of time release as the other twenty-five teachers on staff. A great deal of her time release was spent in meetings with various members of the hierarchy. How can any form of professional development support, involving paired teaching, be provided without an additional time release allocation? This problem must be rectified if the internal support structure recommended is to operate effectively and assist teachers with desired changes to current practices in school health education.

7.3 The Curriculum-As-Lived

It has been documented in Chapter Five that while a teacher is obliged, by his or her ‘professional ethic’, to comply with the curriculum-as-plan, an awareness of the curriculum-as-lived, and its significance for students has been demonstrated. When teachers were asked to list topics they felt were important for their
students, the broad concepts of birth, death, puberty and emotions were included. These topics certainly relate to students and teachers 'lived experiences' and need to be dealt with in the school environment. How children's 'lived experiences' are presently addressed within the school environment and how they should be accommodated, raises significant points for discussion.

Further evidence to support teachers' claims that they attend both curriculum 'worlds' was provided on teacher questionnaires. When teachers were asked to outline their philosophies when selecting content for their students, the following responses were given:

"What I think will be of most value to them".

"Children need to be challenged to think about topics and to make decisions about their learning - what action to take, how can we find out more about a topic etc. I like topics to give children scope for extension and a choice of paths to take".

"1. Based on school course
2. Based on Life Ed Units
3. Incidental teaching
4. Strong push on peer pressure and class/family dynamics".

"- It must be interesting and appropriate to the children's age and development
- It should give them ideas to be acted on to be healthy and happy citizens".

"Content related to children's interests/needs. Often topics arise spontaneously. Topics selected by me fit into themes/focuses in the classroom".

"Children's interests - rough guide as to lesson content but prepared to go off on tangents if the children wish to".
While teachers responses to questionnaires indicate that they are aware of the need to cover both the curriculum-as-plan and the curriculum-as-lived, documentation in the form of teachers work programs gave no account of the curriculum-as-lived. How then is this covered in the classroom environment?

While the responses gathered suggest that some classroom time is spent accommodating childrens’ ‘lived experiences’, it would appear this takes place under the umbrella of ‘incidental’ learning opportunities which arise spontaneously during informal discussions or during the implementation of the curriculum-as-plan. This was evident on two teachers’ questionnaire responses. Both teachers indicated that ‘open’ or ‘whole group discussions’ were held ‘on a needs basis or as opportunities arise’, or to accommodate ‘incidental personal development’.

Consideration of Aoki’s fictitious teacher “Miss O” may lead us towards the question that has been left partially unanswered in this study. How is the curriculum-as-lived accommodated in the classroom environment? Aoki (1991) speaks of the ‘tensionality’ that exists between the two curriculum worlds for “Miss O” and her students. He writes:

"So in this way Miss O in-dwells between two horizons - the horizon of the curriculum-as-plan as she understands it and the horizon of the curriculum-as-lived experiences with her pupils. Both of these call upon Miss O and make their claim on her. She is asked to give a hearing to both simultaneously. This is the tensionality within which Miss O inevitably dwells as teacher. And she knows that inevitably the quality of life lived within the tensionality depends much on the quality of pedagogic being that she is".

(Aoki, 1991, p.8)
Carol Cummings (1985) took on the role of teacher-researcher in her own infant classroom, in an attempt to provide a balance between the two curriculum 'worlds' and document her experience. She describes her task as working towards:

"...a degree of autonomy and self direction for the children, while clinging, perhaps through lack of courage, to a basic scheme of what needs to be learned".

(Cummings, 1985, p.141)

Cummings' (1985) definition of the curriculum-as-lived is 'theme' work, which she describes as 'more exciting' than the curriculum-as-plan, while acknowledging the problematic nature of organisation. In her attempt to accommodate the curriculum-as-lived she was committed to allowing the children to follow their interests and provide them with the freedom to learn what seemed relevant to them. Cummings (1985) questions her own ability to accommodate the curriculum-as-lived when she asks, "Is my 'liberalism' an illusion?" (p.141) Her reflections are also concerned with the degree of teacher-directed interaction that occurs and the conflict between what she intended and what actually transpired.

One problem with self-reflective enquiry, as expressed by Cummings (1985), and recognised in the course of the research project, is the tension it creates. Without this tension a move towards any change in pedagogic practice would not occur. However, reflection on practice must be kept in perspective otherwise, as Cummings suggests, "Once everything becomes questionable, the teacher's task is in danger of becoming overwhelming" (p.138).
My own attempts to accommodate the curriculum-as-lived during the implementation of units piloted, fell into question and led me to reflect on the conflict between what I had intended and what had actually occurred. Hopkins (1985) refers to this conflict as the 'performance gap' which occurs when there is a discrepancy between the perception of the teacher and other participants concerning what has transpired during a lesson.

During the unit piloted titled our 'Senior Citizens', grade five students were given the opportunity to research a health service provided in the local community. The session involved role play activities concerned with using the telephone to gain access to people and information required. The intention of the activity was to empower students by providing learning opportunities which, we as teachers, imagined would enable students to improve their confidence and literacy in communicating on the telephone. Was this simply our illusion of what the curriculum-as-lived should be for students, imposing our own thoughts and ideas rather than giving students the power to control their own learning and genuinely accommodate their 'lived experiences'?

While we believed we had achieved our aims to some degree, and could have measured students achievements using behavioural statements, the outcomes as perceived by students were in contrast to our own perceptions. An example of students' reactions to the activity is as follows:

Teacher: Do you think sometimes I didn’t give you enough information? When you found it hard?
Student 1: When we had to use the telephone to ring up. We didn’t know what to say.
Teacher: But remember we did that role play in the room with people having turns. Didn’t that
help you?

Student 1: Ah no not really. It just looked like people. It was just mucking around a bit.

Student 2: It sorta didn’t help me, it was on the phones.

Teacher: So it wasn’t serious.

Student 2: Yeah.

Teacher: So if you’d been able to actually use the telephone to do it....

Student 1: Yeah. It would have been better.

It is interesting to note that the intention was to allow students to actually use the school telephone to contact their specific services. This was discussed with the Principal and permission was obtained. However, we were unable to gain access to the telephone at the time required. The ‘practicality ethic’ is again impinging on what is actually achievable in the school environment.

A second consideration here is that we would have been able, if requested, to satisfy stated behavioural objectives. For example, students were able to communicate effectively on the telephone to a local community service in a role play situation. What does this really tell us? What it does not tell us is that a number of students had trouble relating the role play situation to the reality of the lived experience, questioning the effectiveness of what was intended and what actually occurred.

As teachers, we often believe we are very aware of everything that goes on in our own classrooms. Cummings (1985) acknowledges, through her own participation in self-reflective enquiry, the misconceptions we sometimes operate under:

"I am increasingly concerned by my lack of explicit knowledge of the children’s perceptions in a situation which I like to think of as child-centred - as responsive to children’s perceptions". (p.143)
"Is this fortnight an example of 'lip service' being paid to children's interests and concerns? Am I merely 'using' the children's enthusiasm as a motivator, much as others might use star charts or negative rewards?"
(Cummings, 1985, p.146)

Authentic action research projects which promote self-reflective enquiry, and involve students' perceptions, can assist us in focusing on what is actually going on in the classroom and close the 'performance gap' between what is intended and the reality of what actually occurs. Self-reflective enquiry could be instrumental in assisting teachers who believe the 'lived experiences' of students must be accommodated in health education in the classroom environment.

7.4 Summary

In this chapter, I have argued that traditional approaches to in-service education are unlikely to produce changes in health education, because they neglect to address the 'lived' experience of the teacher in the school and classroom environment. I have suggested that expertly marketed packages are unable to accommodate the complex and diverse needs of teacher and students in their individual classrooms.

I have suggested that attempts to impose or coerce changes in pedagogic practice are ineffective, and that action research accommodates this problem through voluntary participation.

It has been demonstrated that workshop situations, using involvement techniques, followed by internal (peer) support at the classroom level, can accommodate the successful implementation of alternative strategies, and improve the possibility of continued
use. I have suggested that the current AST structure has the potential to provide the internal framework necessary to improve professional development activities and assist with teacher innovation in health education.

I have argued that teachers are aware of the need to accommodate the curriculum-as-lived for their students. While I have investigated the curriculum-as-lived in the school environment, I have acknowledged the difficulty of determining actual implementation of the curriculum-as-lived by teachers.

The fact that the curriculum is at times unintentionally manipulated by the teacher to accommodate the perceived needs of the students, has been demonstrated. I have suggested that self-reflective enquiry can assist teachers to focus on the real needs of students and consciously accommodate the curriculum-as-lived, giving students greater control over their learning.
CHAPTER EIGHT - RESULTS AND DISCUSSION

(Part Four)

8.0 FACILITATING CHANGE IN THE SCHOOL ENVIRONMENT

8.1 Introduction

Tones (1981) suggests innovation in school health education is necessary to assist in making learning more relevant for students, and to address the 'true social needs' as they exist in today's society.

Throughout this thesis I have argued that the current, traditional, formalised approaches to school health education do not accommodate the 'lived experiences' of students, nor do they extend the professionalism of teachers. Current approaches to school health education actually restrict teacher professionalism, by taking a technocratic view of teaching and learning.

In this chapter I will argue that primary school health education could be more successfully implemented if approached from two perspectives of curriculum-as-lived. Firstly, from the perspective that school health education should purposely accommodate the 'lived experience' of students and teachers, and secondly, where possible, real life experiences which concentrate on actively 'doing' rather than 'telling' should be a priority. An emphasis on the curriculum-as-plan, taught as a single discipline, at a designated time for a specified period cannot adequately tap childrens' interests and motivations, and does not subscribe to Habermas' (1972) critical view of knowledge.
It should be clearly understood that this vision of alternative health education cannot be adopted in schools without a huge effort from those committed to its implementation. An internal facilitator is essential in organising and co-ordinating the implementation of learning opportunities.

Health education contributes to the ‘lived experience’ of the children, at home, in the classroom, at school and in the community. It is therefore necessary to approach health education from the perspective of the curriculum-as-lived, to increase the relevance for students and cater better for their needs. While it is accepted, by the author, that a total emphasis on the curriculum-as-lived in school health education would be the ideal to fully benefit students, it has also been recognised in Chapters Six and Seven of this thesis, that a number of influences and constraints operating inside and outside the classroom environment limit the probability of such a curriculum.

In this chapter I will discuss three approaches, which can be implemented collectively, to improve school health education and to better accommodate the curriculum-as-lived. The first approach is School Based Curriculum Development (SBCD) where teachers are given greater autonomy and the opportunity to collaborate and share expertise. The second approach is the school-community approach to health education which involves the local community in curriculum implementation. The third approach involves the action research process which provides opportunities for critical discourse between colleagues which may promote self-reflective enquiry and has the potential to create change in school health education. The documentation necessary to successfully develop self-reflective enquiry will also be discussed.
8.2 School Based Curriculum Development (SBCD)

To break free from the confines of the curriculum-as-plan, teachers need to be provided with the scope to approach curriculum development which accommodates their ‘lived experiences’ as teachers in their specific classroom situation. This acknowledges teacher professionalism.

Teachers at Smithfield primary school recognised the need to move away from the traditional strategies and content advocated in the curriculum-as-plan and towards alternative options. Teachers indicated this through the following responses on teacher questionnaires. When asked to make suggestions for improving current content and strategies in health education, the following responses were provided:

"I would like to include it more readily into the whole language approach. I feel we need to plan together, work together and support ‘new’ or ‘untraditional’ ideas to make health more on target for today’s climate".

"At present the program is rather teacher directed and offers facts to learn - I would like to see more problems posed and opportunities for children to develop solutions. At times it is difficult to integrate the program into the total curriculum - I would like more flexibility and broader topics".

Genuine school based curriculum development (SBCD) in health education is an approach that can be used to accommodate the ‘lived experiences’ of students and teachers, challenge the technocratic view of teaching and enhance teacher professionalism. The above responses indicate that teachers
would welcome the opportunity to provide greater input into curriculum development, at the school level in health education.

Cross-curricular approaches to health education have been advocated by Arnold (1991), Cribb (1986) and Sleap (1992). The problematic nature of organisation has been acknowledged by Cumming (1985) and described in Chapter Six of this thesis. However, this can be overcome with the appointment of an internal facilitator. The scope for broader approaches to curriculum development in health education have been suggested by teachers at Smithfield primary school. This was accommodated during the project through the action research group participating in school based curriculum development. A cross-curricular approach to health education was adopted.

During the course of the study the action research group was given the latitude to move away from the curriculum-as-plan, and experiment with school based curriculum development. Teachers' written evaluations highlighted the positive aspects of implementing school based curriculum development in health education including, improved self esteem for the teachers involved, greater motivation and commitment and the ability to pursue the curriculum-as-lived to accommodate student interests.

Mrs W writes:

"It makes you feel valued and therefore it gently obligates you to follow through with the whole concept. It also means if you're mid-stream in a lesson, or series of lessons, and ideas change due to the children's input or other circumstances; then you feel free to adapt and pursue the new tangents without the worries of breaking strict guidelines which have been set in prescriptive type units".
Miss N writes:

"The collaborative approach allowed for the sharing of ideas, was a great motivator, enabled the workload to be shared, enabled moral support for those involved".

Teacher’s responses to the positive aspects of school based curriculum development support the views of authors in the field. Marsh and Stafford (1990) state:

"...a teacher’s level of interest will depend very much upon the degree of ‘ownership’ which he or she has with the curriculum. If teachers are engaged in developing a curriculum package, either individually or collectively with a ‘small group’ (my emphasis) of colleagues, it is likely that the amount of enthusiasm for it will be extremely high".

(Marsh & Stafford, 1990, p.102)

Prideaux (1993) and Brady (1990) have questioned the intention of school based curriculum development, suggesting it is merely a transformation of control from one hierarchy to another. I would argue that this might be the case if the focus was on whole school curriculum development where consensus was required. However, in this study ‘small groups’ of participants involved at the level of implementation, contributed to the development of unit frameworks which provided the scope for individual teachers to accommodate their own ‘lived experiences’ in the reality of their own classrooms. According to Prideaux (1993) school based curriculum development will breakdown if the ‘lived experiences’ of individual teachers is not considered.

Little (1990) has identified the need for ‘small groups’ of teachers to work collectively to facilitate change at the school and classroom level in health education:
"Teachers working in isolation have less chance of initiating change than ‘small’ (my emphasis) teams of teachers who are empowered with group commitment and the ability to make collective decisions in relation to curricula change”.

(Little, 1990, p.3)

School based curriculum development (SBCD) as described has the potential to emancipate teachers and allow them to develop a curriculum which truly accommodates students needs and motivations. This may in turn enhance student learning. Evidence presented in Chapter Seven demonstrates teachers’ awareness of student’s ‘lived experiences’ and the need to accommodate the curriculum-as-lived. The ability for teachers to participate in curriculum development allows them to formalise the curriculum-as-lived. Teachers who participated in the study became empowered and began to question the schools current curriculum-as-plan in health education. The following extract from the minutes to a curriculum team meeting demonstrate this:

"The members of the committee were asked to consider any recommendations for a specific curriculum focus for 1994. This may affect budget decisions and professional development.

Priorities included:

(a) Health and Safety - resources, professional development and perhaps a review to ascertain the parent community’s attitude to teaching sexuality (currently a School Council responsibility)".

(Curriculum Team Meeting Minutes, 6/10/93)

This demonstrates, in the context of this research, that if ‘small groups’ of teachers are given the opportunity to contribute to curriculum decisions through school based curriculum development, and participate in critically informed discourse, these
teachers may form 'a critical mass which is small enough to work effectively, but large enough to (potentially) impact on the whole community' (Irwin, 1991a).

8.3 The School Community Approach

The difficulty of implementing a sustainable school-community approach to health education has been acknowledged in Chapter Five with reference to the Health In Primary School (HIPS) project. School community co-operative action is documented as an essential element for success in the School Development in Health Education projects (Irwin, 1991b, 1993; Kennett, 1990). The approach has a great deal to offer students and teachers in terms of accommodating the reality of the 'lived experience' for students advocated in the two perspectives of the 'curriculum-as-lived'. This was demonstrated during the course of the research project at Smithfield primary school.

Community involvement in the study was developed through a combined approach to the Fitness Fun unit with support from the local gym, through the provision of staff and resources and promotional activities to develop community awareness and participation. The Senior Citizens unit involved the students going into the community to explore services through personal interaction, and community members coming into the school to participate and share experiences with students and one another.

The Principal's written evaluation states:

"...the children took on ownership of the program and derived great pleasure from the activities. They recognised that 'work' was based on pupil inputs. Nutrition, Fitness and Aerobic involvement was
Student oral and written evaluations of the units piloted indicate that the students gained the most satisfaction and motivation from the units which required the greatest degree of community interaction. This is supported by following tape transcripts and written statements:

**Teacher:** Which was your favourite activity?
**Student 1:** The friendship thing.
**Teacher:** Yeah. You liked the Friendship Day?
**Student 2:** That was excellent.
**Teacher:** You really enjoyed it.
**Student 1:** Oh yeah and the gym.
**Teacher:** In other words, you guys it seems, you enjoyed the activities where you were out of the school or people were in the school.
**Student 3:** In the school you know all the old people came it was fun for them.
**Teacher:** Was it fun for you too?
**Student 3:** Yeah and like when we went outside the school to the gym and that and got friends there.

Students written evaluations:

"I really enjoyed all the fitness things. I also really liked the dance aerobics".

"I enjoyed going out to places better than doing the activities at school".

"The Friendship Day was really good. I especially liked swapping people and getting to know them".

The activities which demanded the highest degree of community interaction received positive support from teachers in the school.
Teachers involved in the planning of activities continued to acknowledge organisational problems and highlighted the advantages of having the support of an 'internal facilitator'. Comments recorded by teachers on written evaluations included 'shared workload' and 'shared resources and areas of expertise'.

The School Development in Health Education (SDHE) projects acknowledged the importance of 'school-community co-operative action' in implementing effective, in-context school-based health/drug education programs (Irwin 1991a).

The extent to which a school community develops a combined approach to health education will depend on the time, commitment and resources available in the school environment and in the broader community. A school-community approach to health education can make a significant contribution to increasing awareness of health education in its multi-dimensional form for teachers, students and parents. Mrs J's written evaluation supports this view:

"Many parents have shown an interest in one or more units of work. Senior Citizens Day and Healthy Lunch have had several positive comments - caused more thought about food sold in canteen, how can other people be involved?"

"Children have experienced some memorable meaningful understandings and have seen Health in much broader terms than usually seen with current curriculum. Teacher's have discussed special activities and worked together".

Bartlett (1981) believes school health education can be improved for children if schools co-ordinate with community (health) resources. A school-community approach to health education is
advocated by Tannahill (1990) in his health-orientated model of health education. While the difficulties of the school-community approach to health education are acknowledged, including school-community interest and participation, the positive influences for all concerned should be given priority.

8.4 Action Research in Creating Change

Attempts to facilitate changes in pedagogic practice will have minimal impact at the classroom level unless three significant criteria are recognised in the development of any change strategy. The first criteria involves the recognition that teachers are critical agents who must be completely involved in the change strategy (Fullan, 1986; Irwin, 1991a, 1991b; Kennett, 1990; Little, 1990). The second criteria acknowledges that effective change cannot be coerced or imposed (Baird and Mitchell, 1989). The third criteria is described by McTaggart (1989) who expresses concerns regarding teacher ‘privatism’ and suggests the emphasis on individual work, which provides limited opportunities to reflect on practice with colleagues, restricts progress towards changes in pedagogic practice.

Action research which may promote self-reflective enquiry and critical discourse (Brown, 1987; Kommis and McTaggart, 1988) accommodates the three criteria required to facilitate change in pedagogic practice at the classroom and school level in health education. The voluntary nature of action research involved teachers seeking to improve their individual pedagogic practice in health education and the school’s health education curriculum. The collaborative aspect of action research requires group participation in the implementation of the process which may break the boundaries of teacher privatism (McTaggart, 1989).
Considering the time constraints and other limitations which impacted on the degree of collaboration possible, and remembering that change by its very nature is an extremely slow process (Fullan, 1986) significant progress towards a change in the school’s health education curriculum was visible during and at the completion of the study. This has been indicated on the school Principal’s written evaluation:

"I believe that action research can improve the preparation of curriculum and the implementation of programs. Involving teachers and children in decision making refocusses attention and re-affirms commitment”.

Mrs W indicated through her written evaluation that her involvement in the action research project assisted her to reflect on her teaching strategies and the content of the program in the following way:

"I think it made me refocus on health at their level rather than theory (eg. like eye parts or first-aid techniques). It also encouraged me to listen to their ideas (like the joint planning at our level) and when I listened to their ideas I valued them and acted on them. Too easy in the normal classroom routine to put a stop to the lesson after a discussion or a video and not change anything. So maybe I’ve learnt to implement the Social Education ideals in the process of all of this too!"

Mrs W’s above written evaluation describes how the opportunity to plan with her colleagues, implement the planned action with students, observe what was happening in her classroom and reflect on her own pedagogic practices has assisted her in
changing her practices and philosophy, attitude and beliefs concerning school health education. She was able to move away from the traditional approaches to nutrition education during her initial session described in Chapter Five and moved towards giving students greater control over their own learning (Ministry of Education, Victoria, 1989b).

Mrs W concludes in her written evaluation:

"I did enjoy the time we shared and I was pleased with the unit as a valuable learning/sharing/changing time for my teaching and the children generally”.

Mrs W’s comments and my own experiences (documented throughout this thesis) indicated that if we as teachers are given the opportunity to work collaboratively and reflect on our individual teaching situations and experiences, we are able to critically evaluate what we are doing in our classrooms and how this relates to the ‘real’ needs of the students. This will in turn assist us to change our pedagogic practices, challenge the curriculum-as-plan and consequently lead us towards emancipation.

This conclusion supports the work of Baird and Mitchell (1989) and Smith and Lovat (1991) who report that (small) groups of teachers who volunteer to participate in action research process can be effective in improving pedagogic practice and stimulating curriculum change.

8.5 Developing Skills in Self-Reflective Enquiry

It is acknowledged by the author that participation in the action research process may not be sufficient to create change in practice, if self-reflective enquiry is not fully established. This
point has been supported by James, Carruthers and Cameron (1992) who suggest teachers need to record the effectiveness of teaching strategies in health education to analyse their effectiveness. They state:

"...in some cases (teachers) saw the recording exercise as 'judging' rather than evaluating their teaching practice'. In future projects of this kind more emphasis needs to be placed on the process of 'action research' and its value as a learning tool for teachers. This emphasis needs to be given at the initial planning meeting and, if necessary, followed up at workshops".

(James, Carruthers and Cameron, 1992, p.11)

While this point has been briefly discussed in Chapter Four of this thesis, further comment is required. During the course of the research it became evident that teachers were reluctant to record 'reflective' comments about their own teaching practices. I would suggest that just as teachers display a range of philosophies, attitudes and beliefs about teaching and how children learn, their depth of reflection on their own teaching practice will differ. My own commitment to the project as the teacher-researcher, and knowledge of the self-reflective process allowed me to reflect on my own pedagogic practices.

Mrs W displayed her ability to reflect on her own teaching practices through her written evaluative comments recorded in this chapter. Mrs J, who acted as a reciprocal 'critical friend' throughout the research, documented limited reflective comments regarding her own teaching practice and viewed the action research process more in terms of improved content and strategies in health education.
This was demonstrated in her written evaluation:

"(Action Research) Encourages you to plan, act and reflect on 'the unit' (my emphasis) making modifications where appropriate".

Teachers who have been teaching for a number of years are possibly unfamiliar with the concept of keeping a reflective journal. Teachers' knowledge of, and skills in journal writing may be enhanced through professional development activities (James, Carruthers and Cameron, 1992) and internal support, prior to and during action research projects. Genuine reflective journals can assist teachers to analyse their individual teaching practices more closely. Reflective journals may accommodate the justification necessary for changes to pedagogic practice and provide a documented account of practice, which can be used as a form of teacher accountability. Teacher accountability is gaining a great deal of momentum with the move towards 'Schools of the Future' (Directorate of School Education, 1993a). The potential for action research to improve practice may be limited if self-reflective enquiry remains undocumented.

Adelman states:

"Teaching....is an activity which entails reflection on what one had done in order to become more accomplished. This kind of reflection on doing has been called 'practical reasoning'. It is a form of reasoning in which envisaged ends and practical means are considered jointly in order to improve practice. What ever our criteria for judging effectiveness, such practical reasoning cannot be spelt out in operational terms, but only in terms of teachers' reflective understanding of their own practices with regard to specific areas of curriculum, assessment and pedagogy".

(Adelman, 1989, p.175)
8.6 Summary

In this chapter I have suggested that school based curriculum development (SBCD), with an emphasis on ‘small’ groups of teachers committed to improvement in health education, in conjunction with a school-community approach to health education may improve school health education. Teachers who participate in developing curricula in health education which involves the broader community can better accommodate the ‘lived experiences’ of their students and encourage interaction which may assist students to move towards critical thought. School based curriculum development (SBCD) gives teachers greater autonomy and recognises professionalism which can facilitate changes in school health education.

Action research can provide the internal structure necessary to accommodate reflection on current practices at the school and classroom levels. The action research process in this study encouraged open communication between colleagues and promoted self-reflective enquiry in some cases. This allowed some teachers to move beyond personal awareness and act upon their reflection through changes in pedagogic practices. This led to giving students greater control of their own learning (Ministry of Education, Victoria, 1989b).

In some cases self-reflective enquiry of one’s own practice was limited, restricting any shift towards changes in pedagogic practices. I have suggested greater understanding of the process of self-reflective enquiry is necessary if teachers are to gain maximum benefit from participating in the action research process. This will require professional development activities followed by internal support to encourage and develop skills in the documentation of critical reflection on one’s own practice.
CHAPTER NINE - CONCLUSION

9.0 Conclusion

Action research can contribute to the improvement of primary school health education by providing opportunities for collaborative curriculum development and implementation. Authentic action research which consciously accommodates self-reflective enquiry by teachers, and involves student reflections can improve pedagogic practices and extend learning opportunities.

In this study, traditional behavioural health education, based on individualism, has been identified as the dominant form being implemented at Smithfield primary school. The philosophies, attitudes and beliefs of parents, students and teachers have contributed to conservative approaches to health education at the school. The school's curriculum-as-plan which emphasises the transmission of objectified knowledge, and focuses on individual lifestyle and behaviour change, makes no provision for factors which influence health outside the control of the individual. The health education text and educational packages used to support the school's health education program accommodates the individual behavioural approach to health education.

Teachers in this study have recognised the need to accommodate students' 'lived experiences' within the health education curriculum, and have welcomed opportunities to work outside the schools curriculum-as-plan by participating in the action research project. Teachers' declared preferences in using more teacher-directed, traditional strategies when teaching health education, may continue to contribute to the persistence of the traditional,
behavioural model of health education. Unless opportunities are provided which allow teachers to participate in collegial collaboration, to develop and implement alternative approaches in supportive teaching situations, current approaches to health education, which do not create the behavioural changes intended, will persist.

To develop alternative health education curricula, which addresses the individual needs of diverse school communities, and accommodates a holistic view of health with a social focus, requires a shift from the traditional, individualist approaches currently being implemented. This may be accommodated by empowering teachers through participation in school based curriculum development (SBCD), which focus on school-community approaches to health education.

Giving teachers greater control of curriculum development in health education may improve learning opportunities for students because teachers realise that health education goes beyond the confines of the curriculum-as-plan into the day to day lives and experiences of their students. However, the complexities of such a shift have only begun to be realised through this research project. Classrooms and schools are complex social situations that can only be fully understood by those who participate in the ‘lived experiences’ of any unique school setting.

In this study critical factors operating in the classroom and school environment, which need to be considered to facilitate changes in health education, have been identified:

- insufficient time for group collaboration to develop, organise and implement learning opportunities
insufficient time for group reflection, to promote informed critical discourse and accommodate self-reflective enquiry

insufficient resources - time
  - money
  - people

inappropriate professional development initiatives

organisational aspects within the classroom and the school environment

teachers' differing expectations, philosophies, attitudes and beliefs

acceptance of, and sensitivity towards individual teachers contrasting approaches and styles

physical constraints within the school and classroom environment

large class sizes of twenty-five or more students

expendable teacher energy

lack of support from non-participating colleagues

teachers' lack of knowledge and understanding of alternative strategies

teachers' lack of confidence in using alternative strategies

lack of internal support in implementing 'new' strategies
teacher preference for tangible, measurable outcomes for students, to accommodate teacher accountability.

The reluctance of the school to move away from traditional approaches to health education, brings past professional development initiatives into question. While the drastic reduction in support services to primary schools in Victoria have received a great deal of criticism, it may provide the opportunity to re-evaluate the forms of professional development that have been employed in the past, and present the opportunity to re-direct any re-allocation of funds to develop internal frameworks within schools.

This study has demonstrated that despite a significant number of constraining influences operating in the school and classroom environment, action research can contribute to the improvement of pedagogic practices in health education. Action research can accommodate self-reflective enquiry and promote informed critical discourse between colleagues. The consequences of collegial discourse and self-reflective enquiry may influence pedagogic practices and eventually contribute to a change in one's philosophy of teaching and learning. Open communication between teacher and student may assist in providing student reflections on learning opportunities. This discourse between student and teacher may expand the level of self-reflective enquiry engaged in by the teacher, laying the foundations for creating change.

Action research projects developed and implemented by 'small groups' of teachers, committed to improving health education, can create the formation of a critical mass, with the power and confidence to question current school policies and practices in health education. This can stimulate moves towards facilitating changes in school health education, and consequently improve learning
opportunities for students.

A priority for teachers committed to the improvement of school health education involves not only becoming reflective practitioners, seeking continual growth, but becoming promoters of health education in the school and broader community.

9.1 Recommendation

9.1.1 Development of Action Research Groups

The establishment of 'small' action research groups in individual primary school settings, should be a priority if improvements in current practices in school health education are expected. The appointment of a credible internal facilitator is necessary to assist and support teachers who 'elect' to participate in the action research group. The group should be provided with the opportunities, time and resources to work in paired teaching situations to establish 'critical friend' relationships, and participate in informed critical discourse to promote self-reflective enquiry.

9.1.2 Facilitating Action Research

Schools should be provided with the financial assistance required to establish action research groups. Funding should be maintained to continue resourcing at an adequate level. An initial collaborative discussion would be required, supported by a credible external facilitator, to explain in detail the action research process, and outline the factors which will facilitate the process:

- whole school awareness of, and support for the action research project
time to establish a facilitative environment and supportive relationship to accommodate informed critical discourse

a sensitivity towards, and mutual respect for the diverse philosophies and styles of all group members, and non-participating colleagues

commitment of group members to the process

documentation of self-reflective enquiry in a 'reflective' journal

open interactive communication with students to seek their reflections of alternative strategies

Group planning and reflection would need to be seen as a priority in the action research process. Organisational aspects within the school will need to be considered to accommodate the critical factors necessary to implement the action research process effectively. Structures within the school environment need to provide the scope for teachers to work in paired teaching situations, to observe and support one another in implementing the health education curriculum.

Action research groups established in a number of schools within close proximity may have the advantage of promoting networking between groups and allow for the sharing of resources.

9.1.3 Research Reviews of Professional Development

The persistence of traditional health education in schools brings into question the structure, availability and use of professional development activities in health education in the past. The fact that teachers continue to prefer to use traditional approaches in health
education suggests that past professional development strategies in health education have had limited impact at the school and classroom level. Research reviews of past and present professional development initiatives in health education are necessary to explain the persistence of traditional health education and to explore the possibility of providing more effective options.

9.1.4 Further Research

This study contributes to the limited body of knowledge currently available on the actual practice of health education in the school and classroom environment. While the study documents the experiences of upper school teachers and students in the specific context of a large state primary school in the south-eastern region of Melbourne, the school is representative of other large schools in the region. It would therefore be expected that traditional approaches to health education continue to be used with upper primary students in other similar settings.

However, further research is required to extend the research literature available concerning school communities’ philosophies, and classroom practices employed in implementing school health education. This would require the application of qualitative research methods including extensive document analysis, interviews with teachers, students, principals and other members of the school communities and, participation in, and observations of health education in action.
REFERENCES


Education Department. (1954) 'Course of Study for Primary Schools'. Education Department, Victoria.


APPENDIX 1

SMITHFIELD PRIMARY SCHOOL
HEALTH EDUCATION POLICY

Rationale

Health Education is a combination of learning experiences that affects the way a child thinks, feels and acts in relation to his or her well-being and that of others. A comprehensive health education includes personal development, health, safety and home economics.

Aims

To assist and encourage the child towards making rational, informed and responsible decisions about individual, family and community health.

To assist the child to develop feelings of personal adequacy and self-acceptance.

To assist the child to live a healthier, happier and more productive life.

To assist the child in becoming aware of the need for effective responses to environmental hazards and personal injuries in order to develop protection, prevention and treatment strategies.

Implementation

a) It will be the responsibility of the General Studies Co-ordinator and committee to ensure the implementation of the policy.

Teachers will provide a classroom program based on acquiring knowledge, exploring values and attitudes, and developing skills.

b) The guidelines for the course are outlined in the Personal Development Framework of the Ministry of Education.

The program follows "The Southern Cross Health Education for Primary Schools" document.

Main areas covered will be:
1. A look at myself
2. Myself and other
3. Sickness to health
4. Drugs
5. Recreation and leisure
6. Nutrition
7. Personal Hygiene
8. Be safe.
Sessions related to sexuality will be the responsibility of the School Council and will be arranged as a non-compulsory option.

c) It is expected that teachers will devote at least one hour per week to Health topics, which should be integrated with other subject areas when the opportunity arises.

d) Parents and community members with special skills, (e.g. police, nurses, doctors, dentists, nutritionists, etc.) may be invited to share their knowledge with the children.

e) Assessment of health related knowledge on which to base informed decisions can take a variety of forms, e.g. discussions, crosswords, labelling pictures and diagrams, investigation, debates, etc.

Assessment of skills can be done through checklists, anecdotal records, student self-assessment, observation of student behaviour, etc.

f) Health may be taught in isolation or as part of an integrated curriculum with scope for topics of incidental interest.

g) Reference materials such as charts, kits, video-audio tapes, books and models will be made available through the library, and are stored in the library, the photocopy room and the staffroom.

In each class resource box will be a copy of "The Southern Cross Health Education in Primary Schools" document.

Budget

See details in separate budget publication.

Evaluation

The curriculum is maintained and improved through an on-going process of evaluation and development by the General Studies Committee.

The program also provides scope for supplying additional resources and recording of relevant information through an annual evaluation process by all members of staff.

Evaluation of the progress of individual children is another important source of information for curriculum evaluation.
APPENDIX 2

SMITHFIELD PRIMARY SCHOOL
SMOKING POLICY

Rationale

Smoking presents a danger to health and it is important that teachers set a good example in front of pupils.

Aims

To increase pupil awareness of the dangers of smoking to health.

To encourage staff not to smoke in front of pupils.

To protect the health and rights of non-smokers.

Implementation

1. It will be the Principal's responsibility to ensure that this policy is implemented.

2. Ministry of Education directives are to be followed, i.e. smoking is banned in all school buildings.

3. The smoking ban in school buildings applies to all staff, students and visitors on a 24 hour a day basis.

4. All pupils will be involved in a Smoking Education program.

5. It is not appropriate for staff or visitors to smoke in the presence of pupils, either on school premises, or during school associated activities.

6. This policy supports the principles embodied in the Lilydale West health policy.

7. No smoking signs will be placed in visually prominent positions in all school buildings.

Budget

No funds required.

Evaluation

Input from the school community will be invited during the annual August evaluation.
APPENDIX 3

Dear ..........................................................

I am currently conducting research in Health Education at ........................................ school. I would appreciate your assistance by completing this brief survey and returning it to school. I will be taking Health Sessions at school in terms 2 and 3. I would be grateful if you would complete a brief evaluation at the end of the program.

Thank you for your help.

Denise Landers Tear here if you wish to remain anonymous.

PARENT QUESTIONNAIRE – HEALTH EDUCATION

Please indicate relationship to child. (e.g. mother, father, grandmother), and your age.

<table>
<thead>
<tr>
<th>Age</th>
<th>Relationship</th>
</tr>
</thead>
</table>

1. Use the key to describe the strategies you see as the most effective in teaching Health Education to your child at school.

   M = Most Effective  L = Less Effective

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<thead>
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<th></th>
<th>Question Box</th>
<th>Excursions</th>
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<tbody>
<tr>
<td>General Discussions</td>
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<td>Projects</td>
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<td>Promotional Activities</td>
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<td>Group Activities</td>
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<td>Films, Videos, Slides</td>
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<td>Interviews</td>
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<td>Experiments</td>
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<td>Reports</td>
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<td>Dramatisations</td>
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<td>Role Play</td>
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<td>Community Involvement</td>
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<td>Tape Recording</td>
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<td>Puppet Shows</td>
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<td>Poetry</td>
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<td>Worksheets</td>
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<td>Guest Speakers</td>
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<td>Small Group Discussions</td>
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<td>Story Telling</td>
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<td>Notes off Blackboard</td>
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<td>Educational Games</td>
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<td>Surveys</td>
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<td>Quizzes and Games</td>
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<td>Demonstrations</td>
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<td>Construction Activities</td>
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<td>Problem Solving</td>
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<td>Debates</td>
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<td>Creative Activities</td>
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<tr>
<td>Listening to Teacher</td>
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</tbody>
</table>

2. List any other strategies not listed which you feel are effective in teaching your child about health at school.

   ..................................................................................................................

3. List FIVE health topics which you see as the most important for your child at this level.

   a. ..........................................................  d. ..........................................................
   b. ..........................................................  e. ..........................................................
   c. ........................................................................................................

4. Please feel free to make any further comments about the Health Education Program currently being taught at your school.

   ..................................................................................................................

   ..................................................................................................................

   ..................................................................................................................

   ..................................................................................................................

   ..................................................................................................................

Thank you for your participation.
APPENDIX 4

TEACHER QUESTIONNAIRE - HEALTH EDUCATION

Please indicate year level. Grade ............ Your Age ............ Sex (circle) Male Female

TEACHING STRATEGIES

1. Please place an X at the point along each continuum which best indicates your teaching of Health Education.

<table>
<thead>
<tr>
<th>Traditional</th>
<th>Progressive</th>
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</thead>
<tbody>
<tr>
<td>a.</td>
<td></td>
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<tr>
<td>Child Control</td>
<td></td>
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<td>b.</td>
<td></td>
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<thead>
<tr>
<th>Co-operative</th>
<th>Individual Programs</th>
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<tbody>
<tr>
<td>Learning</td>
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<td>c.</td>
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<th>integrated</th>
<th>Subject Based</th>
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<tr>
<td>d.</td>
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2. Use the key to describe the use you make of the teaching strategies listed when teaching Health Education.

<table>
<thead>
<tr>
<th></th>
<th>O = Often</th>
<th>S = Sometimes</th>
<th>N = Never</th>
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</thead>
<tbody>
<tr>
<td>General Discussions</td>
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<tr>
<td>Illustrated Presentations</td>
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<td>Value Wheels</td>
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<td>Brainstorms</td>
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<tr>
<td>Films, Videos, Slides</td>
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<td>Interviews</td>
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<td>Experiments</td>
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<td>Panels and Forums</td>
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<tr>
<td>Dramatisations</td>
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<td>Self Test</td>
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<td>Question Box</td>
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<tr>
<td>Story Telling</td>
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<tr>
<td>Values Clarification</td>
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<tr>
<td>Community Involvement</td>
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<td>Tape Recording</td>
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<td>Puppet Shows</td>
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<td>Poetry</td>
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<td>Worksheets</td>
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<td>Guest Speakers</td>
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<td>Small Group Discussions</td>
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<td>Taking Action</td>
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<td>Educational Games</td>
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<td>Experience Charts and Records</td>
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<td>Reports</td>
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<td>Oral Presentation</td>
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<tr>
<td>Notes off Blackboard</td>
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</table>
3. List other strategies used but not listed.


4. List FIVE strategies you use the most.
   a. .................................................................
   b. .................................................................
   c. .................................................................
   d. .................................................................
   e. .................................................................

5. Briefly outline your philosophy when selecting strategies to use with your students.


6. Please indicate which factors have the greatest influence on your choice of strategies. (Number from 1-7 with 1 having the greatest influence. Each box will have a separate no.)

   □ Resources available in the school.
   □ Resources available outside the school.
   □ Commercially prepared units of work.
   □ Grade Structure (e.g. composites).
   □ Confidence in use of strategies.
   □ Availability of prepared worksheets.
   □ Group dynamics within the grade.
   □ Others (please list)


CONTENT

7. List the Health Education topic areas to be covered this year with your students.


8. List any other Health Education topics you feel are important for your grade level.


Teacher Questionnaire - Health Education
9. Briefly outline your philosophy when selecting content for your students.


10. Please indicate which factors have the greatest influence on your choice of content.
(Number from 1–8 with 1 having the greatest influence. Each box will have a separate no.)

☐ Personal knowledge of the topic area.

☐ School policy and course.

☐ Taught topic in previous years.

☐ Support staff within the school.

☐ Support staff outside the school.

☐ Relevance to student's life situations.

☐ Relevance to student's stages of development.

☐ Student's prior knowledge of the topic.

Others (please list)


11. Are you happy with the school's current Health Education Curriculum?

Please circle.

Yes  No

12. Do you have any suggestions for improving current content and strategies? Briefly explain.


Teacher Questionnaire – Health Education
APPENDIX 5

LETTER OF INTRODUCTION TO TEACHER QUESTIONNAIRE

Dear Teachers,

I am currently conducting research in Health Education at your school as part of a Master of Education by Research degree through Deakin University. The purpose of the research is to review current content and strategies used in teaching health. I would appreciate your assistance in completing the attached questionnaire and returning it to Mrs. J. as soon as possible. There is provision on the questionnaire for you to indicate if you would like to participate further in this Action Research project. If you have any queries about the project please feel free to approach me. I will be pleased to assist you in any way that I can. I look forward to working in your school.

Thank you for your assistance.

Denise Landers
APPENDIX 6
STUDENT QUESTIONNAIRE – HEALTH EDUCATION

SEX (Please Circle)  Male  Female

1. How do you learn about health at school? Place letter in the box to describe how you feel about the activities listed.  E = Enjoy  D = Dislike

☐ Watching films/videos  ☐ Having a debate  ☐ Making up plays
☐ Listening to the teacher  ☐ Notes off blackboard  ☐ Worksheets
☐ Watching slides  ☐ Listening to tapes  ☐ Whole group discussions
☐ Excursions  ☐ Exercises in books  ☐ Reports to grade/others
☐ Writing letters  ☐ Experiments  ☐ Real life situations
☐ Projects  ☐ Guest Speakers  ☐ Conducting interviews
☐ Plays/drama  ☐ Solving problems  ☐ Using real life experiences
☐ Working by myself  ☐ Working in groups  ☐ Studying for tests
☐ Brainstorming  ☐ Using the TV  ☐ Using newspapers
☐ Question box  ☐ Making things  ☐ Writing poems
☐ Listening to poems  ☐ Listening to stories  ☐ Small group discussions
☐ Presentation to others  ☐ Writing stories  ☐ Working with the community

2. List the FIVE activities you ENJOY the most when learning about health.

a. ........................................
b. ........................................
c. ........................................
d. ........................................
e. ........................................

3. List FIVE health topics you think are important to learn about at your age.

a. ........................................
b. ........................................
c. ........................................
d. ........................................
e. ........................................

Thank you for completing this questionnaire.
APPENDIX 7

OUR SENIOR CITIZENS - Unit Outline

PURPOSE
The unit is designed to allow children to explore the similarities and differences between their own needs and the needs of the elderly community. Social interaction is promoted by creating a link between the school and the community.

MOTIVATIONAL ACTIVITIES
Listen to the reading of the picture story book 'Wilfred Gordon McDonald Partridge'.
View the video 'The Purple People Eater'.
Participation in 'Friendship Day'.

LEARNING OPPORTUNITIES
1. Children participate in a brainstorm activity to define a senior citizen. Discuss similar, different, special needs. Use picture story book to promote discussion.
2. In small groups children think about a senior citizen they know. Describe where/how they live.
3. Children individually complete a senior citizen's profile.
4. After viewing the video children discuss prepared questions in small groups and elect a spokesperson to report back to the class.
5. Children suggest proposals for taking action to improve the life of an elderly person they know.
6. Children explore health services available in the local area and discuss how to access information. Role play phone calls to health services.
7. Children research community health services available for the elderly or other community members. Guest speaker from the local council to discuss 'Council Care-givers'.
8. Children create a flyer advertising a community health service to give to a community member who may need to use the service.
9. Children develop and implement action plan for 'Friendship Day' including invitations, activities and refreshments.
ANTICIPATED OUTCOMES

Children will participate in discussion activities exploring the needs of the elderly.
Children will consider the special needs of elderly community members and explore services available to maintain, or improve, their quality of life.
Children will access and disseminate information from a local health service.
Children will develop a school-community initiative to foster social interaction between themselves and elderly members of the community.
Children may act to improve the quality of life for a senior citizen or other community member they know.
APPENDIX 8

OUR EMOTIONS - Unit Outline

PURPOSE
This unit is designed to allow children to share experiences and situations which may create strong feelings and emotions. By sharing experiences children will be exposed to the fact everybody is affected by their emotions. Coping strategies will be explored.

MOTIVATIONAL ACTIVITIES
Listen to story telling of 'The Lost Scarf'.
Listen to the reading of the stories 'The Very Best of Friends' and 'Alexander's Terrible Horrible No Good Very Bad Day'.
View the video 'Charlotte's Web'.

LEARNING OPPORTUNITIES
1. After listening to the story telling of 'The Lost Scarf' children share their own loss experience with a partner.
2. Children rotate around the room to list their loss experiences and feelings on butchers paper.
3. After listening to 'The Very Best of Friends', discuss and list experiences and feelings presented in the book.
4. Children develop their own picture story books about a loss experience or situation.
5. After viewing 'Charlotte's Web', in small groups children analyse the life and feelings of a specific character. Select a spokesperson to report to the grade.
6. Children participate in whole group discussion to define 'stress'.
7. Children rotate around the room to record responses to the following questions:
   What causes stress? (Experiences, Situations, Relationships)
   What feelings do we experience when we are stressed?
   What strategies do we use to avoid or cope with stress?
8. After listening to and discussing 'Alexander's Terrible Horrible No Good Very Bad Day' children create and demonstrate a stress situation using the socio-drama methods.
ANTICIPATED OUTCOMES

Children will develop an awareness of their own and others emotions, and how these affect the way people think, feel and act.

Children will explore strategies to cope with circumstances which trigger strong emotional reactions.

Children will explore strategies to resolve conflicts which trigger strong emotional reactions.

Children will understand how to use their personal networks if the need arises.
FITNESS FUN - Unit Outline

PURPOSE
The unit is designed to promote physical activity in an exciting, pleasant and rewarding way. The aim is to promote positive attitudes to physical activity for ALL children by emphasising a non-competitive, self-improvement model. Community involvement will be encouraged and pursued.

MOTIVATIONAL ACTIVITIES
A visit to the local fitness centre to participate in aerobic and Body Titan circuit activities.
An aerobics demonstration by Year 7 students who competed in the schools aerobics competition.
Participation of upper school students and community members in 'Dance Aerobics Day'.

LEARNING OPPORTUNITIES
1. Children participate in fitness activities three times per week over a six week period recording personal times and repetitions where appropriate.
   MONDAY - Circuit Activities
   WEDNESDAY - 1 KM Jog/Power Walk
   FRIDAY - Aerobics
2. Children select their own music and develop aerobic routines in small groups of their choice.
3. Children practice their routine over a six week period to perform on Dance/Aerobics Demonstration day.

ANTICIPATED OUTCOMES
Children will explore physical activity leisure options available at the local fitness centre.
Children will take part in a variety of physical activities designed to promote enjoyment, participation and social interaction.
Children will plot their physical progress on a personal fitness record over a six week period.
Children will participate in physical activities designed to improve gross motor co-ordination skills.
Children will participate in activities designed to enhance and develop creative movement and sequencing skills.
Children will interact with community members inside and outside the school environment.
APPENDIX 10

NUTRITION - Unit Outline

PURPOSE
This unit is designed to explore food and nutrition from a positive, realistic framework. The focus is on the positive aspects of children's diets rather than the negative aspects (like too much junk food). While nutritional value of food items will be discussed the emphasis in the unit is 'everything in moderation'.

MOTIVATIONAL ACTIVITIES
View the 'More or Less' video.
Participation in 'Health Lunch Day'.
Food preparation activities.

LEARNING OPPORTUNITIES
1. Children participate in whole group brainstorm activity developed from the question, 'What do we know about food and nutrition?'
2. Children verify information generated during brainstorm by viewing and discussing 'More or Less' video. Children take turns to develop their own commentary to the video.
3. Children develop questions and participate in 'Nutrition Quiz'.
4. In small groups children compare and discuss three brands of baby food. Consider which one to purchase and why.
5. Children discuss personal and family purchasing of food items and consider reasons for their choices.
6. In three groups children discuss and list foods under the following headings:
   a) Healthy Food   b) Fast Food/Take Away   c) Junk Food
   Children create a poem about food individually or with a partner.
7. Children discuss and organise 'Healthy Lunch Day'.
8. Children work in pairs to locate a recipe to prepare at home and bring to share for afternoon tea.
9. Children design, compile and create grade recipe book to use at home.
ANTICIPATED OUTCOMES

Children will be exposed to a range of food choices.
Children will develop skills in food preparation in the classroom and home environment.
Children will consider factors that influence the purchase of food items by themselves, their families and others.
Children will develop an understanding of the concept 'everything in moderation'.
CONSUMER EDUCATION - Unit Outline

APPENDIX 11

PURPOSE
This unit is designed to allow children to explore the factors which influence the selection of products and services. Media advertising plays a significant role in influencing consumer choice. Identifying media bias is a skill children may develop to assist them in the selection process.

MOTIVATIONAL ACTIVITIES
Visit to local shopping centre.
View a selection of television advertisements.
Create, perform and tape a radio commercial.

LEARNING OPPORTUNITIES
1. After visiting the supermarket, children continue the discussion of personal and family purchasing beyond food, to include other items. Consider reasons for purchasing particular brands.
2. After viewing the selection of advertisements children discuss, in small groups, the advertisement that appeals most to them and the reasons for their choice. Decide which advertisement would be most likely to entice the group to buy. Select a spokesperson to report to the class.
3. Children discuss various techniques used by the advertisers to sell their product (techniques outlined on prepared handout). From the video children identify advertisements which use the techniques.
4. Children create a radio commercial providing all the information required by the purchaser and focusing on particular techniques outlined.

ANTICIPATED OUTCOMES
Children will express an understanding of reasons for making particular consumer choices.
Children will explore the techniques used by advertisers to entice consumers to buy.
APPENDIX 12
EVALUATIVE RESPONSE SHEET - TEACHERS

TEACHER EVALUATION - HEALTH EDUCATION

Thankyou for participating in the Action Research Project in Health Education. Could you please complete the brief evaluation and return it to me or Mrs. J.

Did the collaborative process allow you scope to provide input in developing unit/s?

-----------------------------------------------------------------------------------------------------------------

What are some of the positive aspects of developing units of work using this approach?

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What are some of the disadvantages of the process?

-----------------------------------------------------------------------------------------------------------------

Were the teaching strategies developed easy or difficult to implement with the students?

-----------------------------------------------------------------------------------------------------------------

Did the Action Research project improve the content and strategies in Health Education for your students?
What changes could be made in the primary school situation to support the collaborative process in improving the Health Education curriculum?
Dear Principal,

Thank you for allowing me access to the school to conduct my research. I have appreciated your time and cooperation in implementing the project. Could you please complete the brief evaluation to provide additional data.

Can Action Research (collaborative processes) improve the Health Education curriculum at the school?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What positive / negative impact has the project had on the school community? (students, teachers, parents)

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________

What are your perceived outcomes of the project?

________________________________________________________________________________________

________________________________________________________________________________________

________________________________________________________________________________________
If Action Research was to be used in the primary school as a means of curriculum and professional development in Health Education, what changes would need to be made to support the process? (if any)
12 February, 1993

Ms D Landers
36 Melrose Avenue
COLDSTREAM 3770

Dear Denise,

Thank you for your recent letter seeking approval to conduct research in government schools in this region into the development of health education programs in primary schools.

Approval in principle is given for contact to be made with the Eastern Metropolitan schools listed in your correspondence, on the following understanding:

- As indicated in the Directorate of School Education's memorandum included with this letter, the principal will decide whether to allow access to the school.
- Issues concerning anonymity and confidentiality should be addressed.
- Copies of your survey should be included in your letter to each school.

A copy of this letter should be shown to principals when you are contacting schools.

I wish you well with your survey, and would be interested to receive a copy of the outcomes.

Yours sincerely,

JOHN S'TUDOR
Assistant General Manager
Education Programs