

# Health education in schools

The challenge of  
teacher training

DIDIER JOURDAN

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## The challenge of teacher training<sup>1</sup>

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1. In this book, "Teacher Training" refers to all the activities aiming at preparing school staff for a professional role as a reflective practitioner. It doesn't mean training staff to undertake relatively routine tasks. It corresponds to "teacher education" more and more used in American publications.

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# Preface

*For all individuals, health is a resource that needs to be maintained and protected. In order to achieve this, all aspects of health must be considered, as should all the factors that determine it, which can be biological, psychological, social, economic, cultural and environmental. In the Ottawa Charter, it was shown that this holistic view of health, which is akin to “well-being”, was not the sole responsibility of the health authorities, and that all institutions and regulatory provisions that are involved in how people live must take their share of responsibility. In their role as places in which people live, schools play a large role in the well-being and health of the children and young people within them. Data from the international scientific literature show the importance of schools as places where health promotion happens, not just because an entire cohort attends a school for several years, but also because there has been shown to be close links between health and education. Promoting pupil health helps with educational attainment: increasing levels of education helps to improve levels of health. In France, the National Institute for Prevention and Health Education (INPES) is tasked with developing health education in the environments in which people live, and with developing training in health education throughout the country. INPES' involvement in schools has been formalised in a partnership agreement with the ministry of education that was drawn up in 2003, and a 2007 agreement with the French asso-*



*ciation of deans of faculties of education (IUFM). The expertise and knowledge within INPES is useful in developing health education in schools, in particular via the creation of many documents and tools that are designed for schools and other educational establishments. The partnership between INPES and schools does not just consist of distribution of documents to staff and pupils: it also involves the creation of a common strategy for the improvement and promotion of pupil health. A central component of this common strategy is training of teachers in health education. The whole of the educational community has a role to play in promoting the health of pupils, and teachers, like others, are called upon to help with promotion of pupils' health. Studies suggest that their training will depend in large part on the extent of their involvement in this area. For this reason, INPES considered that it was important to address this subject and to support published work about it. This book has been written by an expert in the field, Professor Didier Jourdan. The approach he took involved examining the points of view of the main parties involved and the mental representations they hold in this area. This approach also leads to convergence upon a better understanding by public health professionals of the specific challenges inherent in schools. I hope that it will be a foundation for fruitful dialogue among all professionals working in school health promotion internationally.*

**Thanh Le Luong**

Director general of INPES

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# Introduction

If one is truly to succeed in leading a person to a specific place, one must first and foremost take care to find him where he is and begin there.

... Anyone who cannot do this is himself under a delusion if he thinks he is able to help someone else.

Søren Kierkegaard<sup>1</sup>

The Jakarta declaration, like the Bangkok charter, highlighted several health promotion priorities. Chief among these was the development of work in specific environments that would be likely to enable the establishment of overarching strategies. Schools represent one such environment. The WHO and UNESCO have produced several recommendations in this area. The International Union for Health Promotion and Education is also heavily involved in this movement, particularly with its recent publication of “guidelines for health promoting schools”.

Many research projects have been conducted in schools. The results show the importance of health promotion both as a way of improving health and as a way of helping pupils succeed in education. However, as the primary task of schools is not to improve pupils' health, the development of health promotion is not an easy matter. It will necessarily involve consideration of the specific nature of the school environment, and in particular the way in which teachers perceive their own role in health and social well-being. The publications show that many factors are involved in the way in which health promotion schemes are developed and implemented: a) political will, on which depends sustainable involvement by institutions and communities;

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1. S. Kierkegaard. Translated by Howard V Hong and Edna H Hong.

b) a favourable environment, in particular in terms of support by the school's management team, the existence of teaching practices that support health promotion, and the importance that is attached to pupils' well-being; c) teachers' own perceptions of their role in health promotion, their perception of the effectiveness and acceptability of projects, their feelings of competence in this area, any burnout and whether they have received training in health promotion; d) and factors that are connected to implementation of the programme itself (training and support by teams). Training for teachers is often considered as a central factor that determines the quality of project implementation. Studies have shown that teachers who have received training in health promotion are more likely than those who have received no such training to be involved in projects, and have a more holistic approach to health education. Feelings of competence, and motivation to contribute to health promotion, are also directly linked to training.

This book is designed for those involved in training teachers in health education. Its aim is to shed light on the various dimensions of this issue and to explain these using input from several theoretical frameworks and from our experience in training.

Its primary purpose is to clarify what is at stake. We shall not be offering a miracle solution, nor shall we be addressing this issue in the light of just one theory. The reference points we suggest will provide different ways of thinking about training. The purpose of this book is to make explicit the various tensions that are inherent in health education training, and to offer the reader some tools to deal with them.

It is a book that needs to be set in context. Its content is not meant to be universally valid. It cannot be directly transposed into other training contexts which have different target audiences, purposes, and institutional and ethical frameworks. The book has three parts.

The first is focused on showing the context in which training for teachers is developed, in the specific area of health education. The second defines the field of health education in schools, and the role of teachers. The third contains the theoretical frameworks that will help in explaining the basis for training modules and the conditions in which training for teachers in health education can be properly implemented. The theoretical frameworks that are proposed will act as ways of interpreting experience. They do not enable everything to be predicted and controlled, but they do at least help to explain the basis for actions, give meaning, and provide hypotheses that can be used in interpretation.

The aims of this book are to explain what is at stake, to offer starting points for reflection, to show how various parties have

managed conflicting factors in order to enable stakeholders to find their own way in their own specific contexts. The hope is that it will help to support professionals in their work in the service of education and of public health.

## **HEALTH EDUCATION: ONE OF THE TASKS OF SCHOOLS**

In France and in most countries, it is not self-evident that schools, with their public service mission, should be responsible for health, which is essentially a private, intimate matter. Nor is there any consensus on how best to approach health issues. At least two ways of interpreting these issues emerge, if we examine the arguments that are used in various types of discourse. The first refers to security, and the second to promotion of individual and social well-being. The first invokes the idea of the urgency of prevention (if we do not act now, the consequences will be terrible in the future, and risk destabilising our society), and the second invokes broader concerns (promoting social well-being, taking responsibility for one's own health and that of the community). The first was the predominant idea for a long time, but the emergence of both an ethics of individual well-being and increased expectations that the State will provide for individuals have led to greater emphasis on the second idea. These two sources of legitimacy coexist in the educational system and necessarily involve different ways of perceiving the role of schools and of teachers.

In this context, with its multiple layers of tension, the educational system, its partners and the professionals involved in it are all called upon to contribute to health education. The specific nature of work in schools arises from the fact that such work is organised according to our country's democratic project. As stated in the first article of the French law on education reform, "In addition to the transmission of knowledge, the Nation determines that the primary mission of schools is to have pupils share the values of the Republic".<sup>2</sup> The foundation of democracy is confidence in citizens' ability to act in a free and responsible way. However, the capacity to decide for oneself and to take control over one's own existence is not innate. Education builds such abilities. In health, then, the role of schools and others involved in education (primarily the family) is to support pupils while they learn liberty and responsibility. In other words, this is about giving citizens the means to decide for themselves, and not allow the media, commercial companies, gurus or experts to do this for them.

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2. Law no. 2005-380 dated 23 April 2005 concerning school reform.



The main consequence of considering health as part of this project that underlies all school activity is the fact that health should not be considered as an end in itself and the ultimate aim of existence. In a democratic society, health cannot be a substitute for universal emancipation. It is a precondition for being able fully to enjoy citizenship, and not an aim in itself.

It should be said clearly that we consider that it is unrealistic to try to make progress on the issue of training for teachers in health education, while acting as though everything were clearly defined and that the only obstacles were ignorance (they didn't know his was a serious issue, and they only need telling in order to be convinced), willingness on the part of those involved (if they do not do this, it's because they resist it for the wrong reasons, we should understand the nature of the various constraints in order to be able to overcome them) and lack of time (it is true that there are other priorities, but action should be taken to put health higher on the list). The first step in a training plan is to set out clearly what is at stake. This is what we shall attempt to do, succinctly, in this book.

## HEALTH EDUCATION IN TEACHER TRAINING

The specifications for teacher training<sup>3</sup> grant a significant place to health issues. They state that training for primary teachers (para 1.2) must use a common national framework, based on "official texts that state the non-subject educational commitments of the school, in particular health education and education in environmental issues and sustainable development..." Health and prevention are issues that call upon the professional competencies of teachers (para 3), both as subjects to be taught along with all non-subject areas of education, and as components of the civil servant's role (acting in an ethical and responsible way) "to identify students who have difficulties with health issues and high-risk behaviour" and "to take responsibility for students who have disabilities". Finally, the issue of partnerships, which is central to health education, is brought to the fore: working as a team and together with parents and partners (in particular, medical and social work professionals, public services etc.). More generally, this stresses the non-subject educational dimension of teachers' professional practice and emphasises the need for professional practice to take into account the school's collective programme, and for there to be communication with students and parents. This will not lead to the creation of a new area of training. Such a step would only contribute to the fragmentation

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3. Circular dated 4 January 2007 relating to specifications for teacher training.

of teacher training. Training in health education can be a way of bringing the disparate parts of training together, rather than just adding yet more content. All teachers are faced with the issues of high-risk behaviour, and ask themselves about the role of schools in this area (should they contribute to persecution of smokers, or to stigmatising fat people? should they contribute to the “ideal body” movement, as our individualistic societies tend to promote? or should they abandon all conversation about sexuality, violence and drugs?) and about their own individual roles (how can and must I contribute to pupils’ education in these areas, which, although they are fundamental, lie between the public and private spheres? What should I say to a pupil who has used cannabis and who seems not to be doing well? How should I act with regard to alienation that is caused by stereotypes about body shape, alcohol and sexuality?). Daily life in schools is such that the primary challenge is always crisis management, but the issue of prevention and education in these areas rapidly arises. Dealing with such “live issues”<sup>4</sup> of citizenship with students and those in school-based training is a way of encouraging them to bring together their various areas of knowledge, both academic (scientific, historical, legal, ethical) and drawn from their experience, which will help them to find their place as teachers. Health education is one of the elements of the common culture shared by all teachers, whether primary or secondary.

## CONSIDERING THE VARIOUS DIMENSIONS OF TRAINING

In the health education field, as in all other fields, teachers’ activities do not simply consist of implementing government circulars or programmes. The factors that determine this type of education are much more complex. Activities depend on factors that can be institutional (requirements of programmes, the school’s goals, circulars) but also personal (teachers’ own representations of their task in health education, personal narratives) or connected to the intended audience (students and their needs and expectations). Training needs to allow for these three complementary aspects. This does not mean that each module and training session must incorporate all three aspects, but care must be taken to ensure that they are included overall. Implementation of training cannot, therefore, be limited to merely recommending good practice. The issue is to understand the inherent contradictions of the teaching profession, between students’ learning

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4. Legarder A., Simmoneaux L. (2006). *L'école à l'épreuve de l'actualité* [Schools: the challenge of current issues]. *Enseigner des questions vives* [Teaching live issues]. Paris, ESF.

needs and the demands of doing the job, if a truly appropriate type of training can be offered<sup>5</sup>. Teachers, like all professionals, are not robots performing a prescribed series of actions, but are subject to a set of constraints on their actions, and from these constraints emerges a way of performing professional activities. From nursery schools to high schools, “teachers make multiple decisions for which there are many reasons other than promoting students’ learning: for example, in order to remain in the students’ favour, in order that students are not “set up to fail”, in order to maintain a good atmosphere in class, in order to keep up their own motivation levels, or in order to conserve their energy. All teachers have to feel good enough in class in order to “get through” each day and “last” throughout a career”<sup>6</sup>.

Because health education is a marginal area of teaching activity, the various factors that determine it should be taken into account, and work should be done to bring health education together with the other dimensions of the teaching profession. Such education is not at the heart of teachers’ professional identity, and it is not useful to act as though it were. The vast majority of teachers are aware of their role in this area, but the huge number of prescribed activities in all areas means that health education appears to be just one more activity, a further burden to be added to the already heavy load. In order to make progress, we must take care to find the teachers where they are and begin from there.

Training for teachers in health education cannot therefore be limited to organising information sessions on various health-related themes. Progress can only be made on this issue if it is carefully integrated with the other aspects of the modern teaching profession, and if it is placed at the heart of any plan to redefine teaching. We are taking the chance that it is possible to navigate a path between these various obstacles in order to carry out schools’ mission to emancipate individuals, with reference to what they are called upon to transmit: “that which unites and that which frees”<sup>7</sup>.

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5. Goigoux R. (2007) “Un modèle d’analyse de l’activité des enseignants” [A model for analysing teaching activity]. *Éducation et didactique* n°3 [Education and Didactics, issue 3].

6. Goigoux (2007) *Ibid.*

7. Reboul O. (2001) *La philosophie de l’éducation* - 9e éd [The Philosophy of Education, 9th edition]. - Paris: PUF - coll. Que sais-je ? n°2441 [number 2441 in the “What do I know?” collection]. By “that which unites”, Reboul is referring to the elements that will enable an individual to integrate socially into as broad a community as possible, and by “that which frees” he means that which will enable all individuals to be able to express themselves and think for themselves.



The aim of this first section is to make explicit the way in which the issue of the training of teachers in health education is approached. As there are several ways in which the context can be analysed, it should be specified here which analysis was used when writing this book. Our attention is drawn to the point of view of education and schools.

In any case, it is necessary to take into account the set of constraints that currently apply to teacher training<sup>1</sup>. A middle way should be found, between wide-eyed utopianism and conservative realism<sup>2</sup>. It would be of little use to draw up a training programme that is too far ahead of developments of the profession in schools, as though health education were a daily preoccupation of all those involved in school life. It would be of equally little use to adhere too closely to the current situation, limiting training in health education to physical education or biology teachers who transmit health knowledge in close relationship to their subject. Teachers who are currently in the early stages of training must be able to negotiate and master the likely changes to their profession that they will encounter throughout their careers, between 2009 and (at the earliest) 2049. It is necessary to consider the profession now and in the future, and to attempt to identify sources of support for teachers when they seek to contribute to their students' educational success and health.

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1. Jourdan D., Samdal O., Diagne F. and Carvalho G.S. (2008) The Future of Health Promotion in Schools goes through the strengthening of Teacher Training at a global level *Promot Educ.* 2008 Sep;15(3):36-8.

2. Perrenoud P. (1994) *La formation des enseignants entre théorie et pratique* [Teacher training: between theory and practice], Paris, L'Harmattan.

## **Teacher training in health education: context**



# From the school's point of view, is this a marginal issue?

## IS THIS A SUBSIDIARY ISSUE IN THE HIERARCHY OF CHALLENGES FACED BY SCHOOLS?

Schools face multiple types of demand every day. They are places where society's main concerns all converge. How then can health education find a place within the multiple roles of the education system? It is straightforward to show that the issue of health education has links with the main issues that are currently examined in schools, and that it is one of the ways in which the huge changes in our education system are being expressed **[1]**. Health education, if it is not conceived of as the transmission of intangible rules, can be an excellent way of drawing out and making explicit the tensions between potentially conflicting areas of teaching activity, and of exploring ways in which these tensions may be reduced.

Health education is a constituent part of any humanities education programme. All civilisations pass down prescriptive advice about health<sup>1</sup> as part of collective wisdom, and since its foundation the French education system, as well as all school systems, has positioned itself as a participant in public health **[2]**. The idea that positive health behaviours can be acquired in childhood has led the political authorities to assign schools the task of prevention. From the lessons about hygiene, tuberculosis and alcoholism that were common at the end of the last century to the point at which health education was included in the

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1. This issue is eminently political, as Disraeli, who was Prime Minister under Queen Victoria, said: "The health of the people is really the foundation upon which all their happiness and all their powers as a state depend."

French common base of knowledge and skills<sup>2</sup>, schools have always been one of the main places in which health prevention and education take place [box 1]. Despite all this, this health-related education has taken different forms at different times, and must be re-assessed constantly.

### BOX 1

**Extract from book "Health lessons - Secondary schools (girls) - third year", published by Nathan in 1920. In this text, schools and teachers are instruments of public health<sup>1</sup>. "Hygiene must be inculcated in primary school as well as in secondary school; if taught in schools and espoused by schools, it will truly become normal practice".**

In France, not until 1902 did we pass legislation concerning the protection of public health and the organisation of health services, and it would be premature to state that this is currently fully functional. In major centres, hygiene offices have been created in order to watch over public cleanliness; however, in small towns and rural areas, nothing has yet been done. In almost every area, public opinion remains unenlightened, and only when the public becomes supportive of the administrative prescriptions will these prescriptions cease to be mere words on a page and will the principles of hygiene start to become normal practice!

Hygiene rules are at times troublesome for the general public, as they carry an obligation to break with everyday habits; it is therefore necessary that these be properly understood, so that they may be accepted and not merely endured.

As Professor Vidal says, it is not enough simply to promulgate a hygiene law; it has to be applied. Effective implementation of such a law requires individual effort from each citizen; we must start, therefore, by ensuring that this law is understood. Only by introducing young people to the basic principles of hygiene, which should be among the first rules taught to children, will we achieve this result. Hygiene must be inculcated in primary school as well as in secondary school; if taught in schools and espoused by schools, it will truly become normal practice.

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1. This idea can be found in current texts, for example the Flageolet report on this issue (Mission au profit du gouvernement relative aux disparités territoriales des politiques de prévention sanitaire avril 2008 [Government-commissioned report on regional disparities in health prevention policies, April 2008]): "Schools are therefore the primary public and collective vector of health. Age-appropriate health knowledge must be transmitted, by school teachers in particular. It is essential to convey messages about health protection which will, in turn, enable messages about risk (sexually transmitted infections, contraception, addictions) that are conveyed from *collège* level (age 11-15) onwards to be placed in context." p. 52, and "However, in order to provide a culture of health for everyone and to ensure that everyone is aware that it is possible to manage one's own health, many vectors must be used and the same coherent message must be repeated constantly. Regardless of their age, people must be enabled to integrate advances in the health field into their way of thinking. For this reason, it is necessary to call on the things that people hold most dear in order to convey the message repeatedly and have the best chance of reaching people. The advertising industry has understood this well, as shown by the use of children to sell the products the industry promotes." p. 53

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2. <http://media.education.gouv.fr/file/46/8/5468.pdf>



## INFLATION OF DEMANDS ON THE EDUCATION SYSTEM

What does it mean to be a teacher? It is an understatement to say that the identity of the teaching profession is in crisis<sup>3</sup>. It is no longer just about transmission. As Philippe Meirieu states [3], *“schools are torn between multiple contradictory functions: teaching mastery of traditional languages and introducing new technologies; transmitting traditional knowledge and enabling understanding of contemporary situations; allowing for differences and ensuring a common educational base; helping students to succeed in examinations and teaching how to live in society; providing training in environmental awareness and in road safety; providing health education, preventing AIDS, informing of the dangers of drug addiction, and many other things besides”*. The demands on the school system have indeed grown. It is not reasonable to consider health education in schools as just another demand to be added. The main issue we face is that of coherence between the various aspects of teaching, as part of an updated definition of what it means to be a teacher [4]. Promoting health<sup>4</sup> in schools primarily means that those involved should work in an institutional context that enables them fully to carry out their educational task.

Firstly, it is necessary to consider the role of these questions within school life and within the teaching profession. It is also important to ask questions about the way in which training can help teachers to build a professional identity that will enable them to meet current and future challenges. This clearly means that the current situation does not entail that we should demand a few hours for a training module; rather, it should be emphasised that together with other types of education (e.g. sustainable development, environment, law, media, economics, consumer education), the heart of the teaching profession should be a citizenship education that is appropriate to current and future challenges.

The role of health education in the school system must therefore not be considered in terms of a body of knowledge, but as a way of re-assessing the teaching profession and strengthening the core of the school system: an education in “how to be a citizen”. In other words, the aim is to ensure that health educa-

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3. The fact that the teaching profession is currently in crisis does not mean that this situation is exceptional. In fact, all the signs point to this problem being permanent. Even in 1899, in his “Enquête sur l’enseignement secondaire, rapport général à la chambre des députés” [Inquiry into secondary education; general report to the Chambre des Députés], H. Ribot wrote: “We have sought with the greatest sincerity the causes of the malaise in secondary education”. Similarly, in the introduction, the 1972 report by L. Joxe entitled “La fonction enseignante dans le second degré, Rapport au ministre de l’Éducation nationale” [Secondary teaching: Report to the Ministry of Education] contained the following: “It will not be possible to approach the problems caused by the malaise among teachers, and more generally by the crisis in teaching, without first establishing the quantitative elements of these problems”. These two quotations are drawn from the “Livre vert sur l’évolution du métier d’enseignant” [Green Book on changes in the teaching profession] which was created under the leadership of Marcel Pochard and given to the Prime Minister on 4 February 2008, and which contained an attempt to answer the questions that are being asked here, and suggestions for political action that could be taken to answer those questions. We can certainly hypothesise that the position of schools at the heart of social tension and in the midst of a perpetual discrepancy between “what is” and “what should be” leads to ongoing readjustment which has an effect on staff.

4. Health promotion is the process of enabling people to increase control over, and to improve their health. This arises from a concept of “health” defined as “a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment”. This will be more precisely defined in chapter 2.

tion supports a flow of ideas towards a unified vision of the role of the teacher, rather than a movement away from this central vision.

### **HEALTH EDUCATION: PERIPHERAL FOR TEACHERS, BUT NONETHELESS...**

An obstacle to this effort to draw connections among the different aspects of their activity is the fact that there is no demand among teachers for consideration of health education. We cannot fail to note that involvement in collective health education activities is the concern of a minority [5]. For the vast majority of those working in schools, health education remains an activity that is not at the heart of what they have to do. They cannot be blamed if the competitive recruitment process for teachers grants almost no space to these aspects of the job, and if most of those currently working have received no training in health education.

Still more fundamentally, the issue involves collective beliefs about professions. Does a young physics student who is trying to qualify as a teacher today have the means of knowing that the teacher's job goes far beyond the transmission of knowledge in a particular discipline? These observations show the importance of detailed work on the basis of teachers' professional identity.

In addition, analysis of participants' beliefs shows that their initial training, their tasks and their status have a significant influence on the perception they have of health education in a school setting. Two studies on this subject have been carried out, involving primary teachers [6] and secondary physical education teachers [7]. The first study showed that the fact of having undergone training has a significant impact on the implementation of a health education project. The second showed that the professional identity of those involved is the prism through which they form their own beliefs about health education and their role in this area. For physical education teachers, these beliefs mean that they primarily conceive of health education as being linked to cardiac function, effort, endurance and preparation for effort. Being in good health (and preparing for this) means being someone who acts, and acts "energetically".

An important issue is emerging here. When designing training programmes, this diversity must not be overlooked. It is important to take specific needs into account, but also to examine collective beliefs about what schools should be doing in the area of health education. People should be taken "as they are", and the aim should be to identify of what could support an improvement in skills, thereby providing a direction for the contents of training courses and the methods to be used. In any case, the very nature of "health education in a school setting" entails acceptance of the fact that different legitimate readings of the issue in question can coexist, each with its own internal consistency. The aim is not to achieve uniformity in how people see the role of schools in this field, but rather to make the different readings explicit. In order to achieve this, the various professionals must be enabled to share a common store of knowledge, which will enable them to make their own contribu-

tions explicit and ensure that other participants understand them. With this in mind, the first purpose of initial training is to enable students and teachers to perceive that specific types of education of this kind (health education, education for sustainable development, media education...) are part of their core business are part of the “contract” and that they have a specific role to play in this area.

Take into account of teachers’ views also means accepting a diversity of approaches to training in health education, and means first agreeing to “speak the language” of those who are meant to be supported in their development. For primary teachers, working on the holistic approach to children at school is likely to be motivating, but the same is not likely to be true, at least initially, for secondary teachers, for whom education is primarily approached via the various subjects. For the latter, class-based activities in didactic (subject-based) and pedagogical (in the general sense: e.g. motivating students, classroom management, the link between educational well-being, health and educational success) can be useful. For other professionals working in education, the situation is different in other ways. For principals and guidance counsellors (known as CPEs in France), entry points involve prevention of risky behaviour, school climate, and the development of a collective way of working. For health professionals and social workers, training should be based on the development of skills relating to their contribution to the implementation of a health promotion initiative at the school level.

A major issue in initial and continuing training is how to enable each participant in the school to realise that working individually and collectively in health education in schools is at the heart of their role. In order to achieve this, it is necessary to see health education as a way of emancipating students (giving them the means to make free and responsible decisions about health) and creating conditions in which all students can succeed (by developing personal and social skills and by creating a favourable environment in the school) rather than as a way of transmitting health information.

For all groups, participants’ own beliefs about their task in the field of health education are the starting point for a training programme. Given this, it is useful to note that although health education is not central to professional activity in schools, it is still part of the landscape. A recent study involving 207 individuals working in 5 middle schools (age 11-15) showed that 89% of professionals feel that they have a contribution to health education. They consider themselves to be educators in daily life within the school. The proportion of staff who take part, even in a small way, in collective activities, is limited to 23% [8]. Whether we concentrate on the fact that less than a quarter of professionals are contributing to identified health education activities, or on the fact that nine out of ten consider themselves to be educators in this field, the only conclusion to be drawn is that schools can not be considered as a virgin territory that need to be won over.

## HEALTH EDUCATION IN SCHOOLS

Health education, for many professionals, is currently of peripheral concern. Health education is not a “subject”, it is more a “moving field”, that resists any attempts at top-down knowledge transmission. Jean-Louis Martinand described this type of education (when talking of environmental education) as a “non-disciplinary educational form”<sup>5</sup>. Such forms of education are based on a provisional notion of citizenship and not on a body of academic knowledge. This means that it operates in a context of uncertainty, which is usual in the public health field but not in the education system, as the latter is based on reference to a clearly defined body of knowledge. Health education puts the individual at the centre of the debate, whereas most disciplines were built up with an eye to the universal rather than the individual. In any case, there is no unambiguous corpus of knowledge and methods, the transmission of which would be sufficient to transform a teacher, principal, nurse, doctor, social worker into a health educator. As emphasised in the 1998 circular [9], continuing training is “always based on the fact that health education, and more broadly educational action, is global in scope...” Training cannot overlook this complexity, and must take it into account.

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Health education is therefore not a new entity in itself; rather, it is a “non-disciplinary educational form” for which it is currently difficult to find a place in the curriculum [10].

The subject for debate is not so much “health” in itself (nobody would disagree that schools have a role to play in this area) but more the definition of school’s mission in relation to health and the type of contribution that staff can provide. The era, a century ago, of the Schoolmaster who passed down a fixed and unchanging body of knowledge, who showed the way of Good (a healthy life) and the way of Evil (debauchery) in citizenship classes has now gone. It is clear that the question is being asked very differently now, in comparison with how it emerged at the end of the 19th century, when hygiene was the main concern. In this contemporary world in which appearance plays a growing role, is it really desirable that schools promote a single way of “healthy” living, or even idealise the body? In these times in which individual interests hold sway, is it reasonable to expect schools to turn into purveyors of health information that changes according to fashion, and the effectiveness of some communications campaign? The answer is no; health education in schools today means

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5. “By ‘educational form’ we mean a set of activities carried out by teachers and their students, which can be identified in comparison with other forms of activity, particularly because of its educational aims, which meet official requirements and are subject to specific organisational principles and which is included in the school curriculum”. Martinand J.-L. (2003) Séminaire travail conjoint [Joint working seminar]. IUFM Versailles-UIMM. Paris.

examining one's own behaviour in relation to risky behaviour (e.g. illegal drugs, alcohol, tobacco, taking risks while driving, violence), being able to take care of oneself and respect others (e.g. in the areas of nutrition, addiction and sexuality). In the 21st century school system, health education means enabling students to make enlightened and responsible choices, to maintain their freedom of action with respect not only to drugs but to pressure from peers and from the media.

Health education is thus not the realm of specialists; it is one of the daily tasks for adults in charge of children's education, foremost among whom are parents and teachers. Experts, particularly those from the health system, are subordinates in the education process, which is led by parents and teachers.

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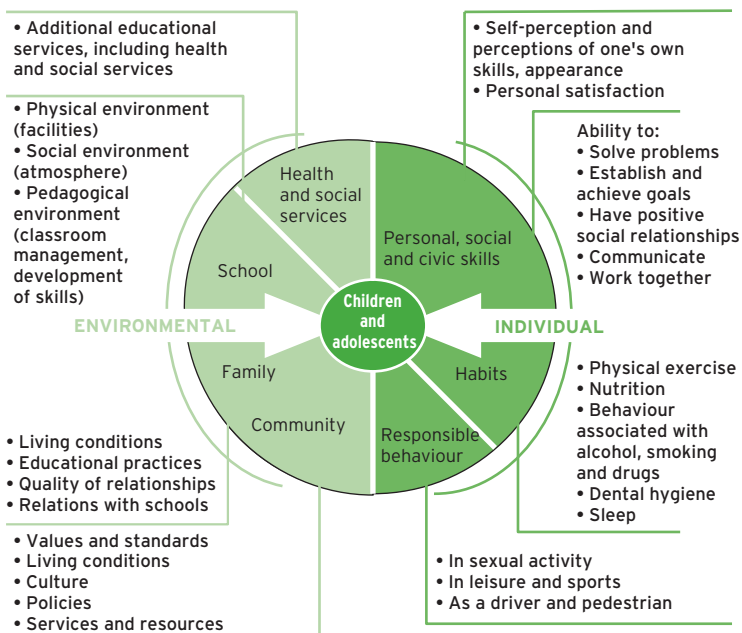
# From the point of view of public health: a central issue

## THE EDUCATION SYSTEM: A KEY ACTOR IN PUBLIC HEALTH POLICIES

From a public health point of view, even if the core business of schools is actually focused on educational outcomes, rather than the reduction of health problems, schools have a mission in relation to health. Only in rare cases, the arguments for legitimising the school system's involvement in health are drawn from the field of education. As a result, mention is not often made of the concept of health education as a dimension of citizenship education, which is designed to support students in their journey towards liberty and responsibility for their own health. More generally, justifications that are given are drawn from the field of public health. In addition, arguments are formed on the basis either that preventive measures are urgently needed (if we don't act now, there will be serious consequences in the future) or that there is a broader purpose (promoting social well-being, taking control over one's own health and that of the community). Schools are one of the places in which children and adolescents lead their lives; they are therefore required to contribute, just as families and communities are, to improvements in the health of these young people **[figure 1]**.

Calls for health education to be included in the school curriculum come in most cases from sources outside the educational system, rather than from within it.

FIGURE 1

The main factors that determine health of children and adolescents<sup>1</sup>

1. Adapted from Martin C, Arcand L: École en santé. Guide à l'insertion du milieu scolaire et de ses partenaires. [Healthy Schools - Guide for the education community and its partners]. Québec national orientation committee, 2005. Online: <http://www.mels.gouv.qc.ca/sections/publications/index.asp?page=fiche&id=1833> [retrieved on 08/01/2010].

More generally, there are three approaches that are recognised as relevant for health promotion [1]. These are targeted to specific population groups (e.g. the general population, the elderly, children, those with chronic diseases, athletes), specific themes (e.g. addiction, obesity, safety) or specific settings (e.g. the workplace, care facilities, regions, schools). The school system lies at the intersection of all these approaches, and therefore would seem to be obviously a key actor of public health strategy:

- schools are places in which all individuals of the same age come together;
- they are places in which preventive measures focused on specific themes are implemented;
- they are a specific environment in themselves.

It is entirely legitimate to call for mobilisation of the educational system. This is particularly true since schools are one of the tools that the State can use

to implement its policies, particularly its public health policy. “The Nation defines its health policy using multi-year objectives... The State is responsible for defining these objectives, designing health plans, activities and programmes that are to be implemented in order to achieve the objectives, and evaluating the policy.” The law is clear: “Public health policy involves”, among other things, “informing and educating the population about health<sup>1</sup>”. The educational system is one of the drivers of this public health policy.

## **MULTIPLE UNDERSTANDINGS OF HEALTH EDUCATION**

The various public health-related pressures on schools are not neutral in character, and result from different ideas about the aims and views of health education. If we look critically at calls to involve schools in health issues, we can clearly see that there are many types of motivation for such calls. These can arise from desired social changes, such as behaviour normalization, reduction in health expenditure, or may even be in response to vested interests. More generally, the different types of motivation are rooted in different paradigms. Following the example of Jacques Fortin, we feel that it is useful to make these explicit. For Fortin, “models of health education are embedded in educational paradigms, which are of varying degrees of complexity and which are expressions of values: efficient rationality which is based on scientific knowledge; liberty, as defined as autonomy of thought, action and decision with the purpose of self-actualisation; the collective and individual responsibility of a person within society; comprehensive fulfilment of a human being whose personal development is closely linked to that of his/her environment.” [2]

### **The rational paradigm, or Man as he ought to be**

The rational paradigm involves a traditional, classical, top-down pedagogy, in which the master dispenses predetermined knowledge to a student who listens and obeys. This idea has inspired a form of health education practice that is centred on a circumscribed area of knowledge that is considered to be objective and that is external to the subject whose behaviour this knowledge will influence. This paradigm leads to a medicalised discourse, which is centred around advice about and prevention of diseases and health risks. The object takes primacy over the subject; the disease is more important than the patient. Information delivered by the expert is the truth, and is the basis for behaviour that is prescribed to all without distinction, using a linear model of causality: in order to be in good health, it is necessary and sufficient to implement these directives, in other words eliminate all behaviour that may cause harm. Any other attitude can only be an error of judgement, a fault, and such omissions will inevitably lead to disease.

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1. Law no. 2004-806 dated 9 August 2004 concerning public health policy.



## The humanist paradigm, or freedom of well-being

In this paradigm, education takes into account the individual's desires, emotions and perceptions, in addition to cognitive objectives. The subject takes an active part in the construction of his/her own knowledge, which is then enriched by the subject's life and experience. The educator interacts with the subject and supports him/her in the subject's unique path, and the educator contributes with reciprocal subjectivity, which increases internalisation of knowledge. Self-actualisation is demanded as an educational goal, and here is confused with the definition of health as complete physical, psychological and social well-being. In this model, the development of confidence, self-esteem and self-affirmation is an essential objective. The subject's autonomy is a stated purpose, and this is combined with liberty that is gained via efforts at self-perfection.

## The social dialectic paradigm

The social dialectic paradigm goes beyond personal development and tackles the permanent relationships between humans and their environment, questioning the degree of liberty that humans have within the social group. In terms of health, the issue is an individual's capacity to master his/her own existence and to exercise control over his/her environment. The educator starts from where the students are (cognitively, emotionally and socially). The complex concept of "empowerment", which is currently used in a broad range of contexts, is part of this paradigm. The aim of this process is both the acquisition of power by a subject and by social groups via optimisation of their knowledge and skills, and the recognition and effective exercise of this power.

## Ecological paradigm

This approach is systemic. The ecological paradigm of education examines the human being and the relationships between him/her and his/her various environments (ecosystem), the combination of which results in development and learning. The primary aspects of this paradigm are: complete democratisation of education; full development of the individual, in other words fulfilling all areas of potential; personalisation of teaching, in other words adapting education to the specific needs of those being educated; and education of the whole person, in other words ensuring that individuals develop optimally in all aspects and areas of their potential. This systemic process uses elements from the other paradigms mentioned above, while providing a dynamic dimension that is lacking from the others, and a contextualised dimension. The idea of schools as places of health promotion is a result of these thought processes.

This forms a framework within which to understand measures that have been put forward in the field of health education. It provides a way of understanding the principles underlying the various approaches.

In general, it is only possible to move forward on the issue of health education in schools if we become aware of the complexity of the educational process, which is resistant to all short-cuts and promises of miracles, and of the fact that schools' primary mission is not to combat some social menace or other, but to create the citizens of tomorrow and enable all to succeed.

Schools therefore have a duty to look at how these social and/or health issues can be included in a system in which the whole person is educated. The educational challenges are constantly shifting. Schools must change their curricula, educational content, methods and ways of accommodating students. Changing curricula, teaching methods and training of those involved in schools, with the aim of facing current educational challenges in health, is a very different proposition to being a means by which health messages are transmitted. The key concept is mediation. The school system cannot just be a mouthpiece of a particular health policy; nor can it be entirely insulated from social requirements. They are required to hold these at a distance, to act as mediators between them, with reference to their allotted tasks and to real-life learning conditions.

It is necessary, when considering health education in schools, to link educational questions with public health issues. It is therefore essential to establish in advance the exact nature of social demands, as a way of making explicit the task required of the educational system in this area.

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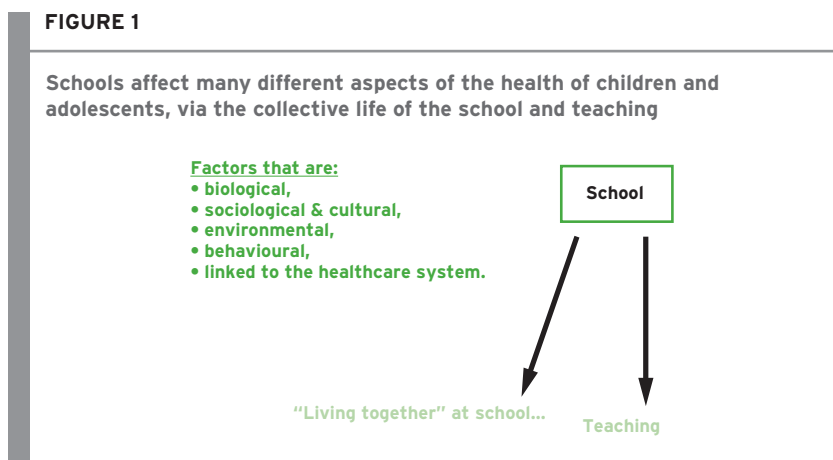
# Educational systems contribute to health improvement

Because of the scale of some health challenges, there is a temptation for those involved in prevention, health education or health promotion to call for a radical change in the attitude of educators to health issues. According to some, schools are not capable of promoting health or preventing risky behaviour, as they are not receptive to the proposed interventions, which in turn is because educators are ignorant of the evidence that shows the need to contribute to students' personal development. It is important to be vigilant to the dangers inherent in calling for educators to adopt "standardized health promoting practices" or "preventive practices". The first step is undoubtedly to assess what already exists and to identify the limitations of what the educational system can achieve.

## **A SETTING THAT SUPPORTS HEALTH EDUCATION AND IMPROVEMENTS IN POPULATION HEALTH**

Educational systems play a crucial role in health promotion. Education in itself plays a part in improving health **[1, 2]**. It enables children and adolescents to acquire a broad range of skills, and in this way has an influence on their health **[3]**. Being able to read; the ability to look for and classify information; knowledge about the body and about health that is conveyed at primary and secondary schools: these are all factors that enable individuals to manage their own health. Studies have shown, for example, that children who develop linguistic and mathematical skills have a reduced risk of dropping out of education and of mental health problems **[4]**. Although

schools do not have an effect on all determinants of health (biological, socio-cultural, environmental and behavioural factors, and those linked to the healthcare system), they do interact with the majority of these factors. Schools have an impact via teaching, and the general life of the school (which is often known as the hidden curriculum) [figure 1].



The fact that almost all children in Western Countries have access to education<sup>1</sup> means that the impact of education on health practices is difficult to assess. Even if other factors that are linked to social inequality may play a crucial role, in order to realise how important education is in this context, it is sufficient to look at countries in which not everyone has access to education. In Senegal, for example, knowledge of where to obtain condoms is positively correlated with levels of education among girls: 32% of those without education had this knowledge, compared with 52% of those with primary education and 78% for those with secondary or more advanced education [5]. 29.7% of adult women with secondary or more advanced education use a method of contraception; this figure is 18% for those with primary education and 6% for those who have never been to school. In such countries, a further study [6] has shown that more than half of adolescents do not know where to obtain advice and care in the field of sexuality. Possession of this knowledge is strongly correlated with having attended “family life” classes: 78.7% of those who attended these classes during their school days have this knowledge, as compared with only 39.2% of others.

1. Education participation rates in France are 100% at the start of primary school and 97% at the end of compulsory education at 16. 90% of students receive fifteen years of education, while across OECD countries almost all young people receive an average of twelve years of education. OECD. Regards sur l'éducation, 2006 [Education at a Glance, 2006]. Online: <http://www.oecd.org/dataoecd/51/25/37392770.pdf> [in French]; [http://www.oecd.org/document/52/0,3746,en\\_2649\\_39263238\\_37328564\\_1\\_1\\_1\\_1,00.html](http://www.oecd.org/document/52/0,3746,en_2649_39263238_37328564_1_1_1_1,00.html) [English version retrieved May 2011]

Schools, along with families and the media, are also a primary source of health information for children. As an example, a study carried out in 2004 involving a questionnaire sent to 883 students aged between 8 and 11 years showed what are the different sources of health information from the students' point of view [table 1].

**TABLE 1**

Responses from a sample of 883 pupils as part of the "Learning to live together better in schools" programme (initial data from 2004) to a series of questions of the form "Have you had any information about...?" Return rate 95.7%, sample distribution 35.6% in CE2 (aged 8-9), 35.4% in CM1 (aged 9-10), 27.9% in CM2 (aged 10-11) and 1.1% in CLIS (integration classes for students with disabilities). 52.9% were boys and 47.1% girls.

They had received information about	At school	From family	By reading	From the television
How the body works (86.3% said yes)	77,8%	42,8%	33,9%	38,6%
Sexuality (57.1% said yes)	40,1%	42,5%	30,8%	52,2%
Diet (90.3 % said yes)	78,2%	47,9%	28,1%	63,1%
Sleep (57.0 % said yes)	42,1%	54,9%	27,8%	38,4%
Rules of school life (92.8% said yes)	91,2%	36,8%	14,5%	19,5%
Violence (80.7 % said yes)	63,7%	47,3%	17,1%	62,0%
Alcohol (74.4 % said yes)	26,3%	56,8%	17,5%	72,5%
Smoking (85.8 % said yes)	28,0%	55,1%	18,3%	79,0%
Drugs (72.1 % said yes)	18,7%	46,5%	14,8%	82,3%
Road safety (90.5 % said yes)	50,6%	53,1%	25,5%	66,2%
What to do in an emergency (76.0% said yes)	41,4%	55,3%	25,2%	60,4%

Even though school is a source of malaise for some students, it is a place of fulfilment for the vast majority. Overall, almost two-thirds of students in French middle schools state that they like school (a lot: 21.7%; a little: 43.8%). Girls like school more than boys do (a lot: 25.9% of girls, compared with 17.3% of boys; a little: 45.6% compared with 41.9%). This positive outlook does benefit from nuanced understanding (one student in ten declares that he/she does not like school at all, and liking of school tends to change with age), but there is no reasons to characterise school life in excessively negative terms [7]. In the later stages of primary education, students' attitudes to school are even more positive. When asked "What is your opinion of your school?" only 4.5% of students offer a negative judgement (great: 44.2%, good: 43.7%, fine: 7.4%, not great: 3.3%, terrible: 1.2%). Similarly, relationships with teachers are overwhelmingly considered to be positive: very good (49.3%), good (39.5%), fine (8.6%), not very good (1.6%), poor (0.7%), did not answer (0.2%)<sup>2</sup>. When considering teacher training, this nuanced vision (most students have a good experience of school, but a minority have real difficulties) should be the basis. In any case, we should not rely on naive optimism ("everything's fine!") or on

2. Study of AMVE (health and citizenship education) in cycle 3 (last 3 years of primary school), the same sample as that which produced the data presented in figure 2, p. 38.

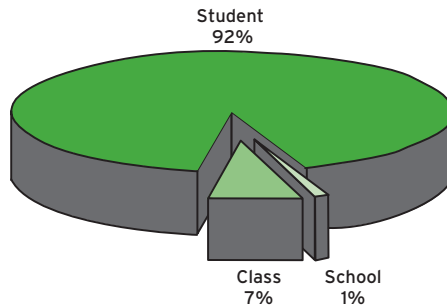
excessively dramatic readings (“schools are grinding students down!”)<sup>3</sup>. In initial and continuing teacher training, the only way truly to mobilise those involved is to work using a vision that is realistic about the limitations and strengths of what schools and educators can do.

## SCHOOLS SUPPORT STUDENT DEVELOPMENT

While highlighting the action that schools can take with regard to health, it is nonetheless useful to put this in perspective. The health of an individual is primarily affected by factors that lie outside schools: individual characteristics, family life, sociocultural environment, the media and peers. Schools are not places in which individuals are moulded or conditioned; they make a contribution to individual development. Their influence can be quantified. The various studies that are available seem to agree that between 8 and 15% of variation in students’ scores can be explained by differences between schools [8]. In the more specific area of health promotion, similar data are found. The climate within the school is recognised as being one of the key determining factors both in educational success and in student health [9]. A study of the well-being of children in the latter stages of primary education shows that institution-linked variables only have an influence on 8% of score variability [figure 2].

**FIGURE 2**

### Segmentation of variance of “well-being at school” for different age groups



This figure represents the results of the multilevel analysis of the “well-being at school” score (11 variables) calculated using the responses of 960 students in the later years of primary education in the study “Learning to live together better in schools”. Total variance is segmented into three parts: one for each level of aggregation. Variance between students is 92% of total variance. Only 8% of variance was connected to school variables.

3. It is also useful to note that this observation is in line with data relating to the health of French children and adolescents. As stated by Dominique Versini, the French ombudsman for children, in her 2007 report (available online, in French: <http://www.defenseurdesenfants.fr/pdf/RappAct2007.pdf> [retrieved 07/01/2010]), though a minority of French adolescents experience significant difficulties, we should not forget that for the vast majority things are going well. Adolescents give 7.5 out of 10 to their overall perception of life (Godeau E, Grandjean H, Navarro F, dir. *La santé des élèves de 11 à 15 ans en France*, 2002 [Health of students aged 11-15 in France, 2002]. *Données françaises de l'enquête internationale HBSC* [French data from the HBSC international survey]. Paris: INPES, coll. Baromètres santé [Health Barometers], 2005: 284 p).

To this extent, then, schools are able to contribute to the health education of their students. The educational system is not a “magic wand”, a wave of which would be sufficient in order to change individual behaviour; the complexity of human behaviour cannot be reduced to simple conditioning mechanisms. Time at school is just one of the experiences that contribute to individual development. This type of experience should be considered alongside other places in which education takes place, e.g. family, peer group, spiritual life, cultural or sporting activities.

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# Supporting change in educational systems

## THE ROLE OF SCHOOLS: TWO UNDERSTANDINGS

The most important question is not whether or not schools are promoting students' health. Schools currently do this both via the teaching that they provide, and the fact that a community of people "live together" in the school. What is at stake is how schools can most effectively contribute in this area, given the current state of health and social issues. This is where tension arises between a focus on the teaching of subjects and consideration of education in (for example) health. In other words, there is a conflict between two different forms of school life, the first being classroom-based, as proposed by Durkheim as a model for organising school activities, with stratification of activities by subject and age group, and the second calling on a more diverse range of activities<sup>1</sup>. Asking how and why teachers should be trained in health education inevitably leads to consideration of the mandate of schools. This debate has been ongoing since the French Republican school system was founded. In the 18th century, two opposing visions developed:

- a vision of schools that was based on the separation between education (the responsibility of families) and instruction (for which the public

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1. "The openness of schools is not a new question, and is addressed in the first edition of Ferdinand Buisson's dictionary of pedagogy in 1887, under 'educational museums, gardens and trips'. It is found later in pedagogical theories by Freinet, Decroly et al., which were described as 'new'. However, this openness remains problematic, as it is contrary to the historical structure of the Republican classroom-based school system. Educational forms still operate according to these principles, and are focused on the transmission of knowledge which is intended to supply order, and which it is necessary to 'protect' from societal disorder." C Mérini, Journées de l'ABDBP. Amiens, 2005.

authorities were responsible): “Civic instruction is limited to regulating instruction, and the other aspects of education are left to families. The public authorities cannot have the right to teach opinions under the guise of fact; [...] their duty is to provide weapons against error [...] but they do not have the right to decide where the truth lies.” (Condorcet, 1791);

■ and a vision which today would be called holistic, which grants the national education system a significant educational role: “a truly and universally national education system”, with the aim of “developing men and propagating human knowledge”, which contested the distinction between instruction and education (Robespierre, 1793)<sup>2</sup>.

In France, the context in which the Republican school system emerged was such that the system was based on that which was recognised as being common to all (universal). Anything that involved choice and opinions was solely a matter for family life.

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#### Education was for the family, instruction for schools.

This was the price to pay if schools were to be recognised and accepted by all citizens. Of course, the broader view of education was still present in the national debate (and then education in environmental issues, sustainable development, health, consumption ...). But it was marginalized, the concept of comprehensive education was supported by the trends of “active” or “new” pedagogies.

Nowadays, many people wonder about this fundamental choice because of the important changes in social context. There is significant social change in family structure and in the place of children within schools and elsewhere, and in expectations placed upon educational institutions. In a period in which doubts are being raised as to the ability of families and “intermediate entities” (e.g. associations, parties, churches) to transmit culture to children, attention turns to the State and to schools as our last hope. The focus is thus being shifted. In concrete terms: until recently, the role of schools was to provide information concerning anatomy, reproductive physiology and contraception methods, while families were responsible for sex education. Today, schools are required to provide children and adolescents with the personal and social skills which will enable them to take independent charge of their own sexuality in all its forms (biological, emotional, psychological, legal, social and ethical).

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2. Health is present as a debate even as early as Robespierre’s speech, as the idea was to promote “a steady form of life, healthy and suitable food in childhood, progressive and moderate work, successive but continually repeated tests: these are the only ways to create habits; these are the way to provide the body with all the development and faculties it is capable of achieving”.

This is how the paradigm has changed. This is not just a change from provision of biomedical information to a more holistic view of health; rather, it is a complete shift in the role of schools. This is true for the field of health, and for many other areas of social and civic life. Education in environmental issues, sustainable development, health, consumption and security have emerged, because of high levels of social demand. This change is not risk-free, as transferring greater educational responsibility to schools entails an increase in social conformity and a reduction in families' freedom to educate. It is therefore not sufficient to persuade educators, who are focused on outmoded discipline-based teaching that resists civic engagement, to convert to a vision of health promotion. The issue is a fundamental change in the role of schools within society, and by extension of the meaning of educators' professional activities.

In other words, the issue of the role of schools is wider than just health education, but health education occupies a unique place in this debate. Increased engagement on the part of schools can only be achieved if there is a similar increase among families. Only by linking school- and family-based education (and not by substituting one for the other) can we encourage the emergence of practices that promote positive child development. There can be no progress in children's health education without a strong commitment to supporting parental involvement. This is the responsibility of all stakeholders, with regional authorities being most important.

### **HEALTH EDUCATION: THE SPECIFIC REQUIREMENTS OF A SPECIFIC EDUCATIONAL CONTEXT**

These facts enable us to gain perspective on those quick international snapshot comparisons which would appear to show that France is somewhat behind. It is useful to remember that the paradigms underlying educational systems vary between countries. The fact that we do not implement an approach to health education in the same way that some English-speaking countries do does not mean that no provision is made in this area. The French educational system is strongly focused on citizenship education; it is centred upon the transmission of knowledge that is recognised as being common to all, while other educational systems place stronger emphasis on the development of individual skills. In Australia, for example, the ability to analyse and solve problems, to communicate, plan and organise activities and to work with others, self-confidence, optimism and high self-esteem are emphasised [1]. It is therefore not surprising that Australia should be one of those countries in which the "health promoting school" [2] approach is broadly adopted. This approach is based on the development of students' social skills. Apart from the fact that other educational systems are not free

from areas of tension, they should be considered within their own cultural and historical framework. It is not useful to mythologise about a particular educational system, nor to attempt to copy it. International comparisons can enable us to gain perspective on our own system. This is all the more true since there is no one “best” system. This is shown by the Programme for International Student Assessment (PISA [3]), which aims to assess how far students near the end of compulsory education have acquired some of the knowledge and skills essential in order to be “well prepared for future challenges”. Even though it is useful to cast a critical eye over this type of international comparison and even though an analysis of the raw results of this survey is beyond the scope of this work, some aspects of the study can shed light on our subject matter. The first interesting item of data is that Finland achieves the best scores, particularly in writing skills and in mathematics. The Finnish educational system is characterised neither by fierce competition between students nor by educational pressure. On the contrary, the Finnish system manages, better than any other educational system, to reconcile effectiveness and fairness (for example: no early selection, recognition for schools which enable the weakest students to succeed, truly child-centred pedagogy, recognition for schools’ activities, consideration of schools’ needs). This system should not be idealised, but it should be emphasised that elitism, a high level of pressure on students and a return to an authoritarian lecturing style of teaching are not obligatory staging posts on the road to educational success.

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A school that is effective in terms of academic knowledge can still consider the social and individual well-being of its students.

It should not be concluded from this that the Finnish model is the only model that should be promoted. Like all educational systems, it is the result of a particular historical and social context. One other country obtains very good results in written work and mathematics: Korea. Its educational system is completely different from Finland’s, and is characterised by high levels of pressure, which generates anxiety, a high level of competition and low levels of intrinsic motivation among students. Very different educational systems can achieve similar results in terms of skill acquisition. It should not be forgotten that every type of educational system is dependent on the social and cultural context in which it is situated. Radical changes cannot be made to an educational system overnight; at most, it is possible to support gradual change.

From this brief overview of the PISA data, two conclusions can be drawn. First, that there is no conflict between the promotion of well-being at school and academic results. Second, that when developing strategies for prevention of risky behaviour, for health education and for educational success, we can only be successful if we take into consideration the specific

features of the educational system. This must be framed as supporting those involved, rather than as a call for conversion to a particular approach.

## ACCEPTING THE INHERENT TENSIONS IN THE SCHOOL SYSTEM

Finally, we should state that social demands on schools are the source of unavoidable tension. Academic demands must be weighed against personal development, school performance must be weighed against self-actualisation and, more generally, socialisation and emancipation. This is nothing new; we just need to realise that we cannot shift our focus so drastically with no consequences. Defining the role of schools in our society requires an act of collective judgement. The work done in France by the Thélot commission in 2004 on the future of the school system took place in the context of a debate in the general population. This was a key event in recent years, which meant that the “school project” was taken back into the hands of citizens<sup>3</sup>. Openness to broader consideration of students’ personal development can only be achieved if the issues are made clear and if all are involved<sup>4</sup>. In any case, there is plenty of scope for debate as to the usefulness of a shift towards broader health education practice. Those who think that schools should focus on the transmission of knowledge are not reactionary conservatives whose arguments can easily be swept aside. They simply have a different view of what schools should do, which is a view that is still broadly held in the teaching profession and in the general public. As we have already seen, French education law allows for multiple interpretations and reflects various different visions of how health should be considered in schools.

We are in search of a new way of defining how we should live alongside one another. This is the question that should always be addressed when thinking about how to transmit a culture to subsequent generations. The “common base of knowledge and skills” published in 2006 is one way to define this. Although this is not explicitly included in the process of cultural transmission, it provides a general overview of the rules that currently operate in schools.

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3. Holding a broad national debate does not prevent these conclusions from being translated into educational policy. Many who are involved in education were disappointed with the content of the Fillon education law of 2005, and considered that it did not adequately include citizens’ concerns as expressed during the debate.

4. The book by M Callon et al. (*Agir dans un monde incertain. Essai sur la démocratie technique*. [Acting in an uncertain world: an essay about technological democracy] Paris: Éditions du Seuil, coll. La couleur des idées, 2001: 358 p) shows both the limitations of a field of knowledge and expertise that are disconnected from citizens, and the importance of allowing everyone to participate in decision-making.

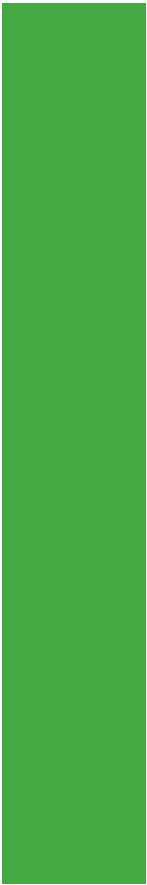
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There are no distinct definitions of health education, prevention and promotion, and it is useful to state clear meanings for these terms. The suggested areas for consideration are to be put in context and the list is not intended to be exhaustive. Our concern is the way in which health education can be managed within the educational system.

## **Health education in the school setting**





# General framework

## Creating the conditions required for educational success and enabling students to acquire the necessary skills to make free and responsible health choices

### MULTIPLE APPROACHES IN THE INSTITUTIONAL TEXTS

An analysis of French institutional texts shows that they contain a wide variety of approaches to health issues. In the French educational system, health education takes place within subject-based teaching, and in a broader context of health promotion on a school-wide scale. It is governed by curriculum<sup>1</sup>, general texts concerning health education, regulatory texts concerning health education and citizenship committees (CESC in France), texts that regulate activities within nursing, social and medical services within the national education system, and government circulars on specific themes (e.g. AIDS, addiction). This institutional framework does not specify a unified vision of health education:

- some texts adopt a health promotion perspective, including all aspects of life within the school (e.g. teaching, school life, physical and relationship environment, health at school, relationships with parents ...). These require a commitment from everyone to adopt a holistic view of health;
- other texts, particularly curricula, are focused on the transmission of knowledge. They represent that which is recognised as scientifically and socially valid at a particular time;

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1. Curricula for primary schools and middle schools are available online at <http://eduscol.education.fr/pid23391/programmes-ecole-college.html>, and for lycées at <http://eduscol.education.fr/cid46464/presentation.html> [retrieved 07/01/2010].

- texts focused on the prevention of a high-risk behaviour or of a public health problem (laws, joint ministry plans, circulars on themes such as addiction, AIDS, first aid training or obesity) in most cases call for inclusion of a series of lessons on these subjects;
- finally, more specific circulars concerning emergency contraception, the installation of condom machines in schools, the nature of the meals served in the school canteen, and food security or procedures involving food created in class, at parents' homes, and for celebrations and fairs [box 1].

### BOX 1

#### The main legislative texts that govern health education in a school setting

- Decree no. 2006-830 dated 11 July 2006 relating to the **common core of knowledge and skills**<sup>1</sup>
- Circular no. 98-237 dated 24 November 1998 relating to **directions for health education in primary and middle schools**<sup>2</sup>
- Circular no. 2001-012 dated 12 January 2001 relating to **health promotion among students**<sup>3</sup>
- Circular no. 2006-197 dated 30 November 2006 relating to **health education and citizenship committees**<sup>4</sup>
- Circular no. 2003-210 dated 1 December 2003 relating to **student health: five-year prevention and education plan**<sup>5</sup>

Other texts, specifically those dealing with specific themes, are also available. The site of the Education ministry (Directorate General of teaching in schools) offers a wide selection of legislative texts and documents relating to health education<sup>6</sup>.

1. Online: <http://www.legifrance.gouv.fr/WAspad/UnTexteDeJorf?numjo=MENEo601554D>

2. Online: <http://www.education.gouv.fr/botexte/b0981203/SCOE9802899C.htm>

3. Online: <http://www.education.gouv.fr/bo/2001/special1/texte.htm>

4. Online: <http://eduscol.education.fr/D0004/vtcrefo1.htm>

5. Online: <http://www.education.gouv.fr/bo/2003/46/MENEo302706C.htm>

6. Online: <http://eduscol.education.fr>

[retrieved on 07/01/2010]

There are two factors that are responsible for this diversity. The diversity found in health education and the multiple roles that schools play (prevention, education and promotion). A coherent view is being constructed, but it is not yet shared by all stakeholders.

## EDUCATION AS EMANCIPATION: THE HEALTH PROMOTION PERSPECTIVE

Health is present within all aspects of life in schools: from prevention of addictive behaviours to inclusion of children or adolescents who have disabilities or chronic diseases, and even an overall school-level approach to health, supported by CESC. In France, the most wide-ranging text about

health in schools is circular no. 98-237. This text drew up the framework for considering health issues in schools. It adopted a “health promotion” perspective, the purpose of which was not defined in reference to high-risk behaviour or health indicators, but in reference to self-determination of individuals and populations.

According to the Ottawa Charter (1986), the purpose of health promotion is to give individuals more control over their own health, and more resources for improving it. The concept of health promotion goes beyond individuals, and considers communities and the interactions between the individual and the surrounding environment, both physical and human.

In the French educational system, health education is given two objectives. One is to enable students to acquire the necessary skills in order to make free and responsible choices about health, and the other is to create conditions in which all students are able to succeed. This insistence on “all” students is related to the particular attention that is paid to those who are vulnerable because of disability, social situation or health. The text defines the task of schools in this area as follows: “Schools have a particular responsibility, working closely with families, to watch over the health of the young people in their care, and to enable them to develop their personalities to the fullest extent. They also take part in prevention and health promotion, providing students throughout their school life with health education that is closely tied to teaching, and which is appropriate for their expectations and needs, and that is well-adapted to current public health challenges. The aim is to enable them to acquire knowledge and to develop critical skills, and thereby to adopt behaviours that will support their future health, by improving their levels of autonomy and responsibility. For this reason, student health cannot only be the business of a few specialists, but should involve the whole of the educational community.”

All stakeholders in schools (parents, teachers, medical and social workers, management, school administration) are therefore required to contribute to health education, in a way that is tailored to the roles they play. Those involved professionally in health and social work – social workers, nurses, doctors **[box 2]** – act as experts and advisers to the school project, for which the main educational content is provided by parents and teachers; management teams and school administrators also play a crucial role by analysing needs, and by creating and monitoring the project. However, the partnership between these groups of people will not arise naturally; it will result from a sustainable collaborative programme which will lead to the emergence of a common culture. With this in mind, training becomes a key issue.

This is an important text and it underlines that all stakeholders should be involved. It states that health education “involves the whole of the

Doctors and nurses working in the French education system, because of their training, skills and professional networks, are key participants in the promotion of student health. In addition, their role is codified in two specific texts arising from circular no. 2001012 dated 12 January 2001. These texts contain details of their role as technical advisers (because of their expertise in public health) to institution managers in the creation and implementation of the school's health policy. These professionals are unique in Europe as they work in a school setting, within the schools themselves. Their activity has both individual and collective aspects.

## BOX 2

### The specific role of nurses and doctors involved in school health is to provide technical advice to the educational teams when creating and implementing the school health curriculum

**Individual activities:** these form a significant proportion of doctors' and nurses' working week, and require close collaboration between these two sets of professionals, whose skills are different and complementary; these require close links with families, and partnership with social services, the healthcare system and any other organisation that is involved in the health and protection of children and adolescents; they enable connections to be made between health and education, while adhering to the student's right to confidentiality.

Some of these activities are routine, obligatory or recommended:

- a medical check-up at 5-6 years for early detection of developmental disorders and learning difficulties. This is enshrined in law;
- screening by nurses in primary schools and in the first year of secondary education;
- medical check-up at age 14-15, with careers guidance in mind. Underage students who are in vocational education are exempt from the list of jobs from which they are forbidden under the French Labour Code, as long as they have approval from a doctor working in the education system;
- check-ups as part of specific programmes or involving priority groups.

Some of these activities are selective in nature:

- nurses provide first aid in emergencies, and support any students who need help and a sympathetic ear;
- medical check-ups on request: often requested by a member of the teaching staff who is worried because of some key signs, or following a conversation or screening by the nurse, or following a request from a parent.
- ensuring that children with chronic diseases or disabilities can receive schooling, taking into account their particular needs and in order to contribute to their therapeutic education;
- intervention with children or adolescents who are in danger (suspected abuse or severe neglect).



**Collective activities:**

- event-linked: contributing to emergency protocols and prophylaxis for communicable diseases, contributing to crisis management in situations that cause trauma among the school community;
- improving students' quality of life in terms of hygiene, safety and ergonomics within the school; beyond this, they contribute to actions taken to protect against significant risk in the school environment;
- participating in health monitoring and epidemiology on a local scale (including in the context of situational diagnosis in a school), regionally (regional health observatories), and nationally, and even on a European level;
- involvement in health education projects as technical advisers to school management teams.

educational community". Health education can therefore only be fully achieved if it is part of a broader health promotion programme within the school. Without a real investment in the collective life of the school, support for students, relationships with parents and partners, social work and health professionals, health educational activities remain merely formal; they are just a superficial gloss, which is unlikely to provide real support for a human being in development. The texts call for health education to be put at the heart of what schools do: "Health education is based on the transmission of knowledge and skills and is provided in the day-to-day life of the school and in educational activities."<sup>2</sup>

The "school project" (defined for a 3 years period in each primary and secondary school) form a set of tools that can be used to consider health in school life. "The goal of the 'school project' is to reconcile national objectives with the local situation, and to create strategies that appear to be most appropriate in order to achieve the objectives, taking into account the context." Depending on the situation and the perceived needs following an analysis of the local situation, the set of goals of the 'school project' can include a "health dimension" involving various partners (e.g. parents, prevention specialists, the local council). This "health dimension" is only one part of a plan that has several components. Inclusion of health in the goals of a school is part of a partnership approach; it helps to make health education a project that is common to all stakeholders in schools. Secondary schools, schools have an institutional tool in the form of CESCs (Health and Citizenship Education Committees), which is embedded in the broader school policy<sup>3</sup>. The role of these committees is to contribute to citizenship education,

2. On this latter point, it is important to be aware of circular no. 98-237 dated 24 November 1998 concerning guidance for health education in primary and lower secondary schools.

3. According to circular no. 2006-197 dated 30 November 2006: Protection in the school setting. Health and citizenship education committees, primary schools can also take part in CESCs, which will enable greater consistency in health education and prevention.

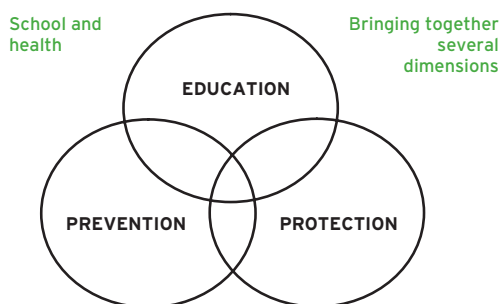
to prepare a violence prevention plan, to suggest ways of helping parents who are having difficulties, to combat exclusion and to create a programme of education in health and sexuality and prevention of high-risk behaviour. CESC's are places for reflection, observation and monitoring which design, implement and evaluate educational goals in the areas of prevention, citizenship and health education, which are fully integrated with the school's goals. This wide-ranging and partnership-centred approach aims to provide greater consistency and transparency to the school's policies.

## AN APPROACH COMBINING PROTECTION, PREVENTION AND EDUCATION

The model on which this policy is based is health promotion as formalised by A & C Tannahil and R S Downie [1], which is adapted to the specific requirements of the French educational system. Its purpose is to enable individuals or groups "to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment." [2]. Developing a health promotion policy involves bringing together protection, prevention and education. The protection aspect involves those actions that aim to create a supportive environment and atmosphere in schools and to implement ways of supporting all students, particularly those who have special educational needs. The prevention aspect involves specific work on behaviours that lead to failure (violence, high-risk behaviour) and the education aspect corresponds to the development of knowledge, skills and attitudes among students [figure 1] [box 3].

FIGURE 1

The three components of health promotion as defined by R S Downie, A Tannahill and C Tannahill (1996)



**BOX 3****Examples of priority areas for programmes in schools that are part of the Swiss Healthy Schools network [3]**

On various levels (classes, the teaching staff, the whole school, the school environment and policy), schools have approached the following aspects:

- social well-being: community, communication, working together, participation, the school's culture, internal regulations, conflict management, prevention of violence;
- physical well-being: diet, physical activity, relaxation, posture;
- prevention of addiction: on legal or illegal drugs, eating disorders;
- school structures: mission statement, training for person responsible for the project, social work in schools;
- health of teachers;
- psychological well-being: improving protective factors, self-esteem, stress management, suicide prevention;
- planning of school facilities: playground, rest rooms, infrastructure;
- working together with parents, authorities, specialised centres, school openness, working together with the local community;
- sex education and AIDS prevention;
- environment, nature;
- risk and safety.

The Swiss “healthy schools” (“écoles en santé”) network uses this model as a reference. Its framework document states that “a school that is supportive of health will work explicitly on themes of health promotion at all levels of school life (teaching, management team, organisation of the school day, network, curriculum) and will invest in implementing appropriate measures. This model also helps to improve the quality of training and of the school and moves the school towards “healthy school” status, while ensuring that all those involved with the school can flourish and that their health and well-being is supported. In order to achieve this, the model uses a holistic concept of health and uses the principles of health promotion as defined in the Ottawa Charter: “participation, acquisition of self-help skills, focusing on resources, sustainability, an educational focus on diversity (equality of opportunity between sexes and those from different social, ethnic and religious origins)” [3].

In concrete terms, protection involves ensuring that there is an environment that is supportive of the social well-being of all those involved in school life (students and staff), while ensuring security for all and making facilities available (classrooms, playgrounds, equipment for physical education and sports); protection also means that competent adults are available to listen to students and help them resolve the difficulties they encounter, whether in school life (educational advisers, school counsellors), health (doctors, nurses) or in the curriculum (teachers). Protection also involves ensuring that high-quality meals are available in the canteen, that children's routines are considered, and that laws concerning alcohol, smoking and illicit drugs are

complied with. Prevention means developing activities that are centred on a type of behaviour or a risk. This may be work with students on (for example) food, accidents in the home and on the road, or addiction. Prevention also involves information sessions aimed at all adults in the school community, including parents as well as staff. This may involve providing a choice that is wider than pastry and chocolate bars for snacks or breaktimes, and installing condom machines in high schools. Education (here) means working on students' skills, both in classroom-based activities and in daily life at school.

## AN APPROACH THAT MEETS CURRENT CHALLENGES

Many studies have shown the close link between education and health, and the usefulness of educational and preventive action in the school setting [4, 5]. Correlations have been established between health behaviours and educational success (grades, absenteeism, involvement in school activities and students' social skills [6, 7]). Together with other factors, in particular factors that are linked to social environment, health is one of the conditions that must be met if students are to succeed in school. Studies involving evaluation of health behaviours and schools success have shown that multi-factor and broad-based interventions are the most effective. The summary by Stewart-Brown [8] stresses that, in order to be effective, a particular action must include activity in more than one domain and must attempt to encompass all dimensions of the student's life within the school. The school environment, relationships, quality of life and the school climate are identified as being significant determining factors. Other studies [9] give similar results and give further weight to the idea that the key elements are duration of action, institutional support, training and support for those involved and implementation of a holistic approach that is centred on the development of social skills (e.g. self-confidence, ability to express emotions, managing risk and stress). In other words, an approach is effective if it combines two dimensions: the pedagogical (class-based activities) and a broader view that takes into account all aspects of life within the school (working to create a supportive physical, social and learning environment). Many primary and secondary schools in France are already doing this successfully. A recent French study, for example, showed that implementation of a health promotion programme in schools (the "Learning to live together" [10] programme) had a positive impact on the school climate [11]. This impact on the school climate appears to be particularly linked to mobilisation of the teaching staff. In France, health education is not the exclusive prerogative of a particular category of teacher; it involves all those involved in education. Other countries have made different choices. In the United Kingdom, the United States and in Ireland there is a school subject<sup>4</sup>.

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4. In Ireland, the school subject is called "Social, personal and health education". In the United Kingdom it is "Personal, social and health education". In the United States it is simply called "Health", but there are significant variations between states. For example, in Wisconsin, students must gain a half-credit in health education between the ages of 11 and 18 in order to receive their diploma.



The interest of the French approach is that it does not transfer responsibility for this area of education to just one category of staff, and it calls upon each to contribute according to his/her abilities. The obvious risk is that there will be a low level of commitment to health education, which will lead to dilution. Another feature that is specific to France is that there are doctors and nurses within the educational system. The idea is not that healthcare professionals within education should be the only providers of health education, but that they should be positioned as experts who can provide technical advice to benefit the school's leadership team. Finally, staff within the national education system (not external bodies) are responsible for health education. This is key, as it means that health education can be clearly positioned as a component of general education and not as a separate entity that is the responsibility of the healthcare system. The risk is that the skills required in order to implement projects in such a complex field may not be available. For this reason, schools are encouraged to form close partnerships with other health education stakeholders, particularly regional and département-level health education committees<sup>5</sup> but also more specialised associations, for example the National Association for Alcoholism and Addiction Prevention (Anpaa)<sup>6</sup>. These are not just sub-contracting relationships; rather, they are true partnerships in which the input of experts from associations is part of the training and support for teams, rather than part of the activities conducted with students<sup>7</sup>. This approach has then strengths and weaknesses.

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# Health education: an aspect of citizenship education

Health education is a component of a health promotion approach, but it finds its true strength as a part of citizenship education. In this chapter, after having established the purpose of health education, with reference to learning about liberty and responsibility in health, we'll clearly define its limits. We will then study the basis on which classroom activities can be created, before suggesting an example of a module for primary schools.

## LIBERTY AND RESPONSIBILITY AS GOALS

Health education is one aspect of citizenship education. It is referred to the goals of schools; in other words it works in accordance with the basic principles of equality, freedom and secularism<sup>1</sup> to create the men and women of the future, who are able to lead responsible personal, civic and working lives, and who are adaptable, creative and aware of others<sup>2</sup>. The reference to secularism is central: this refers both to equality and to autonomy of thought, and it places knowledge in opposition to beliefs and opinions. The aim is to create minds that can think for themselves, and to resist the pressures they face in today's world: stereotyping, peer pressure, the power of the media, and also

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1. The principle of secularism is a central tenet of French public policy in general and especially of the school system (the constitution prescribes the organization of "free and secular state education"). In the French understanding of the concept, it is more than the "separation of church and state" or "state neutrality in religious matters", secularism "rests on three inextricably linked values: freedom of conscience, equality in law of spiritual and religious persuasions, neutrality of the political authorities" (Stasi, 2003).

2. These principles were established in Law no. 89-486 dated 10 July 1989.

short-term emotional reactions. Circular no. 98-237 dated 24 November 1998 states that “health education is not a process of conditioning; rather, its aim is to help all young people to take ownership of the means by which to make choices and to adopt behaviours that are responsible, both towards themselves and towards others and the environment around them. Health education also prepares young people to become responsible citizens, in a society in which health issues are a major preoccupation. It is not simply a discussion about health, and it is not simply the provision of information. Its aim is the development of skills”.

This means that the legitimacy of health education lies not firstly in its relationship with health issues, but in its ability to build skills that enable people to make enlightened and responsible choices.

Let us take the example of smoking. This is legal in France; smoking therefore raises issues of individual freedom (on condition that laws are adhered to, for example those involving bans on smoking in public places). If it is legitimate that schools provide education in this area, it is not because the substance is illegal (as is the case for drugs such as cannabis); rather, it will be part of the idea of human beings as citizens: the consumption of tobacco has significant consequences for health. Like other psychotropic substances, it can lead to dependence, alienation and a loss of freedom. The founding principle of the school system is to provide activities that enable students to gain skills that enable them to preserve their freedom, in other words to make responsible choices. This involves providing individuals with the means to take care of themselves, and to be in a position to take their share of responsibility for their own health<sup>3</sup>.

In order that it is possible to make such choices, knowledge must be acquired: knowledge of oneself and of one’s needs, and knowledge about the effects of various drugs. However, this is not sufficient. It is essential to be able to choose; to be able to distance oneself from pressure and stereotypes (e.g. those which associate smoking with being an adult, or which portray cannabis as a young people’s drug that is harmless and liberating). It is the role of schools to implement activities that aim, for example, to let students know the law (consumption of some psychotropic drugs is illegal), to provide scientific knowledge about substances, to develop self-confidence and the ability to resist pressure from the media and from peers. This involves enabling students to take ownership of the resources that will help them to create their own freedom as individuals and as citizens; in other words, to educate them as citizens.

3. We specify “their share” of responsibility, as it is true that many factors that determine health are beyond the scope of individual choice. It would be very dangerous to assume that health is entirely the individual’s responsibility.

## HEALTH EDUCATION, SCHOOL AND FAMILY

Even though the guiding principle behind health education in schools is the construction of the individual, and not any particular health problem, it is obviously essential to enable children and adolescents to look at lifestyle or the issues involved in smoking. However, it is clear that health education should not deliver a single standard message about these subjects (unlike situations in which such behaviours break the law). A child's education and health are the primary responsibility of the child's parents<sup>4</sup>. The parents' choices must be respected (in so far as they comply with the law). In addition, they can legitimately expect to have clear knowledge of the aims and methods used in the various social structures that educate their child, and in schools in particular. The Education Act<sup>5</sup> and educational curricula are thus contracts between citizens and the State. When I send my child to school, "I agree" that the child takes part in activities that are designed to help him master subtraction and division, and also educational activities that involve health. Legislative texts provide a general framework for this individual education. Sex education<sup>6</sup>, for example, is based on consideration of the various aspects of sexuality as components of human life, which opens the way to a broad diversity of approaches, all within a basic context of respect for human dignity (one's own and that of others). The "contract" states that schools will not tell students that there is a "good" and "bad" way to experience sex; rather, there are many ways, and the most important thing is to maintain respect for oneself and others, and to examine stereotypes critically. Health education in schools is designed to operate in conjunction with family education, with reference to the distinction between public and private. The content of teaching curricula should be defined in this context.

## DEFINING CONTENT IN REFERENCE TO SOCIAL PRACTICES

The particular features of this very specific type of content need to be considered. The fact that this content has a legal, ideological and political status, which is unusual in a school setting, means that it needs to be strongly rooted in a conceptual framework that is drawn from various different disciplines. However, it is also useful to consider the value-laden implicit (or even hidden) knowledge which is associated with them [1]. In the absence of identified knowledge on which to base this content (i.e. an academic discipline), health education calls upon existing social practices, and on that which is recognised as being common practice at a given moment, which nevertheless does not claim to be universal. This situation is not specific to health education or to any other non-"disciplinary" education. Physical education and sports, sustainable development education and technology

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4. This fundamental aspect was summarised in circular no. 2002-098 dated 24 April 2002.

5. Law no. 2005-380 dated 23 April 2005 concerning school reform.

6. Clarified in circular no. 2003-027 dated 17 February 2003.

education, face similar issues. The concept of social practices that are used as references, as defined by Jean-Louis Martinand [2], entails relating school-based activities to “situations, tasks and qualifications in a particular area of practice”. The problem is that in health, and in private behaviour more generally, there are by definition no generally-recognised social norms.

Several examples come to mind here. The law takes a clear position on some behaviours (e.g. illegal drugs, sexual violence, driving under the influence of psychotropic substances). The facts that are taught about these behaviours draw their legitimacy from the role schools play in raising citizens and educating people to “live together”, in which a relationship with the law is fundamental. Other behaviours, though they remain part of individual freedom, are subject to high levels of social consensus: in particular, the examples of smoking and exposure to the sun. Finally, for others, there is no specific social practice that can be used as a reference, either because it is not possible for ethical reasons to respect differences between individuals, or because there is a lack of scientific information or social representations associated with them. This is particularly the case for sexuality. On this theme, a reference to “living together”, in other words the values of dignity, freedom, responsibility, secularism and fraternity, must provide a guide to the content of education programmes, and to the limitations of the contribution schools can make.

## THE VARIOUS THEMES

Health education, as defined in the French education system, involves multiple fields. On the face of it, it would appear difficult to draw together such a diverse range of educational activities that involve nutrition, lifestyle, hygiene, sexuality, prevention of violence, drug addiction, risk behaviour on the road, reduction in cardiovascular risk as well as the development of a positive view of one’s own body and respect for others. The issue of unified health education in a school setting is relevant, as creation of a programme that lists the skills that need to be acquired in all these areas would lead to an overwhelming and complex list<sup>7</sup>. An individual’s education cannot be based on an accumulation of modules, however useful they might be; there must be coherence<sup>8</sup>. That which is valid for education as a whole is also valid for health education. An accumulation of educational material on a broad range of themes means that a very short time will be allocated to each item of material: the school day cannot be extended, and there are many other priorities in education! In general, if teachers are short of time, their action is limited to providing information. These reasons, taken together, mean

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7. Some texts, in particular the five-year plan, advocate an approach involving all dimensions of health promotion in schools, but the drawback of this is that it involves taking into account a very large number of “priorities”.

8. In general, one of the most basic causes of failure at school is encapsulated in the fact that students do not perceive meaning in what they are learning, and that they feel as though they move arbitrarily between one field of knowledge and the next.

saying good-bye to a comprehensive approach to health issues and potential risks. What is more, this list of themes tends to change over time – different behaviours need to be promoted, different risks need to be prevented – and when today’s students become adults, the list will probably be different from that used in current health education. The only option is to trust learners, and approach health education as a coherent whole which occupies an important place within educational activities in schools. This need for coherence in education is not so far from what neuroscience<sup>9</sup> and psychology teaches us, particularly concerning high-risk behaviours. Pathological consumption of psychotropic substances (alcohol, cannabis, heroin, cocaine, anti-anxiety drugs), risk-taking on the road or in sports, eating disorders, drug-taking in sport: these are all brought together under the umbrella of high-risk behaviours, and this is because there are several common psychological and environmental factors that influence these behaviours. Identifying the common factors (on which education is likely to have an influence) does not, of course, mean that all the themes of health education can be boiled down to just one explanation. Such an approach would ignore the complexity that is inherent in human life. The issues raised by high-risk behaviours (drug addiction, risk-taking on the road and in sports, violence) and those relating to “taking care of oneself and of others” (hygiene, nutrition, daily routines, physical activity) are still different, for the most part. However, it is still possible to identify a certain level of coherence, if we analyse factors in an individual’s life history that can interact with behaviour that can endanger the health of the individual and of the community. It is clear that schools are neither required nor able to take action on all the themes raised here; however, some are amenable to educational action in a school setting. This must not lead us to consider that “everything is contained within everything else, and vice versa”. Specific types of content undeniably need to be learned. It is probably just as useless to reduce health education to lists of knowledge under particular themes as it is to limit it to a general knowledge of how to live (in other words, personal and social skills in the broad sense). Once more, we need to bring together all the various and irreducible dimensions of the issue [table 1].

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9. For example, there is a common neurochemical basis for all addictive behaviours: all psychotropic substances modify the way in which some central nervous system neuromediators are produced, and affect hormone production. In particular, they are known to increase dopamine production in the structures in the brain that are involved in the regulation of emotions. Stimulation other than consumption of psychotropic substances can also have effects of a similar type. A particular example is intense exercise; keen practitioners of sport who have to stop suddenly run the risk of falling into physical withdrawal. Drug-taking in sport is also considered by many of those involved as being a form of drug addiction. In any case, there is a link between high-level sports, drug-taking and drug addiction; the latter is most likely to arise during periods of vulnerability, such as injury, times during which the person is unable to practice the sport, and times when results are poor.

TABLE I

**Health education and themes**

The various themes of health education can be divided into two groups. The first involves prevention of high-risk behaviour and the second involves taking care of oneself and of others.

An educational programme that enables students:

- to gain autonomy over their health;
- to make free and responsible choices.

Learning to take care of oneself and others	Avoiding high-risk behaviours
<p>"Taking care" does not imply a standardised way of life. An educational programme cannot impose a standard, as there is such a large number of social factors and human situations. Individuals cannot be held solely responsible for their choices, and conversely cannot be assumed to be entirely at the mercy of social factors that are out of their control. This idea of "taking care" has no moral dimension; it is focused on the ability to choose and to take responsibility, which are skills of citizens. It positions health not as an end in itself, but as a condition under which a fully human life is possible. Finally, unlike high-risk behaviours, the themes involved are not necessarily connected with acute social problems.</p> <ul style="list-style-type: none"> <li>• Nutrition</li> <li>• Hygiene</li> <li>• Lifestyle</li> <li>• Sexuality</li> <li>• Physical activity</li> <li>• Safety (at home, on the road, at work)</li> <li>• Learning first aid</li> <li>• Using the healthcare system</li> <li>• etc.</li> </ul>	<p>High-risk behaviours can be defined as "exposing an individual to a non-negligible likelihood of injury or death, threatening his or her future or endangering his or her health"<sup>1</sup>. These can be single acts or habits that develop over time. This definition says nothing about whether such behaviour is legal or illegal. This approach to health issues, via high-risk behaviour, does not impose standards and does not take a "risk-free" life as a reference point. It does not have a moral dimension; it is focused on the ability to choose and take responsibility which are skills of citizens. Finally, the themes involved are generally related to acute social issues.</p> <ul style="list-style-type: none"> <li>• Use of legal or illegal psychoactive substances (drug addiction, high-risk consumption)</li> <li>• Violence against oneself or others</li> <li>• Dangerous behaviour on the road or in sports</li> <li>• High-risk sexual behaviour</li> <li>• etc.</li> </ul>
<p>In neither case is it possible to invoke a straightforward causality. There is always an interaction between the behaviour, the specific characteristics of the individual and his/her history and environmental factors. In each case, a school programme must refer to citizenship and "living together". Such a programme has a dual purpose: to create conditions in which all students can succeed, and to enable self-determination for individuals.</p>	

1. Le Berton, cited in Bantuelle M., Demeulemeester R., (eds.). *Comportements à risque et santé: agir en milieu scolaire* [High-risk behaviour and health: taking action in schools]. Saint-Denis: INPES, coll. Référentiels, 2003: p. 48.

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# Classroom-based activities that are designed to develop knowledge, skills and attitudes

## BACKGROUND

Because of the education system's role as an agent that enables self-determination, its central focus is not disease or even high-risk behaviour, but the individual. Consequently, classroom-based activities cannot be primarily based on knowledge of the various types of high-risk behaviour. The theoretical basis for practice is related more to factors that make it likely that an individual will maintain freedom with respect to a substance or behaviour, and that instil attitudes of responsibility for oneself and for others. An individual cannot be reduced to his/her behaviour, and we cannot escape the complexity of the factors that are at work in a single life, most of which are nothing to do with the school setting.

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Teachers must demonstrate humility, and must put themselves in a position to support individuals at this point in their lives, without seeking to control these lives.

Research has been done on this issue, and many articles and books have been published. None of them provide a “miracle cure” that can be applied every time. Practice should not involve the direct application of a theory, and professionals have a duty to cast a critical eye over the various interpretations of the results of scientific work. However, although no theory can claim to

account for the complexity of human behaviour, some of the data obtained can provide enlightenment to those involved in health education [1]. In particular, there is considerable agreement in various studies that the interaction of several types of factor is involved in the development of high-risk behaviour. Broadly, these are linked to individuals themselves, to behaviour and to the environment. With a view to achieving the maximum possible clarity, we shall examine addictive behaviour. Thereafter we will generalise the conclusions of this analysis [box 1].

### BOX 1

#### Factors involved in harmful use of a substance, according to Michel Reynaud [2]

Harmful use can be considered as the “situation resulting from the interaction of three factors, which are reminiscent of the three unknowns as formulated by Claude Olievenstein: a substance, a personality and a sociocultural moment. The primary risk factor is the substance, and this has two facets: the risk of dependence, and the risk of physical, psychological or social complications. The second is related to individual levels of vulnerability, whether psychological, psychiatric, biological or genetic. The third is environmental risk factors, which can be social, family-related or sociocultural”.

## Factors related to the individual

The first fact to consider is that not everyone will become dependent on psychoactive substances. The substance or behaviour itself is not the only factor: the example of alcohol can shed light on this. In Western countries, all individuals have access to alcohol, and nearly 95% of those over 15 drink it, but just a fraction of the French population displays problematic use. Five million people have medical, psychological or social difficulties that are linked to alcohol consumption [3]. Despite this, stigmatising alcohol and identifying it as a bad thing in itself cannot be an acceptable approach<sup>1</sup>. This is also true for opiates, which are psychotropic substances that can lead to significant dependence. A classic British study showed that, of 11,882 patients who were treated with opiates for pain for more than six months, just four showed signs of dependence [4]. Exposure to the psychotropic substance is not a sufficient explanation of drug dependence. More generally, recent studies have shown that fewer than 20% of those who consume psychoactive substances develop harmful use or dependence [5]. It is therefore legitimate to ask why only some of those who consume the substance experience difficulties with it. Studies have been carried out to find out which factors are likely to

1. This is all the more important since some types of alcohol consumption have been shown to have positive effects in the prevention of cardiovascular disease and some types of neurodegenerative disease.

explain this particular vulnerability. There are many such factors, and they can be biological<sup>2</sup>, psychological or social. The data on factors that relate to individuals are not easy to interpret, but there is often, in an individual's history, the following type of situation: "low self-esteem, self-deprecation, shyness, excessive emotional reactions, difficulties in coping with events, difficulties in establishing stable and satisfactory relationships, difficulties in resolving interpersonal problems" [6]. In other words, these are difficulties in mastering personal and social skills also called life skills. "Life skills are abilities for adaptive and positive behaviour, that enable individuals to deal effectively with the demands and challenges of everyday life. Described in this way, skills that can be said to be life skills are innumerable, and the nature and definition of life skills are likely to differ across cultures and settings. However, analysis of the life skills field suggests that there is a core set of skills that are at the heart of skills-based initiatives for the promotion of the health and well-being of children and adolescents. These are listed below: decision making, problem solving, creative thinking, critical thinking, effective communication, interpersonal relationship skills, self-awareness, empathy, coping with emotions, coping with stress"<sup>3</sup>. Other factors are involved, which are specific to adolescence: curiosity, a wish to test boundaries, and a desire for new sensations. It is important to remember that our task is to consider the basis on which education should be offered, and not to suggest a therapeutic approach. When considering high-risk behaviours, attention generally turns to how people behaving in this way can be treated and supported. For example, in psychiatry, drug addiction is often linked to a narcissistic injury experienced as a young child, and treatment has been developed in line with this. Health education does not have the same frame of reference. It is aimed at all students, and is not limited to the most vulnerable or those who are already experiencing difficulties<sup>4</sup>. It is also not aimed at correcting or compensating for such disorders, which it would not be able to achieve in any case. Its aim, of developing personal, social and civic skills among students, is necessarily modest. The most important thing for the teacher is that a lack of information on drugs is not the only factor that determines consumption. Health education that aims to enable individuals to maintain their freedom in relation to psychoactive substances should leave plenty of space for development of such personal and social skills.

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2. Biological differences have a role to play in some types of substance and behaviour. The most widely known is that women metabolise alcohol less effectively than men do. It has also been shown that there are differences in sensitivity to psychotropic substances between individuals.

3. Definition taken from LIFE SKILLS EDUCATION IN SCHOOLS Division Of Mental Health And Prevention Of Substance Abuse World Health Organization 1993 p. 5.

4. Programmes co-ordinated by educational health teams and Rased (French network of specialist help for students in difficulty) are designed for students with special educational needs (French Ministry of Education: *Orientations générales pour la politique de santé en faveur des élèves* [General guidance on health policies targeted at school pupils]. Circular no. 2001-012 dated 12 January 2001, BOEN Spécial [National Education Official Bulletin, Special Edition], no. 1, 25 January 2001). Doctors and nurses employed by the French education system are tasked with "ensuring that students with chronic diseases or disabilities receive schooling, that their needs with regard to their education are considered, and in order to contribute to their therapeutic education".

## Behaviours

Individual factors are not sufficient explanation for high-risk behaviours. Not all behaviours cause the same type of problem; not all substances entail dependence. Some define dependence very broadly, basing the definition on the desire to obtain a particular substance or to behave in a certain way. Using such a definition, people could be dependent on chocolate. Although compulsive consumption behaviour does exist, we consider that it is important to distinguish dependence in the strict sense from this other type of compulsive behaviour. Even though someone may consume large quantities of chocolate on a regular basis, this cannot be described as dependence. In order for dependence to exist<sup>5</sup>, there must be both the desire to obtain the substance, a loss of control over quantities consumed, and signs of withdrawal and tolerance. To our knowledge, tolerance, which is manifested as the need to increase the quantity consumed in order to achieve the same effect, has not been described for chocolate, and neither have withdrawal symptoms. A person can be “hooked” on a particular behaviour, but there is only true dependence if there is a loss of freedom in connection with this consumption; when the person’s existence is invaded by the need to behave this way or consume this substance. This point is important enough that a clear distinction is made between dependence as described above and harmful use. The latter is characterised as use that is harmful to health, and is assessed as a function of the observed consequences. It includes neither loss of control, nor an obsession with obtaining the substance. Health education cannot, therefore, get round the need for children to acquire specific knowledge about the nature of various substances, as there are differences between them. The dominant discourse in recent years was deliberately against information; this ought not to be allowed to lead to undermining of action to encourage rational decision-making about behaviour. Just as it is unacceptable to reduce human beings to rational machines that can make choices with reference only to scientific information, so it is dangerous to neglect the knowledge that is required in order to make relevant choices.

As for actual consumption, it is important to note that there is significant diversity between different substances. Take the case of cannabis: the effects of occasional recreational consumption on psychological and social development are very different from the effects of regular consumption, which can lead to dependence [7]. In outline, three types of consumption can be identified, classed by the effect sought by the consumer, and by the impact on social life and relationships that this consumption causes [8]:

- occasional consumption out of curiosity and a desire for new sensations, possibly pleasure, or a way to feel included in a group;

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5. As defined by Goodman (1990): “Addiction designates a process whereby a behavior, that can function both to produce pleasure and to provide escape from internal discomfort, is employed in a pattern characterized by (1) recurrent failure to control the behaviour (powerlessness) and (2) continuation of the behaviour despite significant negative consequences (unmanageability).”

- consumption as self-medication, with the aim of relieving tension, which is often associated with the onset of general lack of motivation and disengagement from school. This is a solitary consumption pattern, which is most often associated with anxiety and sleeping problems;
- addiction, which is linked to a desire for an anaesthetic effect and which can be solitary or group-based, associated with interruption to education or training, and which often results in exclusion from the system [table 1].

TABLE 1

The different types of cannabis consumption, according to D Marcelli and A Braconnier [8]

Effect sought	Types of consumption		
	CELEBRATION Euphoria	SELF-MEDICATING Anxiety relief	DRUG ADDICTION Desire for anaesthetic effect
Social forms of consumption	In a group	Somewhat solitary	Solitary and in groups
Education	Normal education	Signs of "disengagement" Problems with concentration, attention, repeating years Unauthorised absence	Disturbance to relationships Repeated failure, expulsion from the system, prolonged absence, etc.
Social activities	Present	Limited	Marginalisation Increased contact with marginalised individuals
Family risk factors	Absent	Not necessarily present	Present Disordered relationships, conflicts, significant social and economic difficulties, etc.
Individual risk factors	Absent	Present Problems sleeping, anxiety, depression	Present

Medically speaking, "there will always be problematic use that requires help and management, and other types of use for which no specific intervention is required" [9]. It is important for teachers to recognise this diversity of types of use. Different types of consumption cannot be treated in the same way. It is equally dangerous to treat consumption as normal (which would give the impression that the substance is harmless) and to dramatise the issue (which would paint all cannabis consumers as dependent drug addicts who will inevitably move on to "harder" drugs). The meaning of these types of behaviour should also be considered. In all cases, there is a link between a person's needs and behaviours he/she displays. Different behaviours and substance use can also be interpreted as a way of meeting the individual's basic needs. For example, there are links between smoking and cannabis use and the need to belong to a group. Other practices can be linked to management of negative feelings. High-risk behaviour should not be viewed as external to the human being, on the analogy of a parasite that needs only to be removed in order for the individual to be freed from its effects. Such behaviour has its place within the individual's overall balance, and meets his/her needs in some way. It is dangerous to isolate behaviour and to treat it as a separate entity. An educational approach to prevention of risk behaviour

should enable children to identify and express their basic needs<sup>6</sup> and to look critically at ways in which these can be met.

These behaviours do not all have the same status in law. Although it is a fact that 60,000 people die each year in France as a result of smoking, and the epidemiological data do not clearly show the consequences of cannabis consumption in terms of mortality<sup>7</sup>, it is nevertheless true that the first substance is legal and the second is not. Health education in the context of learning to “live together” cannot get round the law.

## The role of the environment

The nature of behaviour and individual characteristics are insufficient to describe the full complexity of these phenomena. The relationship between substances and behaviour differs greatly, depending on the specific culture or background being considered. Relationships to alcohol, coca derivatives and opiates differ in Asia, Europe and South America. The type of people who were consumers and the meaning attributed to consumption of illicit substances in the 1960s (middle and upper classes, counter-culture, artists, poets) are different to those that emerged in the 1980s (working-class consumers, consumption for escape and in order to forget) [10]. In addition, social stereotypes, particularly those conveyed by the media, have a role to play in some behaviours: work performance and consumption of stimulants, body shape of supermodels and eating disorders, alcohol consumption and risk-taking in order to be a “real man”. More fundamentally, family life has an overriding influence on dietary habits, daily routines, hygiene and an individual’s relationship with psychoactive substances. Relationships within the family also have a significant impact: “If the parents show a low level of support, authority and involvement, a coercive, unfair and inconsistent attitude, if the child perceives that he/she is not close to his/her parents, these are risk factors for occurrence of harmful usage or dependence” [5]. Similarly, peer groups play an important role in introducing and encouraging the consumption of psychoactive substances.

The environment (family, peers, and the general cultural and media background) therefore has a significant influence on health behaviour. It is important to note, though, that even if we can assume that there are “rich people’s drugs” and “poor people’s drugs”, and “rich people’s behaviour” and

6. These needs are not limited to basic needs, but affect all dimensions of an individual. They can be classified, according to Maslow’s hierarchy, as physiological needs, safety needs, belonging needs, esteem needs and self-actualisation needs.

7. There is little reliable data, because of the nature of the substance and difficulties in determining levels of individual consumption. According to the study *Stupéfiants et accidents mortels de la circulation routière* [Drugs and fatal road crashes], the annual number of victims whose deaths can directly be attributed to driving under the influence of cannabis seems to be around 180, out of a total of 6000 fatal accidents per year (Laumon B., Gadegbeku B., Martin J. L., Biecheler M. B., SAM Group. Cannabis Intoxication and Fatal Road Crashes in France: Population Based Case-control Study. *British Medical Journal*, December 2005, vol. 10, no. 331 (7529): p. 1371). Online: <http://www.ofdt.fr/BDD/publications/docs/artBMJen.pdf> [retrieved 08/01/2010]

“poor people’s behaviour”, and even though in some disadvantaged areas the availability of illegal drugs is a factor that favours consumption, socio-cultural background has no clear correlation with the emergence of harmful use or dependence<sup>8</sup>. The influence of the environment is at the very least complex; the use of substances as a psychological crutch is not specific to one environment or type of behaviour. The aim of health education is far greater than prevention of marginal behaviours<sup>9</sup>. Here it should be noted that, unlike addictive behaviours, most health problems are strongly linked to socio-economic factors<sup>10</sup>.

This approach to factors linked to high-risk behaviour in the consumption of psychoactive substances can be generalised to other areas of health education. It is obvious that prevention of cannabis consumption cannot be treated in the same way as hygiene or nutrition, but it is still nonetheless true that all these phenomena feature the same complex interaction of factors that are linked to the individual, to behaviour and to the environment. For example, work on personal and social skills is a determining factor in the area of hygiene, as self-care is only possible for those who have a positive view of themselves and who are capable of identifying their own needs. Knowledge of practices that inhibit and stimulate the spread of microbes is also required. Also necessary is the ability to identify, classify, prioritise and critically examine information and to gain perspective on it; to be able to distinguish facts from belief, and to be aware of the role and influence of prejudice.

This approach to high-risk behaviour, just like the approach to self-care, is based on reinforcing those factors that are protective<sup>11</sup>. The factors that determine health and well-being on one hand, and high-risk behaviour on the other hand, are two aspects of the same situation, observed from different angles. A low level of risk perception and a constant desire for sensation are risk factors, just like having sufficient self-knowledge and an appropriate appreciation of risk are factors that support health. Protective factors are mirror images of risk factors. Along the same lines, an analysis was done of the factors that determine health in children and adolescents [table II] and

8. In the study *Les usages de drogues des adolescents parisiens. Analyse de l'enquête Escapad* [Drug use among Parisian adolescents: analysis of the Escapad study], François Beck, Stéphane Legleye and Stanislas Spilka show that “for the most common substances (tobacco, alcohol, cannabis and psychotropic drugs), the map is drawn clearly: young people from the North-East of Paris [of modest origins] seem to consume less, and the South-East [a more affluent area] has a larger proportion of users, regardless of the particular substance or level of usage” (Beck F., Legleye S., Spilka S. *Les usages de drogues des adolescents parisiens. Analyse de l'enquête Escapad*. Saint-Denis: OFDT, 2005: 200 p). Online: <http://www.ofdt.fr/ofdtdev/live/publi/rapports/rap05/epxfblc.html> [in French. Retrieved on 08/01/2010]

9. Studies have shown that 12-18% of French people in high-level management jobs with high levels of stress state that they take drugs without medical advice, and consume tranquilisers, antidepressants or stimulants. The MNEF study showed that 25% of students took tranquilisers or stimulants during examination periods, and that this figure was 40% for medical students!

10. A study looking at this issue was carried out by school health teams, as research is part of their job description: Guignon N., Herbet J. P., Fonteneau L., Guthmann J. P. La santé des enfants scolarisés en CM2 en 2004-2005. Premiers résultats [The health of French children in the CM2 class (last year of primary education) in 2004-2005. Preliminary results] *Études et résultats de la DRESS* [DRESS studies and results], April 2008, no. 632: 8 p. Online: <http://www.sante.gouv.fr/drees/etude-resultat/er-pdf/er632.pdf> [in French. Retrieved on 08/01/2010]

11. The French Education ministry signed a framework partnership contract with the Ministry of Health in 2003. In particular, this contained plans for action to promote the factors that protect children and young people, with a holistic approach to health.

then those that could be changed were selected, which gave rise to methods of supporting individual and environmental factors that promote health and reduce risk factors.

**TABLE II**

**Factors that influence the health and well-being of school-age children and adolescents according to M Hamel, L Blanchet and C Martin [11]**

Sex Ethnic origin Illness, disability	Parents' personal characteristics Socio-economic characteristics of the family (enough money, poverty, parents' level of education) Type and composition of family Parents' attitudes and values Parent-child relationship Parents' educational practices	Tolerance of violence Role given to young people Culture based on competition or co-operation Advertising and media pressure to consume
View of the self Social skills Other skills (e.g. motor, intellectual)	School climate Educational practices Characteristics of school population Openness of school to community	Social policy Co-operation between sectors Income level and security Employment and unemployment
Physical activity Diet Sleep Drug and alcohol consumption Smoking Sexual behaviour Strategies for coping with difficulties, stress etc. Attitude to risk, danger	Support from parents, teachers, other adults, peers  Access to other high-quality environments: neighbourhood, sports clubs, cultural organisations etc.  Safety and cleanliness of housing & schools Freedom from toxic materials and pollutants (air, water) Safety of environment	Availability and accessibility Coordination

## KNOWLEDGE, ABILITY, ATTITUDES

Based on the data from the previous section, and taking into account the specific nature of the French educational system<sup>12</sup>, (though we cannot claim to have exhausted the subject), we can classify the purposes of health education into three main areas:

- enabling acquisition of knowledge and skills, particularly those related to the body and health and enabling students to express themselves in ways that use values, laws and scientific knowledge;
- contributing to learning life skills (personal, social and civic skills);
- helping students to develop resistance to pressures from their surroundings (stereotypes, media and peer pressure) and providing them with the ability to identify local sources of support and resources.

12. Based on the French common core of knowledge and skills (2006).



The activities of health education are often limited to the first type. Nutritional education is one example. The school curriculum, which is often highly pedagogically sound, enables students to gain knowledge and skills about a balanced diet. This, while necessary, could be complemented by (1) work on self-image, body perception and self-confidence, and (2) activities that aim to provide a critical look at (for example) media stereotypes of extreme thinness and food advertising. **Table III** contains a summary of the various points that need attention and that could be considered as part of a programme to create a nutrition curriculum.

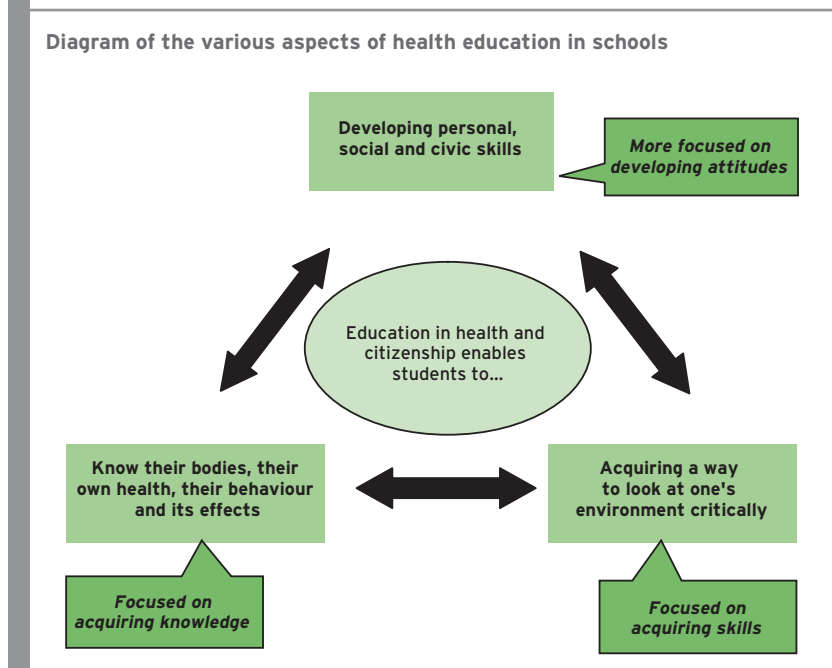
**TABLE III**

This table provides some specific points that can be included when creating a nutrition education programme in schools [12].

Items for attention	Questions
The role of schools	How does the nutrition education programme take into account the specific requirements of schools, and in particular the need to bring together education within the family and education within the school? What precautions are taken to ensure that the content of lessons is connected with "living together"? How does the content reflect the ethical issues inherent to education of this type?
The purposes of school-based education	How does the programme bring together the purpose of education in schools (self-determination for individuals, education for citizens) with the aims of public health? How does the programme develop the ability to make free and responsible choices?
Consideration of various aspects of nutrition education	How does the programme bring together the development of: - knowledge and skills relating to nutrition; - personal skills (e.g. self-knowledge, self-confidence, respect for others, the ability to make choices); - knowledge of the social dimensions of nutrition and the skills required in order to achieve a critical awareness of stereotypes or the nature of the media?
The collective dynamic within the school	How does the programme mesh with the curriculum and the overall direction of the school? To what extent does it fit within the existing joint projects rather than constituting an "additional" part? How are the general life of the school and educational activities within it included in a view of health promotion? How is it formalised in contracts?
Contributions from various partners	How does the programme bring together the involvement of various partners, whether inside or outside the school? What role is really granted to teachers, who are the major constituent of the school's strength? How does the programme distance itself from a primarily biomedical approach and incorporate other aspects that teachers can approach? What role is really granted to staff in management, administrative, service, kitchen, reception, school organisation, health and social work roles? How are coherence and continuity ensured? Is this true of both primary and secondary education?
Training and support	How are those involved trained and supported? Who provides technical advice, support and expertise?

In other words, providing health education involves enabling the student to develop the ability to act, choose and decide autonomously and responsibly, and the skills to confront reality and cope with conflict. Health education is therefore not peripheral; rather, it is at the heart of what schools do [figures 1 and 2]. With reference to the French common core of knowledge, it is possible to give more details of the knowledge and skills that correspond to these three areas.

FIGURE 1



## HEALTH EDUCATION: CLASS-BASED ACTIVITIES IN PRIMARY AND SECONDARY SCHOOLS

The common core of knowledge and skills (decree no. 2006-830 dated 11 July 2006) provides a general framework. Details of the corresponding knowledge and skills are given in curricula. Health education does not appear as a separate discipline. However, the primary and secondary school curriculum includes knowledge and skills that contribute to students' health education in several areas<sup>13</sup>: for example languages, civics education, art, physical education, sciences...

Health education has an important role to play in nursery schools. In general, this takes three forms: the development of skills that are linked to autonomy, self-confidence, relationships with others, to acting appropriately, and to adjusting to "living together"; daily hygiene at school (going to the toilet, washing hands, having a snack); awareness of health issues (daily routine, diet, hygiene) which leads to the creation of a simple set of rules for living.

<sup>13</sup>. We use the word "area" which refers to broad fields of learning, rather than the word "subject", which refers to a more limited set of knowledge.

FIGURE 2

Knowledge and skills involved in health education, with reference to the common core of knowledge and skills

### IN THE CLASSROOM

Education in health and citizenship enables students to acquire skills, and to develop personal, social and civic skills and a critical view of their environments.

#### Developing personal, social and civic skills

##### Knowledge

- Knowing the rules of collective life

##### Skills

- Self-confidence, affirming oneself in a constructive way
- Being autonomous, knowing how to solve problems and make decisions
- Knowing how to manage risk
- Expressing and communicating emotions, knowing how to manage stress
- Developing verbal communication skills, learning to speak up
- Working together and exchanging ideas, knowing how to manage conflict

##### Attitudes

- Self-respect
- Respect for others (civility, tolerance, rejection of prejudices and stereotypes)
- Involvement in social life
- Willingness to resolve conflict peacefully
- Sense of responsibility to oneself and to others

#### Knowing one's body, one's own health, knowing about behaviour and its effects

##### Knowledge

- Knowing one's own body, how it works and what it needs
- Knowing what determines health: biologically, socially & culturally, environmentally, behaviourally
- Knowing about high-risk behaviour and its effects, particularly in addiction, sexuality, diet etc.
- Knowing recommended action to take in cases of significant risk and management of crisis situations

##### Skills

- Understanding the nature and validity of a piece of statistical data
- Knowing how to take care of oneself and of others: sleep, hygiene, eating habits, exercise, sexuality, safety in the home and on the road, first aid etc

#### Acquiring ways to look at one's environment critically

##### Skills

- Identifying, classifying, ordering, criticising information and gaining perspective on it, being able to distinguish knowledge from beliefs
- Awareness of the role and influence of prejudices and stereotypes generated by society and by the media, and knowing how to resist such pressure
- Knowing how to resist peer pressure
- Developing creative and critical thought processes, knowing how to form an opinion and being able to question it
- Identifying those individuals and institutions locally who will help in case of difficulty

### SCHOOL LIFE

Health education is a daily part of classroom activities across all subjects. It also requires ongoing attention and work on the school environment and the school climate.

Nursery schools are the main places in which, because of their teaching conditions and the attention paid to children's well-being, it is possible to provide truly holistic health education. This is an ongoing task, supporting children in situations that enable them to discover that they are individuals with identities, and in time to explain their own feelings, wishes, suffering, constraints and rules for collective life, which can be enriched by specific projects.

In primary school, health education activities can be implemented using a multi-disciplinary approach, which may include physiological aspects (linked with work done in biology on how the body works), self-knowledge (linked with language skills, and physical and artistic activities) and respect for oneself and for others (in all situations in daily life, or using a more specific approach). In secondary schools, an explicit role is given to health education as part of life sciences, physical education and sports, and in history, geography and civics education. For example in the latter discipline, education in safety and health education (dignity of the individual) are identified as part of the curriculum for those in the "cinquième" class (aged 12-13). In middle schools, road safety education is also a major challenge for teachers of history, geography and civics. Work on resisting discrimination and on solidarity requires consideration of health. In high schools (for those aged 15-18), classes on civics, legal and social education are forums in which health issues (e.g. cannabis, AIDS) often arise. Teachers have a variety of tools that enable them to carry out health-related activities. These are listed in the pedagogy library catalogue that can be found on the Inpes website<sup>14, 15</sup>.

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15. Those who wish to know more about this can refer to the main reference work (which contains an analysis tool that enables professionals to assess the quality of the tools they use or are considering): Lemonnier F, Bottéro J, Vincent I, Ferron C *Outils d'intervention en éducation pour la santé : critères de qualité* [Tools in health education: quality criteria]. Saint-Denis: INPES, coll. Référentiels, 2003: 76 p. Only the analysis tool is available for download. Online: <http://www.inpes.sante.fr/CFESBases/catalogue/pdf/883.pdf> [in French: retrieved on 08/01/2010]

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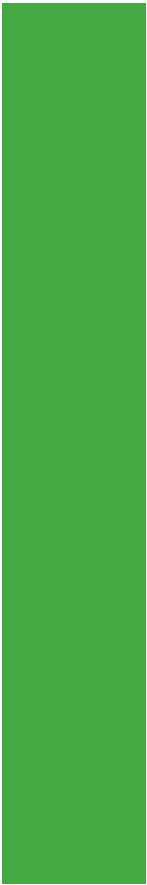
Having outlined the context in which teacher training in health education takes place, in the third part we shall approach the issue of how to implement this training. In this next part, only the most relevant issues that relate to the objectives of this book will be examined. More specifically, the various types of tension produced when training teachers in health education will be made explicit, and the reader will be offered some key methods for managing this tension. After outlining the general context in which teachers are trained in this area, five main points will be approached:

- the purpose of training, with reference to the reflective practitioner paradigm as described by authors such as Schön, Argyris and Perrenoud;
- the various dimensions of training, using the approach suggested by Caspar;
- the intended audience (i.e. teachers), using the “activity analysis” type of conceptual framework (Leplat, Goigoux);
- details of how training is organised, with contribution from the field of andragogy<sup>1</sup> (Knowles);
- concrete ways this can be implemented, with reference to the requirements of teacher training.

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1. Andragogy is “the art and science of helping adults learn”. The term was introduced in order to distinguish this discipline from child learning (pedagogy).

## **Implementing training**





# Teaching is a skill that can be learned

## CLASS-BASED AND WORK-BASED TRAINING

Teaching is a skill that can be learned.

Planning lessons and learning, leading a class and providing individually-tailored teaching, demanding effort and instilling confidence, awakening interest, evaluating skills and identifying talent, providing guidance: all of this requires in-depth initial and continuing training. Nothing must be left to the vagaries of vocation or to chance.

None of this is easy. There is still a widely-held view that teaching is nothing but the expression of charisma, which one either has or doesn't have. If this were true, the only requirement of training would be that future teachers master their subject. The rest would fall to the art of teaching; learning the "tricks of the trade", which could be picked up by shadowing an experienced professional. If, as Antoine Prost notes, teaching is not a skill but an art, there is nothing to learn and watching other practitioners would be sufficient [1]. However, this simplistic vision is not borne out in reality. Providing someone with knowledge about hygiene and health does not make him or her into an educator who can lead students towards freedom and responsibility. It is certainly essential that teachers master the scientific knowledge without which rational choices are impossible, so that they can pass on this knowledge.

However, it is just as essential for them to be able to identify how students are most likely to learn.

Even this is not enough. Theoretical knowledge that is disconnected from practice is ineffective in professional training. Similarly, the situations students encounter in the workplace are only learning opportunities if they can be analysed using conceptual tools that are drawn from university-level research. It is this alternation (between university teaching and experience in schools) which means that training is truly professional.

Every society has a set of goals for education, regardless of whether or not this is made explicit. Society entrusts schools with a set of goals, and professionals' activity must be organised around these. In France these goals are self-determination for all individuals, and the ability to take one's place as a citizen, and these are at the heart of what schools do. These very general purposes must be made manifest in the daily work of everyone involved in education. For this reason, training for teachers cannot be limited to learning didactic and pedagogical techniques, at the expense of basic study of schools' aims and teachers' mission. In the area of health education, which affects us more directly, this involves continually questioning the ends as well as the means; the way in which teachers contribute to students' success, as well as how far they help students to take charge of their own health.

Finally, as we showed in the previous chapter, teaching as a profession is being redefined. R. Bourdoncle and L. Demailly stress that "today, educational establishments, and learning and training themselves, are experiencing a loss of stability, which is affecting both organisations and professional practices. Education and training are caught between a demand for rationalisation, a push towards professionalisation, consensus about their high priority within society, and conflicting uncertainties about their objectives" [2]. This background tension means that high-level training, which will enable teachers to face current and future challenges, is all the more necessary [box 1].

This chapter is therefore based on a series of premises: that teaching is a skill that can be learned; that the training needed in order to teach must unite subject knowledge with methods for conveying this knowledge to students. This should be valid for knowledge transmission and citizenship education, for high-level theoretical knowledge that is linked to research, and reflective work on day-to-day practices. We therefore adopt the view that training is the means by which teaching becomes more professionalised.

First, it is important to put current practices in perspective. In France, there is a "consecutive" model of teacher training: academic training first (bachelor's degree) followed by professional/workplace training (master's). In the majority of European countries, teachers receive subject-based academic teaching and professional pedagogy training during their bachelor's degree. "This 'simultaneous model', which gives a higher status to professional training, has been gaining ground over the last twenty years, particularly in the training of teachers in primary and lower secondary schools. Teaching in these

**BOX 1****The mission of the teacher according to the Ministerial order dated 19 December 2006 relating to specifications for teacher training**

Everything that is involved in being a teacher (learning, methods, and gaining students' attention) is the result of a rigorous and gradual learning process. Regardless of background and where they work, all teachers must somehow have developed the awareness that their work and position draw their meaning from the progress and results achieved by their students. Teaching in the national education service is a mission: a mission to instruct the young people who are entrusted to our schools, which involves mastery of all the necessary skills at the right level; a mission to provide education according to the values of the French Republic, which involves a precise knowledge of what these principles are, and the laws that encode these principles, and also demands exemplary behaviour when carrying out these tasks; a mission to help students find their place in society and in the workplace, which involves an ability to encourage students to be open to different cultures and a good knowledge of the economic and social environment in which the school operates.

age groups has a professional culture that is more oriented towards pedagogy. For these age groups, training usually lasts between three and four years, and professional training occupies more than 30% of total time spent on training. In upper secondary teaching, which historically has been more centred on knowledge transmission, training mainly takes place within universities, over 5 years, and the 'consecutive model', although not dominant, is present in many places. Professional training has a more reduced role, and occupies less than 30% of training time<sup>1</sup>. The way in which training is currently organised in France is not the only possible way, and it is appropriate to question the basis on which it is built.

**DIFFERENT APPROACHES TO TRAINING**

As Philippe Perrenoud reminds us, there is no reason to believe that a unified and valid theory of human behaviour, learning and educational interaction, from which an optimal teaching method can be generated, will be available any time soon. This does not mean that research into good practice, which can be validated using appropriate evaluation tools, is not useful, but it does mean we need to recognise that there are various ways to manage a class and regulate learning. Training must therefore bring students into contact with various practices, each of which should show that there is consistency between individuals, their way of doing their job, and a certain level of effectiveness. Professional training for teachers, in general and specifically in health education, can therefore not be limited to passing on an orthodox method.

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1. Quotation from N Mons in an article in *La Dépêche*, Thursday 5 June 2008.

Other dimensions should be explored, in particular the acquisition of processes that enable students to reflect and to cope with change. In any case, it should be noted that the problems of teaching are too diverse and changeable for us to hope to provide trainee teachers with a range of ready-made solutions [3]. As it is impossible to prepare teachers for all the situations they will encounter, the essentials must be sought, which will provide them with the means to acquire key skills. But what are the essentials? There are many ways of defining what is at the heart of teacher training. So that the basis for training is made explicit, we will follow G Ferry [4]<sup>2</sup>. This author distinguishes three types of teacher training:

- acquisition-centred training;
- process-centred training;
- analysis-centred training.

### Acquisition-centred model

In this model, it is first necessary to acquire the knowledge and ways of thinking that are specific to teaching, and also about child or adolescent development, adult psychology, group behaviour, learning processes and assessment. It is also necessary to acquire skills and expertise, using systematic practice or simulation sessions.

Practice is considered to be an application of theory. Content, methods and techniques are learned. Training is a preparation for professional activity. The design of training involves successive steps. This type of training consists of providing students or trainees with the tools they need to develop an approach to health education in the classroom or school. This can involve, for example, doing work during training sessions on project methodology, encouraging teachers to adopt tools that bring together the various phases of analysis, from needs assessment to evaluation. It is up to them subsequently to apply the methods they are given.

### Process-centred model

This involves a focus on the ability to mobilise and use all available resources to solve a problem, start a project or approach a new situation, using life experience, research skills and creativity. This model is based on the idea that it is unrealistic to expect trainee teachers to store in their minds all the knowledge and skills that they will need in the future. If this were the case, there would be no need to anticipate the specific problems of teaching practice. The first thing to do would be to ensure that teachers are able to confront these problems. Practical skills can be transferred from one area of practice to another, with no need for mediation via theory. This involves

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2. In the following exposition, we shall closely follow M Develay's analysis of G Ferry's position: Develay M. *Peut-on former les enseignants?* [Can teachers be trained?] Paris: ESF, 1996: 156 p.

seeing social experience through one's own journey, which provides the opportunity to create projects. Training is an opportunity to have such experiences. The design here involves detours. Training is based on the ability to adapt and use initiative which is thus acquired (this is what untrained teachers do). They learn using trial and error, by successive steps, each of which is an improvement on the last, which will gradually give rise to what might become their theory.

### Analysis-centred model

This last model is focused on the ability to observe and analyse situations. The premise is that there are no all-purpose leadership methods, that no two classes are the same, and that students' reactions are unpredictable. The ability to analyse and solve problems is developed using a wide range of methods: case studies, experience analysis, class observation, staff meetings, simulations and roleplays. There is a two-way relationship between theory and practice. At the heart of this type of training is the ability to analyse and to make explicit what is happening during the act of teaching. This involves learning how to look at one's own practice objectively. The main principle is observation of one's own practice, and putting this practice in perspective. Theory and practice interact, and there is an ongoing two-way process that regulates both. Implementing such a training method requires close co-operation between schools that take trainees and universities. For example, trainees should be given the opportunity to establish a health education plan in their placement school and should be provided, throughout the school year, with the time and tools they need to perform a reflective analysis of the work they have done.

Existing training methods do not use one approach to the exclusion of all the others. It is not necessary to choose between these various models; rather, it should be made clear on what basis a particular type of training is created, and we should be open to other models. The current trend towards a five-year training structure (bachelor's and master's degree) means that it is becoming possible to develop a longer form of professional training. It will then become possible to use more varied methods than the traditional knowledge-based approach.

These different approaches are subordinate to the goals that underly training, which it is now useful to clarify.

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# The purposes of training

Teachers can variously be considered to be professionals, workers, craftspeople or artists, and the way in which their work, status, knowledge and training is viewed will change accordingly. These “visions, however common they may be – and particularly if they are widely held – are not neutral: by naming them, we create reality” **[1]**. We now need to state how we view the teaching profession, so we can consider how training in health education should be designed. This will be done in two stages. First, we need to invoke the idea of professionalisation, and then the paradigm of the reflective practitioner.

## TRAINING WITH PROFESSIONALISM IN MIND

In both education and public health, the challenge of professionalising careers is recognised as crucial. This concept is very often invoked as a way of justifying change **[2]**, but the extent to which it is accepted varies widely<sup>1</sup>. As P Perrenoud points out (whose ideas we shall closely follow in this section) “professionalisation involves providing access to the ability to solve complex and varied problems using one’s own resources, with a set of general goals and an ethical framework, without being obliged to follow detailed procedures that are designed by others. This involves a greater degree of

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1. The difference could, for example, lie in the fact that a professional purpose is provided for training (if teaching is professionalised, this means that students can rapidly take their place in working life, because of the importance of placements and the fact that professionals contribute to training). Professionalisation is also invoked in areas in which an activity is performed only by professionals, in other words a well-defined group of people who hold specific diplomas and qualifications. In such cases, this is a corporatist approach. There are other meanings.

autonomy and responsibility than exists in an executive job.” [3] “This is a long-term view, a structural process, a slow transformation. It is a change that can be supported, but that cannot be effected unilaterally overnight by any government or company” [4].

Although this idea is present in many types of discourse on this subject, it is far from being subject to consensus in health education. Many still consider that the role of schools and teachers is to apply a set of instructions. According to this view, teachers are responsible for the execution of a particular programme, which is created by expert health professionals, and designed to prevent obesity or addiction. Pressure groups are pushing for implementation of a quota of hours on specific courses of lessons, which would be very narrowly prescribed. Philippe Perrenoud, adopting ideas originally described by Raymond Bourdoncle, proposes a way of explaining the process of professionalisation, based on the difference that exists between a profession and a trade. “All professions are trades, but the opposite is not true. The English language reserves the label ‘profession’ for a particular category of jobs, in which it is neither desirable nor possible to tell practitioners in detail how they should do their jobs and make their decisions<sup>2</sup>. The work of a professional in this sense is primarily governed by objectives (whether set by an employer or as part of a contract with a client) and a code of ethics (laid down by a professional association)<sup>3</sup>.” In other words, though the terms “trade” and “profession” are sometimes used as synonyms, their etymology and the way in which their respective meanings have changed over the years sheds light on the structural differences between them. It is useful to consider these differences when approaching the issues of health education training. The differences fall into two main categories: the type of knowledge involved, and the way in which the knowledge is acquired.

■ Trade:

- manual, technical or mechanical work that is based on an integrated body of knowledge;
- a skill that is acquired via experience or training (practice, repetition and routine).

■ Profession:

- an activity that calls upon scholarly knowledge. In particular, the humanistic professions (e.g. medicine, teaching) require the highest level of knowledge and an ability to abstract in order to identify the principles underlying the specific situation of each individual patient or student;
- an activity that is “professed”, in other words that is taught via oral

2. For example, a carpenter is described as having a “trade”, but a doctor has a “profession”.

3. We do not intend wholly to adopt this dichotomy, which creates a radical separation between jobs that are exclusively executive and those that are not. Autonomy, room for manoeuvre, an ability to consider one’s activity in response to a prescribed task: these are things that are necessary for all jobs.

explanation of knowledge and practices, which involves discursive rationalisation of action. This rationalisation is conveyed in written form, which means that knowledge can be capitalised on and distributed more widely [5].

Although it is not fully recognised as a profession, teaching does fall into this category. An education cannot be reduced to a few recipes that can be used blindly, which is all the more true when health is at stake. Many problematic situations are not at all amenable to a technical, rational “good practice” approach, which can be because the issue is not well-defined, or because there is a conflict of values, or because the situation is specific in nature [6]. Professionals must have the ability to adapt to new situations, organise their work, make decisions and to find relevant solutions to problems, even though they may not have these solutions immediately to hand. This does not mean starting from scratch and certainly does not mean that professionals’ work is entirely made up as they go along. On the contrary, professional practice is only possible for those who have mastered a wide range of skills. There is no need to reinvent the wheel, and professional practice uses theories, tested methods, precedent, experience, established forms, and the “state of the art”. There can be no profession if there is no formal knowledge base that can provide a direction for practice. This is one of the difficulties we face in health education. The large amount of work done by very many people, which reflects very different preoccupations, makes it difficult to create a corpus of reference materials. This is a key issue, and attempts are made to address it in the current book as well as in the study co-ordinated by R M Bantuelle and R Demeulemeester *Comportements à risque et santé : agir en milieu scolaire [High-risk behaviour and health: taking action in a school setting]*<sup>4</sup>. This is all the more urgent because many tools based on militant action and the goodwill of those involved have been shown to have little or no effectiveness. In-depth studies have shown the limitations of prevention and health education processes in the school setting [7].

These steps towards professionalisation, which increases teachers’ autonomy and responsibility, go beyond the acquisition of knowledge and an ability to reflect during and following practice. The aim is not only to acquire tools with a view to applying reflective practice; more important is the adoption of a truly reflective position. In this sense, professionalisation involves building a professional identity on the part of the individuals involved [box 1].

Consideration of training for teachers in health education involves making a fundamental choice. Either their autonomy is limited and more and more detailed prescriptions made (X hours on obesity in year Y, using Z method and ABC document), or they are trusted and their skills improved. The position taken in this book is, clearly, that we need to train people who are skilled

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4. This can be downloaded from: <http://www.inpes.sante.fr/CFESBases/catalogue/pdf/ComportRisque.pdf> [In French: retrieved on 07/01/2010].



enough to “know what they have to do”, to train “reflective practitioners”. This choice has consequences for the way in which we see the profession.

### **BOX 1**

#### **Professionalising individuals [5]**

Professional socialisation involves gradually building a professional identity for teachers, and is akin to “initiation” in the sense in which ethnologists use the word, or even “conversion” in the religious sense, which gives access to a new idea of the self. The greatest changes in the individual’s professional identity occur at the beginning of the training process. However, the informal process of adaptation continues throughout a teacher’s career.

## **TRAINING THAT ALLOWS ROOM FOR REFLEXIVITY**

### **Active reflection**

Health education cannot be limited to the application of predefined procedures. It is intended for human beings, which means that it needs to be adapted constantly. This must occur in real time, which is what Schön calls “reflection-in-action”. We can examine the example of a series of sex education classes. The teacher will have defined the skills he/she wishes to develop in the students, and will have prepared pedagogical tools that he/she assumes will be implemented. However, it will not be possible to predict all the students’ reactions, and the way they will engage with the proposed tasks. Each of the students is experiencing a development narrative which is specific to that student. The group will also react in a unique way in terms of its involvement, in what is said, in mutual trust between the members. The practitioner can respond spontaneously, changing strategies, theories or ways of setting out a problem on the fly, and inventing experiments to test how well the group has understood. “This is a way of exploring, building hypotheses and testing simultaneously, as we go along, and not using reference after the fact, or interrupting the flow of teaching.” [6]

The framework for our action is thus fixed: the task is to develop the scientific knowledge that can serve as a basis for health education practice (using e.g. what anthropology can teach us about health, what epidemiology can tell us about prevalence of various behaviours, and what psychology can say about the factors that are linked to high-risk behaviour) and to unite this rational approach with a reflective practice. Reference to the reflective practitioner is not a theory of training; rather, it is a “paradigm of integration and openness”. It says nothing about the content of the practitioner’s reflection, or how the reflection should be accomplished: this will depend on the specific context and professional field.

## Approaching the relationship between theory and practice [8]

This emphasis on reflective processes during training arose from the debate about the relationship between theory and practice. In particular, the traditional idea that training involves a top-down process from theory to practice, in which the latter is supposed to be a concrete application of the former, was challenged. For D.A. Shön, universities do not dedicate themselves to creating and transmitting fundamental knowledge generally. They are institutions that for the most part adopt a specific epistemology: a limited view of knowledge, made worse by a lack of selective attention to practical competence and the art of the professional [9]. For the author, professional skills cannot be built using a model drawn from applied science. Practice is no longer in a dependent relationship with theory. The two have an interactive relationship, in which the one feeds the other and vice versa [10, 11]. This is very relevant to teacher training. In the field of health education, it is clear that there is a need for constant adaptation, because of changes in the social and cultural characteristics of populations, in scientific knowledge on which educational content is based, and in pedagogical tools themselves. Reflective practice assumes that there is a constant two-way process involving practice and reflection, and is applicable to any rational action that is somewhat complex, and which requires anticipation, continual adjustment and (if failure occurs) repetition on the basis of an explanation that suggests a different strategy [4]. In addition, because health education is at the intersection of human, social and biomedical sciences, expertise from all these disciplines is required and there is a need for a real partnership [12]. This requires designing and creating new forms of identity, which means that there is an even greater need for reflection.

In addition, working with human beings on a subject that involves intimacy, emotions and cultural identity means that teachers need to consider their own narratives. Teachers must be capable of managing their own emotions while teaching, and of distancing themselves from personal matters in a workplace context in which they are required to act as professionals. “Teachers today are professionals who manage people, and like other such workers they must rapidly learn not to suppress or deny these aspects of humanity. They must learn to consider [emotions] as normal, to analyse them, talk about them, and to ask for help when they feel overwhelmed by a relationship that is too strong or a situation that is too complex.” [13]

Schools have a highly specific set of goals and values. This job is unavoidably technical in nature, and is based on a constantly shifting body of scientific knowledge and in which a set of validated and complex knowledge is needed. This knowledge must then be transposed into educational material, and we need to emphasise the moral, political and emotional dimensions of this field, which require ongoing reflection on practice. In this context, teaching activity cannot just involve transmission of knowledge, but requires reflective practice

that is based on an analysis of “past, present, future and conditional” teaching experience [14]. This must be accompanied by a process of structuring and transforming one’s own perception and knowledge. This requires teachers to become aware of and manage their own professional development, using a process of rational thought, within a framework of explicit educational values. This is not just a reflection about action, but it is a true reflection on action within a framework that is “methodical, regulated, codified, dispassionate and effective” [15], and which is acquired using a continual and deliberate process. The aim is not just to be able to cope with unplanned or spontaneously-arising situations, but to be able to regulate one’s own actions according to pedagogical objectives, predetermined goals and a coherent set of values, which are based on professional practice but also on the goals of the education system as a whole, and on the specific purposes of health education.

Subsequently, reflective work will lead practitioners to distance themselves from the situation and to achieve perspective on their own systems of representation [16]. This externalised view means that a link can be created between a body of theoretical knowledge and professional experience. Reflection then consists of finding and formalising the common features in professional action and pedagogical experience, taking into account the specific nature of the context. This formalisation is part of the process of building a professional body of knowledge, for teaching in this instance. It becomes possible to improve practice on the basis of analysis of this practice, and to move towards consideration of other possible practices. This process is a way of questioning pedagogical practices after the fact, based on changes in scientific knowledge, stated objectives, the strategies used and the intended audience.

A two-way process of reflection thus contributes to professional development, going beyond questions of “how things should be done”. It leads to a consideration of the most fundamental ethical and political issues, and also of emotional issues, of meaning in relation to social demands and values, and of personal benefit and development. This “reflective” position provides a means of gaining perspective on action (by using frameworks that are specific to teaching, and those of the individuals themselves).

We should therefore be considering our training methods in the broad context of building a professional identity for teachers. This does not simply involve relying on “professional practice modules” or “modules to support newly qualified teachers”; rather, it promotes a general approach to training. Once more, the issues raised by training in health education are indicative of a broader issue.

As an illustration, we provide a table to be used in analysis of the ethical dimension of health education practices. A document (or an activity or module in isolation) cannot give rise to a reflective process among students; at most, it

can contribute to the development of such a process. Our experience has shown that an ethics-based approach is among the most productive ways, particularly in continuing training, of working on “reflection-in-action”. The aim is to ask questions about the ethical basis for actions carried out (or to be carried out) in lessons, using appropriate tools **[box 2]** in a two-way process involving the school and the university.

This type of table can help teachers to rethink their practice, and can also start a dialogue between different types of professional, which will lead them to make clear their different points of view on the same situation. The collective dimension of this activity is one of the key aspects of a project that aims to create a common culture for those involved in health education in a school setting.

## BOX 2

**Example of document used in continuing training. This is a resource to be used in analysis of the ethical dimension of health education practices.**

### Case study table

This table is not exhaustive and is not effective in all situations; it is simply a tool that can be used by those involved in health education in schools. It can enable these professionals to structure their reflective process in order to evaluate past actions or make a decision in a particular situation. This involves adapting the table suggested by M J Thiel to the specific context of health education. **[17]**

#### 1 Ethical dilemma

- 1.1 Name those involved in the situation described (not omitting the main parties: the students) and state their relationships to one another (e.g. involved within the school, an external partner).
- 1.2 State the ethical dilemma: where does the ethical problem arise (knowing whether or not it is acceptable to deliver a certain message, use a certain method, approach a particularly intimate topic with students, weighing up the benefits and risks of implementing a health education programme in a school setting)? Where does the difficulty emerge? Sort and organise the various questions that arise.

#### 2 Analysis of action

- 2.1 Circumstances: time, place, context. Ask questions: where, when, how, why did this situation arise?
- 2.2 Intention: what was the intention of the primary agent (single person or group, school professional, partner, family)? Was there an explicit purpose, or is there an implicit goal, a meaning of which the agent is not explicitly aware but which may nevertheless be motivating the agent's action? What are the expressed and (if applicable) unexpressed motivations? Have the consequences been planned for or considered?



2.3 The issues: what is at stake for each person involved and for their respective institutions?

This is particularly relevant for the education system on a school level, but also regionally and nationally.

2.4 The action itself: what is the purpose of the action? What resources were used or intended to be used? Are these ordinary resources in the school, or should they be described as unusual?

The techniques used in health education (information for the general public, strategies aimed at changing behaviour) are not without side-effects. What are the risks and benefits of the technique(s) used in health education action? How do these operate in this particular case?

2.5 Standards, values, principles: what are the principles governing this action? What are the primary agent's ethical standards and moral values? What has the highest priority for this agent? Try to establish, for each individual involved in the health education action, a scale of values, ranked from most desirable to least desirable. This scale of values may differ, depending on the position of one or more of those involved with respect to the project. Do teachers, headteachers, partners from associations, doctors and nurses working in the education system have the same priorities? Are these principles, standards and values compatible? At this stage, it can be useful to work on the texts that govern health education at the national level [18-20]. This involves looking for consistency between the principles governing action and those that are specific to a school context.<sup>1</sup>

2.6 Decision: have we approached the problem of how useful the health education action and the methods used are? Have there been conversations about it, who was involved, and was everyone able to express themselves in this conversation?

2.7 Consequences of this action: if the action has taken place, what were the direct and indirect consequences over the short, medium and long term? What were the effects on all those involved? How was the issue of evaluation dealt with? Action involves a set of (potentially) contradictory consequences. Try to discern and evaluate the humanising effects and dehumanising consequences of the action.

2.8 What is your overall view of this action? What are the decisive factors?

### 3 Ethical assessment of the decision

3.1 Overall assessment: if this is a past action, does it seem to you ethically right or wrong that the decision was made to carry out this health education action, or to change the methods used? Why? If the action has not yet taken place, what is your view?

3.2 Other "possible ways of acting": consider other possible solutions, taking into account their respective ethical consequences.

3.3 What should be taken away and used in practice from this case study?

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<sup>1</sup>. See the section on "Health education in the school setting" p. 47.

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# Training is not limited to pedagogy

Now that we have stated the general framework for training teachers in health education, we will now suggest how to approach implementation of this training. At this stage, this involves explaining its various dimensions. Among the various possibilities, we have chosen to start with the functions of training, with the aim of explaining the political, technical and pedagogical issues, and the issues surrounding support for adult learners. Pierre Caspar identifies four complementary functions **[1]**: political, technical, pedagogical and advisory<sup>1</sup>. This way of dividing up the territory is certainly arguable, but we consider that it is potentially useful in a broad consideration of the issues. It is only possible to implement a programme of training in health education if the various dimensions of training are understood, and if we do not limit ourselves to the technical aspect.

## POLITICAL FUNCTION

The political function is provided via the Ministry of Education (e.g. framework texts, management) and by training and supervision bodies (e.g. training plans, training for trainers). In the field of health education, this function encompasses assessment of to what extent needs are met by current training offers (reflection about training needs, consideration of how far changes in the skills required of those involved in school health education are reflected in the available training), operational decisions about political

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1. We prefer the term "support".

choices (translating overall directions into training objectives) and resource management (management of teams, training of trainers, budget management). There are multiple political issues. Coherence and meaning are the most difficult to address. There are multiple priorities, and this leads either to an accumulation of training modules, or to health education being overlooked completely. Creating training policies that are centred on educational activity and a holistic view of the child remains a very difficult task, given the traditional emphasis on knowledge and subjects in the French educational system. There is a second challenge, which is linked to the development of a truly multi-institution and multi-category training policy on various levels (from local to national). Finally, a training policy can only exist if it is supported by a supply of trainers (e.g. university teachers, teachers who train teachers, educational advisers) and if these trainers are themselves trained and supported according to an appropriate strategy. Such strategies are complex to implement, as they require anticipation of needs and long-term support for high-level initial and continuing training (master's or doctoral level). This is the third major challenge.

## **TECHNICAL FUNCTION**

This covers everything involved in creating training: design, planning, management, leadership, evaluation of training tools and activities. In our field, this differs widely between training institutions and between categories of professional. However, there are two areas of convergence. There is a general movement towards professionalism in training, which has led those in charge to create common tools. Given that there are still not many universities which provide health education training to training managers, some training and evaluation methods are common at a national level.

When creating training, the main challenge is the skill level of those responsible for the training. The most important thing is to remember that training organisers are not created overnight. Someone who has professional expertise in health education (as an experienced teacher, an advisory nurse or doctor, a prevention professional) does not necessarily have what it takes to create training programmes. This ability is a skill which can be learned via placements and university courses that teach training of adults. There are two issues for our particular training system: first, a growing number of health education specialists need to be trained in how to create training programmes; second, those in positions of responsibility need to be offered training in health education. The issue of training for training creators, and for trainers, is highly relevant today. Political activity to raise awareness (or lobby) among universities about the issues surrounding health education is unlikely to have any tangible effect if there are no internal resources in the form of training managers and trainers.



## “PEDAGOGICAL” FUNCTION

The objective of training is to enable those involved to develop the skills they need to be able to implement health-related educational projects. As has already been indicated, health education cannot have as its sole purpose the transmission of a fixed body of knowledge and intangible rules. Neither can it be an effort to transform behaviour definitively (which would be a form of conditioning). Education is considered to be a mean by which attitudes and skills are developed; its aim is to enable the student to be self-determining, and to learn freedom that is based on autonomy, critical reasoning and creativity. It also allows space to consider students’ own ideas about their bodies, well-being, fears and health. With this in mind, training for those involved cannot be limited to providing trainees with information which they will, in turn, impart to their students. They need to be enabled to construct their own identities as educators. In the previous section we placed great emphasis on the challenges connected with establishing training, given the complexity of the subject. We shall not go over that again here.

Philippe Meirieu defines a pedagogue “as an educator who sees his goal as allowing the people for whom he is responsible to achieve self-determination, and gradually to form their ability to decide for themselves what their own story is to be. The educator is able to achieve this via the mediation of a specific body of learning” [2]. A trainer of adults, whose purpose is to convey professional skills, also has the goal of imparting autonomy via the mediation of a specific body of learning. Training for teachers is primarily training of adults, and the specific requirements of adult learners cannot be avoided. Training should be structured accordingly. Trainees’ experience must be called upon; the trainer is primarily a facilitator who supports adults who wish to acquire or refine knowledge, skills and attitudes for professional purposes. This requires maturity, and autonomy in the student’s relationship to the knowledge, learning and skills that are the component parts of the teacher’s professional identity. The challenge is to support adults in a training process which is adapted to their needs. The students should be described as adult learners, as “being adult” is more the result of a process than a fixed condition. At different times in their personal and working lives, their relationships with experience, time, social roles and the role of training in their careers may all vary greatly. In the following chapters, we will examine these issues in more depth. Other pedagogical questions arise: for example, how far courses should be personalised, and consideration of the experience and motivation of those involved.

## SUPPORT FUNCTION

This is not the provision of expertise with the sole aim of ensuring that teachers “reach the standards”; rather, it is a way of listening to those involved, of considering their needs and eliciting what they require by way of support.

P Caspar stresses “that this involves an entirely new intellectual and emotional stance in relation to others: a ‘clinical’ position that is very different from traditional relationships between trainers and trainees”. In the field of health education, support in training is all the more important because the subject brings into question the usual ways in which those involved think about their allotted tasks. There is a real risk of destabilisation<sup>2</sup>. Other challenges are how to create tools that account for adult learners with all their specific needs and characteristics, and how to enable the emergence of trainers who are able to support these trainees. This question will be examined in more depth in the fifth chapter of this part of the book. This rapid analysis of the various functions of training leads to an appreciation of the importance of reflection and action in all four areas at once. Nationally, as well as regionally and at a university level, health education will only be included in teacher training in the long term if the issues are clarified and if these various functions are addressed. Now that the various functions of health education training are clear, the practice of including a module of just a few hours within a training programme (as often happens currently) is untenable. If we are to make progress on this issue, we must rethink the institutional and political framework, the human resources implications, as well as approaches to training and the tools used.

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2. See for example Jourdan D., Stirling J., Mannix Mc Namara P. and Pommier J. (2011) The influence of professional factors in determining primary school teachers' commitment to health promotion *Health Promot Int.* 2011 Jan. 4. <http://heapro.oxfordjournals.org/content/early/2011/01/04/heapro.daq076.abstract>

# Factors conditioning teachers' practices in health education

As we previously stated, making progress on the issue of training in health education involves accepting schools, the teaching profession and teachers as they are at the moment, and to consider that what we do is a way of supporting this current position. In order to achieve this, we need more than just a willingness to proceed. In the first section, we painted a broad picture of the context in which schools and teachers operate. Next, we need to achieve a better understanding of what teachers do in health education. We need to go beyond reference to implementation of Health promotion programmes, and move towards consideration of teachers as participants in their own right. These teachers are professionals whose actions can be studied, using (for example) the conceptual framework provided by occupational psychology<sup>1</sup>. Analysis of these actions, and the factors that determine them, can serve as a basis for a new process of reflection on training. Theory functions as a way of interpreting experience. It does not enable everything to be predicted and controlled, but it does at least help to explain the basis for actions, to give meaning, and provide interpretative hypotheses.

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1. We shall adopt the stance of occupational psychology, and will use R Goigoux' model for analysing the actions of teachers. We will make close reference to this author's work in our text (R Goigoux, Un modèle d'analyse de l'activité des enseignants [A model for the analysis of teaching activity]. *Éducation et didactique*, 2007, vol. 1, no. 3: p. 47-70). Online: <http://education-et-didactique.bretagne.iufm.fr/IMG/pdf/goigoux.pdf> [in French. Retrieved 08/01/2010]

## TEACHERS DO NOT JUST IMPLEMENT THE CURRICULUM

Any job, including teaching, has four components [1]:

- taking positions and carrying out tasks;
- processing information and “communicating” with the subject, either directly or via intermediaries;
- regulating complex processes which arise from interactions between the parts of a system, with workers being among these parts;
- it brings into play those thought processes that govern the above activities; it involves deploying strategies and representations.

In the health education field, as in all other fields, teachers' activities do not simply consist of implementing government circulars or curriculum, or directly applying predefined protocols. The factors that determine this type of education are much more complex. Activities depend on factors that can be institutional (requirements of curriculum, the school's goals, circulars) but also personal (teachers' own representations of their task in health education, personal narratives) or connected to the intended audience (students and their needs and expectations). This all takes place in a specific context (working conditions).

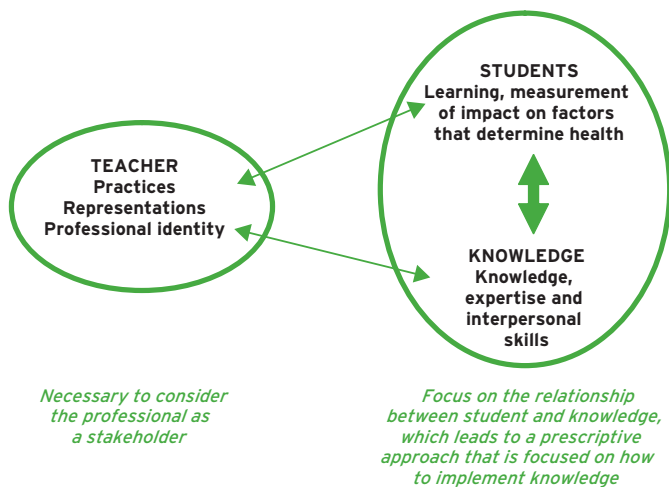
## TRAINING IS NOT LIMITED TO PRESCRIPTION OF GOOD PRACTICE

Since professional activity is governed by many different factors, understanding it involves understanding the inherent contradictions of the teaching profession, between students' learning needs and the demands of doing the job, if a truly appropriate type of training can be offered. Teachers, like all professionals, are not robots performing a prescribed series of actions, but are subject to a set of constraints on their actions, and from these constraints emerges a way of performing professional activities. From nursery schools to high schools, “teachers make multiple decisions for which there are many reasons other than promoting students' learning: for example, in order to remain in the students' favour, in order that students are not ‘set up to fail’, in order to maintain a good atmosphere in class, in order to keep up their own motivation levels, or in order to conserve their energy. All teachers have to feel good enough in class in order to ‘get through’ each day and ‘last’ throughout a career”. They seek a balance between two ways of regulating their activity: the knowledge they teach (knowledge, personal skills and expertise) and how they lead the class (social regulation of conversation and behaviour). It is clear that the second type of factor can rapidly overwhelm the first when working conditions deteriorate: the greater the difficulties with students, the more teachers' decisions are focused on “keeping the class alive”, in other words orderly and working, which is sometimes at the expense of learning [2].

The fact that our field (health education) is on the margins of teachers' activity means that it is all the more important to take this type of tension into account. This means developing the skills of those involved, and not simply prescribing good practices in the hope that these will be implemented in the classroom [figure 1]. Any training needs to unite health education with the other aspects of the job.

**FIGURE 1**

Training for teachers in health education cannot be limited to just prescribing good practice in the hope that these will be implemented. Teachers must be considered as individuals who "bring together" all the dimensions of their professional practice.

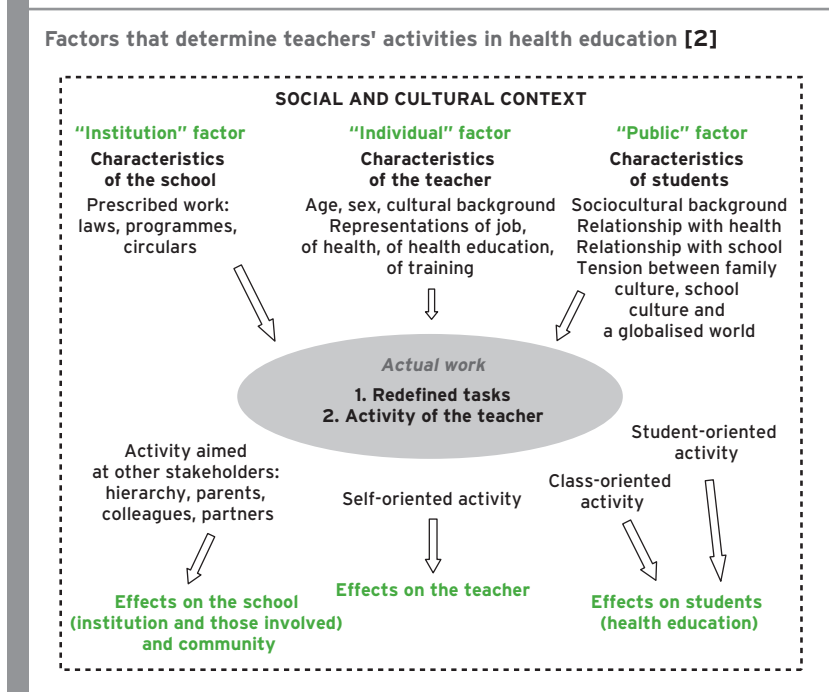


## THE RELATIVE IMPORTANCE OF VARIOUS TYPES OF FACTOR IN DETERMINING TEACHING ACTIVITY

As stated above, many factors determine what teachers do. The relative importance of these different factors varies depending on the specific type of activity involved. The institutional factors have a significant role when for example primary teachers are being trained to teach reading: teaching children how to read is at the heart of these professionals' work, and is governed by a highly prescriptive set of texts. However, it is still true that other factors (both personal and public) play an important role here. Health education is different, as it is not a "subject" in the traditional sense.

We shall look at the characteristics of schools as institutions and as social contexts in which teachers work, and the characteristics of students (the way in which they learn and their relationship with learning and school, their skills, individual and collective behaviour) and the characteristics of teachers (purposes and objectives, knowledge and expertise, ways of seeing, values and beliefs, experience and training) in relation to the specific area of health education [figure 2].

**FIGURE 2**



### Institutional factors

The first thing to do is to identify the nature of what is being prescribed in schools. Prescribed work is everything that is defined in advance by the school and that is provided to teachers to help them to design, organise and carry out their work. These are: the teaching programmes and curricula that define in advance the expectations the school has of its teachers; evaluation of teachers' work by inspectors, done while they are working but which does carry an added burden because of the anticipation of the inspection; and evaluation of students' performance, which defines what is expected in future, as a result of teachers' professional activity. As an example: regional educational inspectors for biology routinely look at education in health, the environment and sustainable development during inspections. This means that teachers have to think about their contribution in this area, and need to be able to explain what this contribution is, before the inspectors arrive. In health education, even though there is prescribed material (curricula, the common base of knowledge and skills, circulars<sup>2</sup>), these do not have a significant impact on practice, as practice is entangled in a great many other

2. The institutional texts are described and analysed in the first part of this book ("Teacher training in health education: context").

priorities which, until the teaching profession is further redefined, cannot result in practice that is common to all teachers. Similarly, the programmes drawn up by the school or by CESC, which are also prescriptive (on a school level), only have a limited effect on teaching practice. This general approach would benefit from more nuanced examination, as health issues have an important role to play in some contexts and subjects in middle schools (particularly technical, medical and social sciences (STMS), social and work life (VSP), life and earth sciences (SVT), physical education and sports (EPS)). In primary education, the most important tend to be those themes that are part of the prescribed programme (diet, road safety, hygiene). The fact that health education is explicitly included only in some subjects can be an impediment to the idea of health education as part of an individual's overall education (as opposed to a body of knowledge that needs to be provided).

### Personal factors

As many studies have shown [3], personal factors play a central role in teachers' health education activities. It would not be accurate to say that health education in schools falls to a few militant souls, but it is clear that the teacher's narrative and values are central. A study [4] involving interviews with 207 teachers from five middle schools shows that 55% of professionals consider that their own conviction and personal commitment is the primary factor: "We have to build something with them [the students], we can't limit our work to just subject knowledge, we have to listen to the students." Institutional factors are the most important for less than a third of professionals, and these were primarily managers, counsellors and medical and social work professionals. Another study [5], which was focused on prevention of addictive behaviour, attempted to identify how professionals working in high schools see this complex field, which is subject to significant social pressure, which has strong moral connotations and which involves the most intimate parts of people's lives. The results showed that, although none of the professionals questioned believed that prevention should not be addressed in high schools, there was a great deal of variation in levels of involvement. Personal factors also have a central role to play: smokers vs. non-smokers, individual representations of addictive behaviour, attitudes towards the illicit and to prevention, as well as the perception that members of the educational community have of the goals of schools in general.

### Factors linked to the public

Public factors (students' circumstances and needs, social situation) have a modest role to play in professionals' levels of commitment. In the survey carried out in middle schools (mentioned above) these are only a primary concern for 4% of professionals. These factors are mentioned by many teachers, however, particularly those working in difficult social situations. This brief analysis reinforces the view that many factors determine teachers' activity in the field of health education.

## PURPOSES OF TEACHERS' HEALTH EDUCATION ACTIVITIES

Activities are steered in several directions at once, which is why they are described as having multiple purposes [6]. Like R Goigoux [2], we distinguish four main targets for such activity:

- students: teachers aim to help students to learn about health (in the form of knowledge, abilities or interpersonal skills);
- classes: teachers aim to support the class collectively as a social group; this group has a relationship with the teacher, the rules of which are not defined in advance and not definitively established. Teachers seek to remain in control of the group, without losing sight of individual students. They make an effort to gain control over the intellectual and interpersonal dynamic of the class as a whole, for whose development they are responsible;
- others involved in school life: teachers devote part of their resources to ensuring that others can understand (and value) their professional activity. Teachers' activity has to be incorporated with that of others: parents, the school hierarchy, the teachers who taught these students in previous years and those who will teach them next, other teachers who teach in this area, and various other educational partners. To realise what is at stake here, one only has to think about the factors that determine a primary teacher's activity in sex education. In this type of activity, the school hierarchy and families play as much of a role as students' prior knowledge;
- teachers themselves: the activity of teaching has effects which can be physical (fatigue, effects on health) and psychological (fulfilment). Teachers' choices depend partly on the costs and benefits they can personally draw from the activity. These will depend on their own goals, examples of which are educational goals, values, professional pride, self-esteem, comfort, health, fitting in to the workplace, social recognition, and career progression.

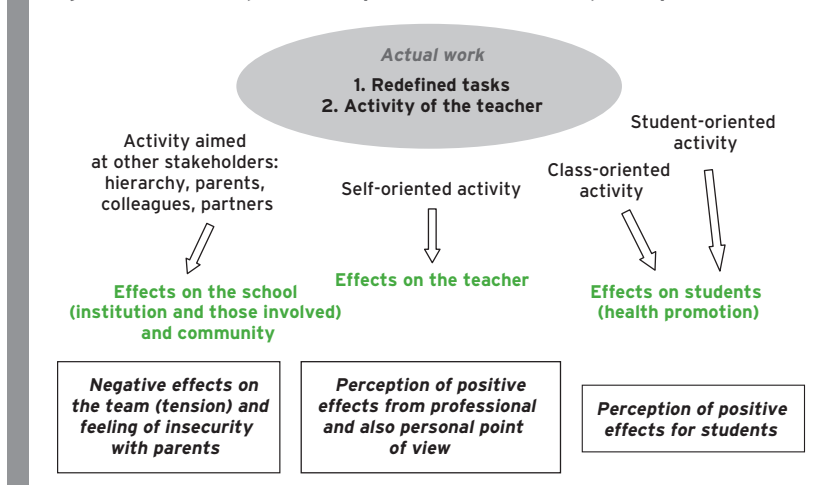
There is a risk that teachers' activity, and therefore their training too, will be considered only in reference to students' learning. These ideas have broader implications for how teachers' activities in health education are viewed, and more generally how this contributes to health promotion for students. The fact that teaching has multiple purposes leads to conflict: for example, between the many different prescribed activities and the need for a consistent teaching programme, between students' needs and social demand, between commitment and the risk of burnout, between the desire to act and the limitations of what can be done in the public sphere. Health education, if it is not conceived of as the transmission of ill-defined rules, can be an excellent way of drawing out and making explicit these tensions between potentially conflicting areas of teaching activity, and of exploring ways in which these tensions may be reduced. The challenge of defining the purpose of a professional's activity is usefully illustrated in the consequences



for professionals of involvement in health promotion programmes. In the literature, such intervention is rarely described as having negative consequences. The fact that there are such negative consequences should not necessarily lead us to judge this action harshly, or question its right to exist. The aim is to show that professional activity occurs within a complex context, and that it is governed by many factors other than students' learning. For example, we can consider implementation of a health promotion programme "Learning to live together" ("*Apprendre à mieux vivre ensemble*") in a large urban school [7]. An in-depth study involving interviews that were carried out one year after the start of the programme showed that professionals were committed (22 of 24 teachers were committed, and were implementing in substantial part the activities contained in the programme). This commitment, according to those who were interviewed, resulted from the fact that the programme largely coincided with their own goals and with the school's goals (24 of 24). They perceived that the programme had a positive impact on students and on the teachers themselves; in particular, they mentioned that they got a lot from it personally (12 of 24) and professionally (19 of 24). However, for 16 teachers, implementing the programme had a negative effect on the team (e.g. tension, ill-feeling, destabilisation, a feeling of insecurity in relations with parents). It was as though health education, just like health promotion, involves professional practices that are not consensus-based. Establishing a collective programme is therefore not without its tensions. In addition, the involvement of parents meant that parents developed particular expectations of the school, and this led to a feeling of insecurity among teachers [figure 3].

**FIGURE 3**

**Presentation of the impact of health promotion programme "Learning to live together better" as perceived by the 24 teachers in a primary school**



This quick analysis of the factors that determine teachers' activity in health education shows that there is a need to bring together all these different dimensions. For a training programme to be relevant, it must make these dimensions explicit and it must position professionals as participants in their own right, and not just as people who carry out prescribed tasks.

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# Tools for implementing training programmes

This final chapter provides practical suggestions for implementation of training programmes. We shall address the specific characteristics of training for adults, how to organise training sessions, support for teams... Although the suggestions will be well-known to many trainers, they are not universally known by the various other parties. As was the case in other sections of the book, the idea is not to provide formulae, but to offer resources that can clarify what is happening during training that offers an opportunity for individual or collective reflection. We shall therefore summarise some of the main aspects of andragogy, and then examine proposals that involve inclusion of health education in training plans.

## PROFESSIONAL TRAINING FOR ADULTS

### Adult learners

Initial and continuing training for teachers falls under the category of adult learning. Adults have specific learning requirements. They approach content, methods, trainers and peers as adults, in other words very differently from children and adolescents. In 1958, Malcolm Knowles introduced the term “andragogy” to describe training that is aimed at adults, in order to distinguish this from the teaching of children (pedagogy). Andragogy is “the art and science of helping adults learn” [1]. We shall use this framework, though we shall bear in mind the criticisms that have been made of this approach [2].

Work by social psychologists, from the mid-20th century onwards, has shown that being an adult is not a fixed state but a process [3], and that adults behave differently from children when they are in a learning situation. The trainer is not an instructor but a facilitator, who supports adults who wish to acquire or refine knowledge, skills or attitudes for use in a profession. Trainers aim to instil maturity, autonomy in students' relationships with learning, expertise and personal skills, all of which are part of teachers' professional identities. There are many ways of presenting the specific characteristics of adult learners, and of drawing conclusions as to how these should be reflected in training. Following the andragogy framework [4], we are putting forward four ideas. (1) Adults wish to be autonomous in their learning (they are not in a dependent situation, as children are). (2) They have rich experiences to draw on (both professionally and more broadly; as we have seen, the issue of health requires teachers to draw upon their own narratives). (3) For master's students and those in continuing training, the ability to put training into practice immediately, and the lasting value of learning, are important motivating factors. (4) Adult learning is affected by the adult's concept of time. We shall give details of these various aspects, starting from the principle that the success of training depends on allowing adults to learn in their own way and according to their own needs.

### Adults want to be autonomous when they learn

Autonomy is the primary characteristic of adult life. Adults know themselves and feel in control of their own plans and decisions. Adults have a profound need to be seen, and treated by others, as individuals who are capable of managing their own affairs. Autonomy is particularly important for adults since this is an attribute that is valued by a society in which freedom and independence are unquestionably good things. However, when adults find themselves in a training situation, old representations they may have of dependent behaviour may rear their heads, and in such cases trainees may demand: "Teach me!". If the trainer responds directly to this demand, which is influenced by the education the trainees received as children, the adult trainees will rapidly find themselves involved in a conflict between the intellectual model (the learner is a dependent being) and adults' profound need to manage their own affairs. This conflict explains many cases in which adults withdraw from continuing training programmes. The trainer's role is to take note of adults' desire for autonomy, and to help adults to emerge from the dependence stage and move into the role of autonomous learners. The following are useful ways of incorporating this significant characteristic of adult life into a training situation:

- involving adults as far as possible in the preparation of an activity, so that they can have their say about their needs and objectives and about the schedule and methods used in the training. The extent to which such participation is possible may vary, depending on the nature of institutional requirements and the context in which training is happening. In such cases,

there should be negotiation with the adult learners, showing them the utility of the non-negotiable aspects (which result from institutional requirements). One way of getting participants involved is to inform them in concrete terms about what will happen;

- the adult learners can then amend the schedule, with the consent of all participants. It can happen that an unforeseen event will require a change to the previously agreed schedule;
- as far as possible, participants should be able to express their experiences and opinions of the subject being examined. This attitude means that adult learners can take a personal view on the subject, and can also learn to cope with positions that are different from their own. Their experience is therefore used to its full, and also put in perspective.

### Adults have rich experiences to draw upon

Adults come to training with more extensive and complex experience than children or young people. The richness and diversity of experience in a group of adults means that differences between individuals are greater than in a group of children. Experience structures mental representations, and therefore determines how individuals view their own professional activity. Some opinions are viewed as tried and tested, and adults are not easily persuaded to question them. Training is one place in which adults can test the limitations of their own frames of reference and start a process of change. Trainers are more likely to achieve success in training if they take into account the experience of their adult participants. They can do this in the following ways:

- by eliciting participants' experiences in the initial stages of the activity. By doing this, trainers can obtain useful information about participants' current level of knowledge and their level of hesitation or interest when faced with this objective;
- by inviting participants to explore their experiences: this phase is very important, as it enables the adult learners to gain some perspective on their own experiences, while stressing that these experiences are of value. Trainers provide tools (for example tables) that enable adult learners to understand the strengths and limitations of their own experiences. This process enables participants to consider themselves a resources and sources of learning. Trainers therefore no longer have exclusive control over learning, and invite participants to consider their own experience as a learning resource. Such an attitude not only encourages a positive self-image among learners, but displays a basic respect for their autonomy. Consideration of participants' experiences will change their relationship with learning. Adults' experiences can be considered as learning situations. This can be described as "experiential learning". Ensuring that the experiences of adult learners in the area of health education are taken into account means that learners can incorporate their new knowledge into what they already know. Any

activity involving adults should include time for reflection, in which adult learners are invited to consider what they have learned from their prior experience.

### Direction and utility of learning are important motivating factors

There is a change in time perspective as people mature – from future application of knowledge to immediacy of application. Thus an adult is more problem-centered than subject-centered in learning. Adults direct their learning with reference to a plan. They are ready to invest energy and time if they consider that this will help them to solve professional problems or progress in their careers. They will feel drawn to a proposed training course only in so far as the subject is connected with their current preoccupations. Although adults are sensitive to external motivations (salary, promotion, social image), they are still open to more inward motivation (which arises from the individual's basic choices: being trained in sex education, for example, may for some teachers be a response to a wish to serve the cause of sex equality or women's emancipation). Another example of internal motivation is the wish to increase personal job satisfaction, self-esteem and quality of life. A trainer of adults who wishes to take into account adults' desire for utility and stimulate their motivation would be wise to:

- explain how the subject approached in the training session can contribute to an individual's professional development;
- offer learning outcomes that are useful to professionals;
- ensure that each training session contains new material that adults can use. After each session, adults must be able to say that they have learned something new;
- the subject should be addressed using questions from learners, and tasks and roleplays for them to do, and not just using the trainer's own questions.

### Adult learning is affected by the adult's concept of time

Unlike children, who have little or no notion of time, adults are very aware that their time is limited. As a result, adults value time, in line with the norms of Western society, according to which speed is an indicator of quality. When adults attend a continuing training session, taking on the role of adult learner, they first experience a type of grief (for all they will not have the time to do because of the training session). They therefore expect to make best use of the time they devote to this training. Accounting for the time factor when leading an activity that involves adults can be done:

- by clearly determining before and/or when the training starts how long it will take and how much time the student will need to devote. It should also be made clear how the time will be spent and how it will be divided (schedule);

- activities should be suggested that enable participants to see rapidly how useful the content will be for them. If adults have to await the last session to see the utility of the training, their motivation will be reduced and they will participate less;
- sessions should not be overloaded;
- start and finish on time: this is part and parcel of respect for individuals, and the commitment made by all parties to this training.

These suggestions are not hard and fast rules; rather, they are reminders, which may help the trainer to design training courses and support materials. The suggestions can also be used as a basis for collaborative work between trainers. Conversations about these issues can give rise to deeper collective reflection about the intended audience, and can thus offer the possibility of thinking about training not as imparting a collection of lectures, but as a process of development that takes adult learners on a journey from where they are at present **[box 1]**.

### BOX 1

#### Training teachers in health education [5]

Training teachers in health education involves content and methods that are somewhat non-specific.

(1) The first task is to enable reflection about oneself, one's own relationship to health and health education, and one's role as a teacher. This involves leaving a situation in which one has a detached view of universally valid rational knowledge, and entering a situation of complete immersion in a dynamic that is potentially destabilising, because it allows broad scope for diversity in views about the body and about health. (2) For those being trained, the next task is to be able to analyse the data about the factors that determine health and to identify, from a psychological and sociological perspective, the various dimensions involved in choosing how to behave (particularly those that go beyond a simply rational approach). (3) It is also necessary to know the nature and meaning of high-risk behaviours, and the relationship that children and adolescents have with such behaviour (which will vary depending on, for example, learner age, specific representation of behaviours). Another objective of training is mastery of various approaches and techniques (4) in terms of lesson sequences: methods and resources for expressing representations and developing students' social skills (self-esteem, conflict management), with real involvement from learners; (5) and also in terms of planning, from a health education perspective (information given in isolation is of limited relevance); (6) and in terms of managing partnerships. It is difficult to conceive of a type of health education that could be limited to work done in a school setting; the need for the involvement of parents and other members of the educational community is inescapable. Moreover, teachers cannot be the only reference point for students' views on health (7). Finally, thought is needed about ethics in this context, both for the resources employed and for the intended purpose of the exercise. There is no evidence that is universally recognised. Work on health requires consideration of values and of individual and collective beliefs about health, within the secular context of the school system.

Other pedagogical challenges arise: how to personalise a series of lessons, how to take into account the experience of those involved, and the identity and social roles of the adult learners. We wish to stress that this consideration of individuals when designing training entails a particular type of ethical framework. As soon as participants in training are considered not as objects for training, but as subjects of training, trainers need to adhere to a certain set of rules. We will use the framework proposed by Inpes **[box 2]**.

## BOX 2

### Ethical principles for training in health education **[6]**

Trainers, in their dialogue with participants, should:

- adopt an attitude that promotes the development of those being trained, which means that they must:
  - take up a position of respect for others, and for their professional cultures and representations,
  - help all trainees to develop their ideas and to express themselves to the others in the group, using relevant questions and rephrasings,
  - help the group to make use of anything that is of interest and value, with the aim of helping the trainees to develop;
- favour educational attitudes that promote freedom of expression and individual reflection. For example, it is important to emphasise that there are no “right and wrong answers”;
- do not fall into the trap of giving fixed formulae, but endeavour to provide ways of analysing facts, understanding situations and create examples that stimulate reflection and steer students towards relevant responses.

## Organisation of training

As stated in the introduction to this section, we will not be addressing the issue of learning again here. We shall simply note that adults, like children, are “complete” beings; they do not move from a state of ignorance to a state of knowledge. They have models that help them explain reality and the way in which they operate, and these are organised and coherent. All learning processes are ways of reorganising the learner’s knowledge **[7]**.

Learning cannot be imposed by others; it is an activity carried out by the student or trainee. The primary criterion for judging the success of a training process is whether the students were put to work.



In order for training (in other words, a creative encounter between trainees and the subject in question) to take place, three conditions must be met. These three conditions determine the three phases of a training programme [4]:

- exposing presuppositions and expectations (the initial phase);
- taking a critical stance and an in-depth look at the issues raised (analytical phase);
- incorporating and interiorising what has been learned, within a new context (appropriation phase).

The boundaries between these phases may become blurred, particularly if trainees are taking part in a long training programme.

### Initial phase

Trainees, particularly those in continuing training, never come to training with a completely blank slate. As we have mentioned several times, health issues are closely enmeshed with participants' personal and work histories. These initial representations are the core material with which the knowledge acquired in training will interact. It is necessary to consider how these representations work for the trainer (in knowing where students are at present) and for the students (clarifying their own ideas of the problem, and showing them that there are other ways of seeing things). Our experience has shown that it is useless to hope to develop skills in students if there has been no prior work on the place of health and safety in schools, in order to "purge" preconceived ideas. As we have shown several times in this book, in this field students are reliant on representations that are based on their own narratives, and also on their fears. The issue of managing emergencies and reporting abuse will come up routinely. The planning phase will elicit these questions. The trainer can refer students to further training and/or provide some answers. It will then be possible to focus on the non-subject educational aspects. The process whereby personal and subjective meaning is attached "objectively" to the issue at hand is known as projection. This does not just involve knowing how much students and trainees know; they should also be enabled to express their own relationship with the issue at hand. Several techniques can be used during this phase, and can support learners in expressing themselves<sup>1</sup>. The important thing is not just to list what is expressed, but to show which issues are raised. The challenge is to define the problem accurately. This enables progression to the second stage: the analytical phase.

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1. In the Profédus tool, published by Inpes and Auvergne IUFM, these techniques are addressed in specific documents that give precise descriptions of how to use photo training, Régnier's abacus (known as "Colorvote" in English) etc., or they are presented as part of documents that describe the training modules. This does not mean that work needs to begin with "photo training" at the start of each module. For the trainer, the idea is to ensure that it is possible to "take people from where they are". <http://www.univ-bpclermont.fr/LABOS/paedi/spip.php?article193>

### Analytical phase

This phase consists of collecting and processing information. Knowledge is constructed and links are made. This assumes that the trainer has defined objectives in advance in terms of knowledge, expertise and interpersonal skills. Trainees must become involved with knowledge and must engage with it. Knowledge must be imparted, but conditions should be such that trainees are truly involved in the process. It is important to state that there is more than one way of organising activity, because of the various types and size of groups involved, the contexts in which training takes place (initial or continuing training) and the issues that are addressed. The forms of learning (individual, collective) and the methods used (lecture, literature search, worksheets) will also differ. There are no right or wrong methods. Lectures, for example, are often criticised, but are entirely appropriate in some contexts. The most important thing is unconnected with the form the training takes; it is whether the trainees are put to work.

### Appropriation phase

This phase is very important as it enables trainees to incorporate their reflections and discoveries into their experience. If this phase is missed, there is a risk that what is learned during the analytical phase will remain superficial. During the appropriation phase, the result of the previous phase (analysis, in which the trainee stands back from what has been learned) is absorbed and incorporated into individuals' professional identities. The objectives of this phase are (1) to encourage students and trainees to activate and reinvest the learning they have acquired, via a personal or collective process; (2) using the outcome of this process, to hold conversations with and between trainees; (3) to evaluate the knowledge that has been acquired. These outcomes can be of several types; for example, a document may be written, such as a class activity, or a school-level project.

These ways of reflecting on the work done during training should become embodied in practice, within a variety of training contexts for a variety of audiences, involving a variety of personalities among trainers. This way of representing the situation is still a caricature. For readers who are approaching this on their own, and for groups who wish to go into this issue in greater depth, there are many references in the bibliography at the end of the chapter which provide more information. To illustrate this idea, we shall present three examples of tools that incorporate the various phases outlined in this chapter. These are designed to be used in master's-level modules. One is a partnership-based activity which, over the year, provides support for trainees, with a two-way process involving work in schools and analysis of practice. The second is a four-session module which is designed for primary teachers. The third involves trainees in history, geography and civics education. It describes a session that is focused on the role the history, geography and civics teacher plays in health education (in class and within the school) **[tables I, II and III]**.

**TABLE 1**

**Example of training module that is focused on partnership. This is designed for students who are studying to be primary teachers.**

<b>Partnership in health education: the example of implementation of multidisciplinary projects in physical education &amp; sports</b>		
<b>Intended audience</b>	<b>Note from the trainer</b>	
Masters students undergoing teacher training	<p><i>“Working in partnership primarily entails establishing a space in which exchanges can take place, which are focused on jointly defined objectives. The aim is not to establish a competitive relationship, or a sub-contracting relationship, but a complementary relationship.”</i></p>	
<b>Duration</b>		
3 one-day sessions (or 6 half days) plus one project presentation at the end of the year		
<b>Place within training plan</b>		
Training module linked to students’ multidisciplinary projects or supporting school placements		
<b>Organisation</b>		
30 students per group		
<b>Advantages</b>		
<p>This training module is useful in three ways:</p> <ul style="list-style-type: none"> <li>• It prepares teachers to work in partnership, which is an essential part of the teaching profession. The idea is both to broaden the context in which a teacher takes part in collective work, and to try out this area of professional activity. Working on one’s ability to build connections and take part in negotiations is by no means a neutral activity. It is important to realise that involvement in partnership working brings individual character into play and can be a source of destabilisation.</li> <li>• The existence of such a module symbolises the fact that joint working is an “integral part of the contract”, that partnership is not optional for teachers, and that it is essential in carrying out some aspects of the teaching profession.</li> <li>• It emphasises the fact that health education is the responsibility of teachers, and that it is not carried out in isolation. This requirement is linked to the status of health as a goal that is “shared” between families, schools, health and education stakeholders.</li> </ul>		
<b>Objectives</b>		
<p>The aims of this training are:</p> <ul style="list-style-type: none"> <li>• To enable students to approach partnership work: involving students, schools and partners, by defining a common project and implementing this out in schools.</li> <li>• To create an intermediate space between the training system (universities) and the educational system (schools).</li> <li>• To use a cross-disciplinary approach to health education, using a “red line”: a discipline (physical education and sports).</li> </ul>		
<b>Skills targeted</b>		
<b>With reference to the specifications</b>	<b>Institutional component ++</b>	
<ul style="list-style-type: none"> <li>• By working together with partners within or outside the institution, contribute to resolving specific difficulties that students have in the areas of health and high-risk behaviour.</li> <li>• Work together to carry out activities as part of a partnership between the establishment and its economic, cultural and social environment.</li> <li>• Be aware of the partners and interlocutors outside the school with whom they will need to work.</li> <li>• Take advantage of versatility in order to acquire a fundamental body of knowledge.</li> <li>• Implement multidisciplinary approaches.</li> <li>• Professional practice to be carried out with consideration of school life.</li> </ul>	<ul style="list-style-type: none"> <li>Become aware of the non-teaching aspects of the teaching profession.</li> <li>Identify the framework within which partnerships are established.</li> <li>Identify the school’s role in health education.</li> </ul>	
	<b>Personal component ++</b>	<ul style="list-style-type: none"> <li>Refine relationship to all aspects of the profession.</li> <li>Work on relationship to joint working.</li> </ul>
	<b>Public aspect</b>	
<b>Methods</b>		
<b>Trainers and other contributors</b>	<b>Training methods</b>	
<ul style="list-style-type: none"> <li>- University trainers</li> <li>- School principals</li> <li>- Local partners</li> </ul>	<ul style="list-style-type: none"> <li>- Theoretical knowledge</li> <li>- Leadership tools</li> <li>- Role-play</li> <li>- Tangible products (student projects)</li> </ul>	

TABLE I (end)

Description of sessions		
Sessions	Duration	Methods
No. 1	Half day (October)	<ul style="list-style-type: none"> <li>➤ Reception, presentation in pairs.</li> <li>➤ Presentation of training and objectives.</li> <li>➤ Work on students' perceptions of partnership work: (Q-sort® table<sup>1</sup>).</li> <li>➤ Use of Q-sort<sup>1</sup>.</li> <li>➤ Theoretical knowledge: Official bulletin and current regulatory texts about multidisciplinary projects. Concrete examples of multidisciplinary health education work linked with physical education &amp; sport, and starting points for work. Provide resource documents.</li> <li>➤ Considering team working:               <ul style="list-style-type: none"> <li>- Partnership: what is partnership? Definitions.</li> <li>- Approach to partnership working: (emergence of an idea, search for partners, meeting partners, making the partnership official, defining operations, carrying them out, finishing a joint project).</li> <li>- Possible partners: internal and/or external?</li> </ul> </li> <li>➤ Creating teams involving several students and determining the trainers who should be referred to, depending on the groups and themes being worked on.</li> </ul>
	Half day (October)	<p style="text-align: center;"><b>Physical education has a key role to play in health education</b></p> <ul style="list-style-type: none"> <li>➤ Health education: definitions, concepts, objectives, methods etc.</li> <li>➤ Presentation of expected objectives and skills in physical education and sports in primary education.</li> <li>➤ Presentation of pedagogical resources.</li> <li>➤ Presentation of partners.</li> <li>➤ Launch of inter-session work.</li> </ul>
<p>Inter-session work: students make contact with teachers in schools in order to understand the school context in which the interdisciplinary project is taking place</p>		
No. 2	1 day (November)	<p><b>Discussion between students and referring trainer concerning what to do</b></p> <ul style="list-style-type: none"> <li>➤ Choice of a theme for health education activity.</li> <li>➤ Students establish a project.</li> <li>➤ Identification of skills targeted in each discipline.</li> <li>➤ Planned content.</li> <li>➤ Identification of resources and partners.</li> <li>➤ Evaluation of pupils.</li> <li>➤ Discussion with trainer regarding feasibility.</li> <li>➤ Consider possible difficulties and any adjustments that might be needed.</li> <li>➤ Distribution of tasks between students.</li> <li>➤ Formalisation of project.</li> <li>➤ Timetable.</li> </ul>
No. 3	1 day (January)	<p><b>Regulation of multidisciplinary projects</b></p> <ul style="list-style-type: none"> <li>➤ Plan a meeting between the referring trainer and the students.</li> <li>➤ Assessment of progress of students' work.</li> <li>➤ Any necessary additional guidance given.</li> <li>➤ Reminder that the project needs to be aligned with the school's own plans.</li> <li>➤ Appropriateness of choice of objectives.</li> <li>➤ Checking that the various disciplines have been brought together appropriately.</li> <li>➤ Guidance in implementation.</li> <li>➤ Help with formalising a record.</li> <li>➤ Starting points for analysing the work that has been carried out.</li> <li>➤ Advice on choice of tools for creation and presentation of project.</li> </ul>
No. 4	Half day (end of year)	<ul style="list-style-type: none"> <li>➤ Oral presentation in front of an extended group (referring trainer and trainers from other disciplines, peers and other students) using a platform (slides, Powerpoint etc.).</li> </ul>

1. This technique enables analysis of the various dimensions of a given concept or representation.

**TABLE II**

**Example of training module designed for students preparing to enter teaching, or for currently employed teachers. Its main objective is to enable students to identify the nature of roles in health education.**

School teachers and health education		
Intended audience	Note from the trainer	
Students in the second year of Masters training or employed teachers as part of continuing training	<p><i>"This module is the result of work by a group including university trainers (IUFM), teachers involved in training, school health units, leaders from the National Association for Alcohol and Addiction Prevention (ANPAA), Departmental health education committees (CODES) and health insurance bodies."</i></p>	
Duration		
12 hours, 4 sessions of 3 hours over 2 months		
Place within training plan		
Module is part of teaching units focused on the broader educational aspects of the profession		
Organisation		
Group of 24-30 students		
Advantages		
<ul style="list-style-type: none"> <li>➤ Health education is part of official programmes and instructions; it is a constituent part of teachers' role in the area of citizenship (element 6 of the common core of knowledge and skills).</li> <li>➤ Training is mainly focused on the role of the teacher. With health in schools as its starting point, training enables work on the way in which secularism and the values of the school system are put into practice.</li> <li>➤ Training is provided by a group involving university trainers (IUFM), teachers involved in training, school health units, ANPAA, CODES and health insurance bodies.</li> <li>➤ The structure of this module is common to all IUFM sites that are involved.</li> </ul>		
Objectives		
<p>To enable students to:</p> <ul style="list-style-type: none"> <li>➤ reflect on the nature of health education and be aware of the various themes involved in the programme (knowledge);</li> <li>➤ reflect on the ethical issues that are linked to teaching in the areas of health education and safety;</li> <li>➤ be neutral with respect to individual and family health practices when practising their profession (apart from the specific case of those practices that break the law);</li> <li>➤ provide pupils with the means to acquire lucidity, responsibility, critical reasoning and autonomy (interpersonal skills);</li> <li>➤ be able to create health education projects (expertise).</li> </ul>		
Skills targeted		
With reference to the specifications	Institutional aspect ++	
<ul style="list-style-type: none"> <li>• Knowing the educational system, those involved in it and specific provisions.</li> <li>• Taking part in the life of the school or establishment.</li> <li>• Being aware of the various resources and tools that are required in order to design and implement learning.</li> <li>• Develop multidisciplinary and cross-disciplinary approaches, based on convergence and complementary features of disciplines.</li> <li>• Managing a group or class, handling conflict, developing pupils' participation and co-operation.</li> <li>• Ensure that all pupils have a positive regard for themselves and for others.</li> <li>• Work together and communicate with parents and external partners.</li> <li>• Contribute, by working with partners within and outside the institution, to resolving specific difficulties that pupils may have in the areas of health, high-risk behaviour and major poverty or abuse.</li> </ul>	<p>Identify the framework underlying health education in schools (individual and collective dimensions). Identify the nature of the role of teachers in this area. Working together with teachers' partners, the link with families.</p>	
	Personal aspect ++	<p>Refine relationship to all aspects of the profession. Work on relationship with health and high-risk behaviour.</p>
	Public aspect +	<p>Be able to analyse the relationship between children and health.</p>

TABLE II (end)

		Methods	
Trainers and other contributors		Training methods	
<ul style="list-style-type: none"> <li>- University teachers and teachers involved in training</li> <li>- Health education staff: technical advisors (doctor, nurse, social worker)</li> <li>- Institutional partners (CPAM) and partners in associations (ANPAA, CODES)</li> </ul>		<ul style="list-style-type: none"> <li>- Work on the perceptions that students or employed teachers have (role plays, Colorvote ("Régnier's abacus"<sup>1</sup>)/photo training ("photoformation"<sup>2</sup>).</li> <li>- Case study analysis.</li> <li>- Educational first-hand accounts.</li> <li>- Theoretical summaries.</li> <li>- Discussions.</li> </ul>	
		Description of sessions	
Sessions	Duration	Methods	
<b>Session 1</b>  What should health education in schools look like?	<b>3 hours</b>	<ul style="list-style-type: none"> <li>- Initial perceptions about health education and the role of schools and teachers (Régnier's abacus/Colorvote).</li> <li>- Inventory of interviews with students in this area.</li> <li>- Role of the teacher in health education.</li> <li>- Objectives and methods used in health education in schools. Reference texts.</li> </ul> <i>Participants: trainers, partners from institutions and associations.</i>	
<b>Session 2</b>  Health and safety of children at school	<b>3 hours</b>	<ul style="list-style-type: none"> <li>- 3 case studies (prescribed drugs, abuse, individualised support plan) that highlight the role of the teacher, enable an analysis of the limitations of teachers' neutrality and their responsibility to provide notification of abuse.</li> </ul> <i>Participants: school health team, technical advisers to the regional inspectorate (doctors, nurses, social workers).</i>	
<b>Session 3</b>  Establishing a health education programme	<b>3 hours</b>	<ul style="list-style-type: none"> <li>- Building a project in partnership, using a roleplay (difficulties, advantages).</li> <li>- Implementing a health education project in a class or school: trainers describe their personal experiences.</li> <li>- Methodological input.</li> <li>- Presentation of pedagogical tools.</li> </ul> <i>Participants: teacher trainers, trainers, other partners as required.</i>	
<b>Session 4</b>  Media and health education	<b>3 hours</b>	<ul style="list-style-type: none"> <li>- Summary "a pedagogical approach to health education".</li> <li>- Detailed explanation of one aspect: media education.</li> <li>- Work on social (body image) and sex stereotypes in advertising.</li> <li>- Education in the freedom of the individual, with presentation of a project done in class.</li> </ul> <i>Participants: teacher trainers, trainers in TICE (audiovisual).</i>	

1. The aim of this technique is to enable representations and practices in health education to be highlighted and confronted, using a colour chart.
2. Using an image, "photoformation" ("photo training") enables the members of a group to talk, to express their emotions and impressions, to clarify their perceptions and to confront them.

TABLE III

Training session designed for students in History/Geography/Civics. Its main objective is to enable students to identify the nature of their role in health education.

Health and citizenship	
Intended audience	Note from the trainer
Masters students in History/Geography/Civics	<i>"The issue of health is an identified area of the curriculum for those aged 12-13 (in connection with the dignity of the individual), in ECJS (civic, legal and social education), issues linked to cannabis and AIDS are frequently addressed. The aim of this module is to provide a teacher in History/Geography/Civics with the means to address health as a current citizenship issue."</i>
Duration	
Two three-hour sessions	
Place within training plan	
Module is part of teaching units focused on the broader educational aspects of the profession	
Organisation	
Groups of around twenty students	
Advantages	
<p>There is a double challenge in this area of training:</p> <ol style="list-style-type: none"> <li>To identify the role of the History/Geography/Civics teacher in health education, in the context of his/her teaching. This type of teacher has a specific role, as they are able to look at health issues from the point of view of life as a citizen, and thus with reference to the historical, cultural and political aspects of health. This training module places such teachers somewhat apart from a prescriptive approach. The aim is to: <ul style="list-style-type: none"> <li>➤ provide pupils with emancipation (the ability to make free and responsible choices in health, both individually and collectively), by approaching current citizenship issues that affect pupils directly (alcohol, tobacco, cannabis, violence, sexuality, AIDS etc);</li> <li>➤ ask questions about the dignity of individuals (respect for oneself and others), the relationship between individual liberty and the common good (public health measures concerning smoking or alcohol), the role of the law, the role of citizens in the debate (e.g. using the issue of decriminalisation or legalisation of cannabis as a starting point).</li> </ul> </li> <li>Being able to contribute to citizenship education (as it concerns health) within a broader project on a school level: this is why involvement in CESC (health and citizenship education) is being approached here too. It is useful to clarify at this stage that students of History/Geography can also take part in cross-disciplinary training in "health education and citizenship education at school level" with their colleagues from other disciplines.</li> </ol>	
Objectives	
<p>The aim of this training module is to enable History/Geography teachers to identify their own role in health education (on a school level, as part of CESC, in lessons etc.) but also to acquire theoretical and methodological training in the main issues raised in the practice of health education.</p> <p>At the end of the training module, the student should be able:</p> <ul style="list-style-type: none"> <li>➤ to identify various types of relationships to health;</li> <li>➤ to identify various approaches to health education and prevention and to explain the basis for these;</li> <li>➤ to explain the role of schools in health education with reference to the liberty and responsibility of the individual;</li> <li>➤ to be able to identify the role of the History/Geography/Civics teacher (individually and collectively) in health education.</li> </ul>	
Skills targeted	
With reference to the specifications	Institutional aspect ++
<ul style="list-style-type: none"> <li>• Being aware of and being able to explain and share the values of the Republic and its founding texts.</li> <li>• Contributing to pupils' social and civic education.</li> <li>• Looking at the civic dimensions of teaching.</li> <li>• Helping to build a common culture for pupils.</li> <li>• Developing multidisciplinary and cross-disciplinary approaches, based on convergence and complementary features of disciplines.</li> <li>• Ensuring that all pupils have a positive regard for themselves and for others.</li> <li>• Preserving equality and fairness among pupils.</li> <li>• Contribute, by working with partners within and outside the institution, to resolving specific difficulties that pupils may have in the areas of health, high-risk behaviour and major poverty or abuse.</li> </ul>	<p>Identify the framework underlying health education in secondary schools (individual and collective dimensions). Identify the nature of the role of History/Geography/Civics teachers in this area.</p>
	Personal aspect ++
	<p>Refine relationship to all aspects of the profession. Work on one's own relationship with health and high-risk behaviour.</p>
	Public aspect +
	<p>Be able to analyse the relationship between adolescents and high-risk behaviour.</p>
Methods	
Trainers and other contributors	Training methods
<ul style="list-style-type: none"> <li>➤ Two university teachers (History/Geography and cross-disciplinary training)</li> </ul>	<ul style="list-style-type: none"> <li>➤ The sessions alternate theoretical teaching with discussions and group work</li> </ul>

TABLE III (continued)

Description of sessions (I)		
Sessions	Duration	Methods
<b>Step 1: work on perceptions of health (initial phase)</b>	<b>1.5 hours</b>	<ul style="list-style-type: none"> <li>• Reception of students</li> <li>• Explanation of the aims of the session</li> </ul> <p><b>1/ Which view of health?</b></p> <p>Technique used: photo training<sup>1</sup></p> <ul style="list-style-type: none"> <li>• Show the perceptions that students have about health: Instructions “We are now going to work on health. Before talking about health education, we have to agree about what health is. In order to do this, you are going to choose a photograph that, for you, represents health (this may be an image of what health is, or of what it is not). Then, after 10 minutes to think about this, you will explain your choice to us, and using the photograph, you will tell us what health is for you. We are not aiming to analyse your various perceptions; rather, we are seeking to list the various existing approaches”.</li> <li>• A summary of the various ideas will be noted on a projected slide or on a flipchart.</li> </ul>
<b>Step 2: Identification of various approaches to health education (analytical phase)</b>	<b>1.5 hours</b>	<ul style="list-style-type: none"> <li>• Grouping and classification of ideas.</li> <li>• Summary showing the complexity of the idea of health and the various interpretations that can be placed upon it. The trainers will systematically draw links with the role of schools, the role of teachers, and the public and private spheres<sup>2</sup>.</li> </ul> <p><b>2/ Which form of health education?</b></p> <p>Technique used: analysis of prevention and health education tools</p> <ul style="list-style-type: none"> <li>• Instructions: “From observation of the three tools: What is the underlying vision of the ‘problem’ (alcohol abuse, smoking, road rage)? (Is it a disease, a vice, a fault, a deviant behaviour?) Which approach to health education is favoured by these tools? (informing, influencing behaviour, creating skills (which?), instilling fear?). It is useful to present the outcome of the collective discussion in the form of a table”.</li> <li>• Summary of various approaches to health education in schools, role in citizenship education.</li> </ul>
<b>Step 3: production relating to a current citizenship issue (taking ownership of knowledge)</b>	<b>1.5 hours</b>	<p><b>3/ What is the task of History/Geography teachers?</b></p> <p>Summary of ECJS objectives (contributing to the training of citizens in schools, outside subject-based teaching). According to the document that accompanies ECJS programmes</p> <ul style="list-style-type: none"> <li>- pupils should feel involved in the chosen theme;</li> <li>- reliable references should be used when looking for meaning;</li> <li>- a rigorous form of reasoning should be used;</li> <li>- debates should involve subjects that are of interest in society;</li> <li>- scientific resources should be sought in a wide variety of subjects;</li> <li>- work should be interdisciplinary and joint.</li> </ul> <ul style="list-style-type: none"> <li>• Work on a “current” citizenship issue: the challenges of democratic debate: the case of the legal status of cannabis. Technique used: group work, searching for information on the internet, and creating a poster around 4 issues:</li> </ul> <ol style="list-style-type: none"> <li>1. Why is this issue relevant today?</li> <li>2. Which arguments seem to you to be most relevant: 3 arguments for and 3 against decriminalisation.</li> <li>3. Your opinion, with reasons, in 3 lines at most.</li> <li>4. The 3 key elements that should be included in any work on ECJS with your pupils.</li> </ol> <ul style="list-style-type: none"> <li>• Looking at work by other groups, with an analysis table.</li> <li>• Summary: well-argued and structured debate is a constituent part of democratic life, and the role of the teacher is to conduct a debate around: <ul style="list-style-type: none"> <li>- the status of the law and a summary as necessary, regardless of the teacher's own opinions;</li> <li>- the importance of well-argued and structured debate.</li> </ul> </li> </ul>

1. Using an image, “photoformation” (“photo training”) enables the members of a group to talk, to express their emotions and impressions, to clarify their representations and to confront them.

2. See part 2 of this guide.



TABLE III (end)

		Description of sessions (2)	
Sessions	Duration	Methods	
Step 4: the role of teachers in work on a school level (analytical and ownership phase)	1.5 hours	<p><b>4/ Role of the History/Geography teacher: involvement in the overall plan for the school?</b></p> <ul style="list-style-type: none"> <li>• Health education input on a school level.</li> <li>• Technique used: role-play<sup>3</sup> CESC: How to implement a health/citizenship project in a highschool.</li> <li>1. 20 minutes for one member to prepare an argument and choose one member of the group to take part in the debate.</li> <li>2. 20 minutes of debate.</li> <li>3. 20 minutes to summarise the debate.</li> </ul> <p><b>Conclusion:</b> Summarise:</p> <ul style="list-style-type: none"> <li>• the teacher's role;</li> <li>• the methodological aspects involved in citizenship and health education in secondary schools;</li> <li>• ethical issues.</li> </ul>	

3. The role-play technique means that group members can be placed in a situation in which they are confronted with a situation that is similar to those they might encounter during their work.

## Support for teams

In France, support is not generally considered to be part of the training process itself. It is not left to training bodies, but is the role of inspectors, who are responsible for both support and monitoring<sup>2</sup>. However, if training is assumed to be a process that helps teachers to build their own professional identities, support is not just an “after-sales service” but is a contribution in itself to the professional development process, both for individuals and for the profession as a whole. In this short section, we will confine our analysis to the collective aspect of support.

This will focus on teams within schools and establishments. It is essential to carry out this work in the places in which health education occurs, as “among the conditions that are considered necessary if changes in education are to occur and to be sustainable, research shows the importance of highlighting teachers’ professional knowledge and of developing a sense of belonging within the teams in which they work and learn together” [8]. The focus here is therefore on continuing training.

Because of the various different perceptions of the role of schools and of teachers, support for teams can be viewed in various different ways. If the focus is on application of curriculums by teachers, this is a top-down mechanism. This form of support is common in the educational system, far beyond the context of health education. It typically takes the form of staff meetings or courses in which a new resource, text or curriculum is presented. In this context, support is fully justified, as universal schooling

2. Inspectorates do have a similar dual function in some other places, but not everywhere. In some other countries there are two bodies: the inspectorate, and school support services.

is only possible if teachers' activities take place within a framework that is defined by the State. As we have previously seen, the institutional framework (formed by curriculums, and institutional texts in general) is the key to the link between the school system and citizens, which is the basis on which parents agree to entrust schools with their children. This type of support, when applied to health education, is shaped on the basis of political choices, and sometimes on research which has demonstrated "good practice"; intervention programmes or guidelines developed using this good practice are tested and validated, and are eventually implemented in schools. This last step involves specific work with teams (from information for teachers to evaluation of how well the material is being implemented, as well as the extent to which the tool was adapted to the local context).

This process is of limited usefulness, because there is a need to mobilise teams, improve collective work, improve the status of the work that has already been done, and support new practices. If teachers are required to act as reflective practitioners, support can be considered as a process of professional development in its own right. The practices that need changing are no longer an end in themselves; they become an opportunity for providing support. Practitioners are considered as experts, and as professionals who are able to stand back from their practices, explain them and carry out reflective analysis on them. This process puts these practices in direct juxtaposition with the practices suggested during training, and these practices are then used as a source of experience and knowledge, which gives rise to new forms of practice. Support for teachers in adopting new practices is thus a process of mediation between the intention to change and the action of changing. In this context, support is primarily focused on teachers' representations of how they contribute to students' educational success and to health promotion. The next step is to explain the practices that are already being used, by providing frameworks for analysis. These tools are based on well-defined theoretical frameworks and their only purpose is to provide a way of reading the current practices. Our experience leads us to suggest that it is useful, where possible, not to be limited to just one tool but to offer several, which increases the likelihood that each teacher and team will find a type of support that suits them. We shall present two examples of support tools which, although they have similar purposes, are based on different theoretical models [tables IV and V]. This work brings together scientific and theoretical knowledge (for example the model by Downie, as outlined in the section "Health education in a school setting" of the present book) with practitioners' experiences. It therefore becomes possible for all teachers and all schools to update their practices with reference to their own expertise, what they learn in training and the context in which they work. Thereafter, a constant two-way process of change takes place.

The two proposed frameworks are modest in scope, but they have been shown to be useful in the context of support for the "Learning to live together"

project. Its purpose was to improve the status of educational practices in schools, and to enrich and pool these practices, using:

- collective reflection on educational practices (based on analysis frameworks and evaluation of the school climate);
- exchanges between schools;
- the contribution of the support team (in the district, university, school health).

**TABLE IV**

**Support form as completed by a nursery/primary school in the context of a support programme. The intention is not to provide a value judgement on what is suggested here; rather, the aim is to improve its status and support it, including the areas we would wish to see developed, in order to enrich practice.**

“Learning to live together better”

This is a project that aims to increase the status of educational practices in health education and citizenship in schools, to enrich these and to ensure that these are uniform  
Individual section

**Primary School A**

This form summarises some of the actions carried out by the pedagogical team which aim to educate children in health and citizenship, and to prevent violence and high-risk behaviour. There are many ways to present these activities. In this case, analysis was done with reference to children's needs. In order to be able to take their place in society, individuals need to be able to accept themselves and affirm themselves as people. At school, in addition to learning the rules of collective life, the essential skills for social life is acquired by taking into account children's needs.

<b>Need to challenge oneself (self-fulfilment, creativity, having plans for the future, giving a meaning to life...)</b>	Creation of various workshops in which all children can achieve fulfilment and play to their strengths (sports, arts, visual arts). Plan for a musical show, to be performed in front of parents, with all children taking part. Many varied plans in the school in order to avoid routine, promote motivation, the pleasure of learning, developing a "whole-school" spirit, and to give meaning to the subjects that are taught.
<b>Need for respect and consideration (self-esteem, independence, autonomy, being recognised as capable, being recognised by others...)</b>	Reassuring and valuing, without "dumbing down". Encouraging autonomy, reflection, building learning. Creation of a children's council (representatives from each class, chosen by the others). This council meets once per month, and the minutes are kept on file. If possible, children's requests are implemented.
<b>Need for belonging (being recognised, being part of a group, taking part...)</b>	Workshops with small groups Rotation of these workshops. The children know all teachers in the school better. Children are recognised not only by their own teachers but by the whole school team. Specific attention to vulnerable children. Educating children in not keeping themselves apart, in sharing and including.
<b>Need for security and self-confidence (stability, protection, core learning...)</b>	Listening to children. The rules are the same in all classes (same rights, same duties, same punishments). Through other experiences in collective life (with the whole educational team) "I am responsible for my actions and words at all times". Safety, establishing rules for different places. Female teachers are prepared for emergencies sanitary protection. Development of each child's concentration.
<b>Physiological needs (food, rest, freedom from injury, consistent temperature...)</b>	Controlling snacks, controlling meals, nutrition education. Adjustments to school day. Timetable is in line with each child's concentration span and areas of interest. Nap for PS (aged 3-4) and some of MS (aged 4-5), education about sleep. Regular visits to the toilet, and attention paid to facilities and cleanliness. Changes of clothes and equipment. Windows are opened regularly.

Such support does not aim to effect radical transformation of practices; rather, it aims to improve the coherence of what is already done in schools, to support implementation of new practices (by e.g. providing contributions, making available educational resources, providing evidence) and evaluation as a way of supporting change.

**TABLE V**

**Support form as completed by a primary school in the context of a support programme. The intention is not to provide a value judgement on what is suggested here; rather, the aim is to improve its status and support it, including the areas we would wish to see developed, in order to enrich practice.**

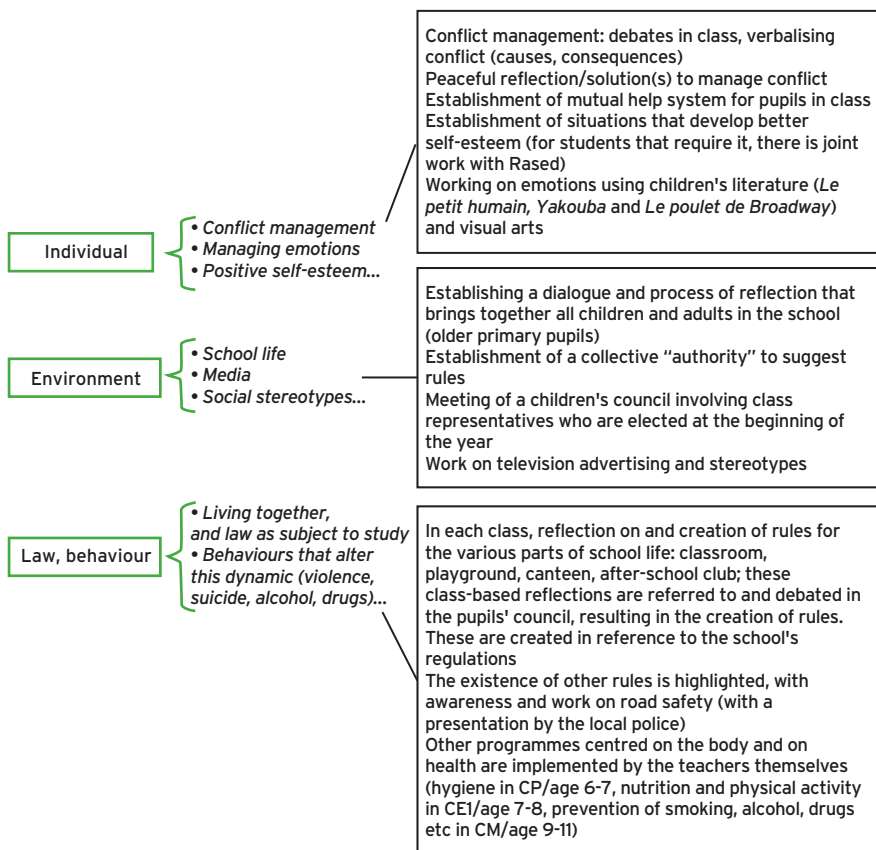
“Learning to live together better”

This is a project that aims to increase the status of educational practices in health education and citizenship in schools, to enrich these and to ensure that these are uniform Collective section

**Primary School B**

This form summarises some of the actions carried out by the pedagogical team which aim to educate children in health and citizenship, and to prevent violence and high-risk behaviour.

There are many ways to present these activities. This was done with reference to three essential aspects of education: learning personal, social and civic skills, work on the law and the child's environment.



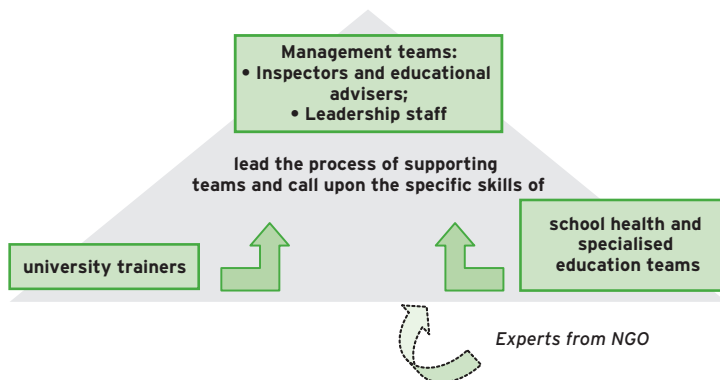
In the French educational system, this support is organised differently in primary and secondary education. In primary schools, the “district team” (inspectors and educational advisers) is responsible for this aspect. In secondary education, support is the joint responsibility of the principal of the school and the inspector.

These parties lead the process but do not by themselves have all the skills required to support health education teams. They call upon the skills of school health teams, advisers working in the school and in the district, and academics from the university. Specialised education teams do not have the specific role of providing health education, but they do have extensive skills in this area, and are the main form of support for teams in their specific fields. As for partners working with schools: associations have real expertise that can be made available to schools. The main such associations are CRES and CODES (Health Education Committees)<sup>3</sup>, Anpa, mutual organisations such as MGEN, Adosen (Health Action and Documentation for National Education) and OCCE (central schools’ co-operative body in France).

However, support is not provided only via organisations and resources. It is also a state of mind. According to Arthur Gélinas, professionals providing support have to face five major challenges [9]: 1) consider the challenges faced by those involved; 2) be open to diversity; 3) share visions, rather than having a shared vision; 4) specify practices, rather than making them uniform; 5) have a clear view of their role, mandate and expertise. It is clear that support professionals are not created overnight, and the question arises as to how to train staff for this specific role [figure 1].

**FIGURE 1**

**Diagram of the contribution of various stakeholders to support for teams in health and citizenship education**



3. These bodies are gradually becoming Regional Health Education and Promotion Bodies (Ireps - Instances régionales d'éducation et de promotion de la santé), in line with the statutes of the National Federation for Health Education and Promotion (Fnes - Fédération nationale d'éducation et de promotion de santé).

In concrete terms, this support has two main forms. One is time set aside for district-level educational activities, and the other is “presence” within teams. It is important to remember that the fact that inspectors and doctors working in the educational system (among others) meet teachers and ask about health education projects is in itself a significant way of supporting teams. If this work is seen to be valued and if it attracts attention from the hierarchy or from experts, this is a major source of motivation for professionals.

## IMPLEMENTING TRAINING

This last section will contain suggestions for ways in which health education training for teachers can be implemented, based on the ideas outlined elsewhere in the book. As previously stated, we are using the specifications for teacher training that were published in 2007<sup>4</sup>.

### Contributions from all areas of training

If all teachers in training are to develop the competencies that will enable them to fulfil their roles as health educators, their training cannot be limited to mere implementation of specific modules. Building a professional identity is a complex and lengthy process. The issue therefore is to find out what, apart from modules that are explicitly focused on health education issues, can help teachers to build these competencies.

On the basis of bibliographical data [10-16] and the work done by groups of trainers, we have tried to show the different areas of training that contribute to development of teachers’ competencies in the areas of prevention and health education. These areas correspond to the “didactic triangle” described by J Houssaye [17] which defines any pedagogical act as the space between three points of a triangle (the teacher, the student and the knowledge<sup>5</sup>). Because of the challenges involved in sustaining partnerships with various stakeholders, the issue of context is also taken into account.

The whole can be represented in a diagram [figure 2]. Although this is by necessity reductive, the diagram is useful because it clearly highlights the areas of teachers’ activity that interact with students’ physical, psychological and interpersonal health. The idea is not to make a list of what should be added to the training process, but to show which factors contribute to health education. In this sense, providing health education training improves these tools, by making explicit the aspects of teachers’ activity that contribute to

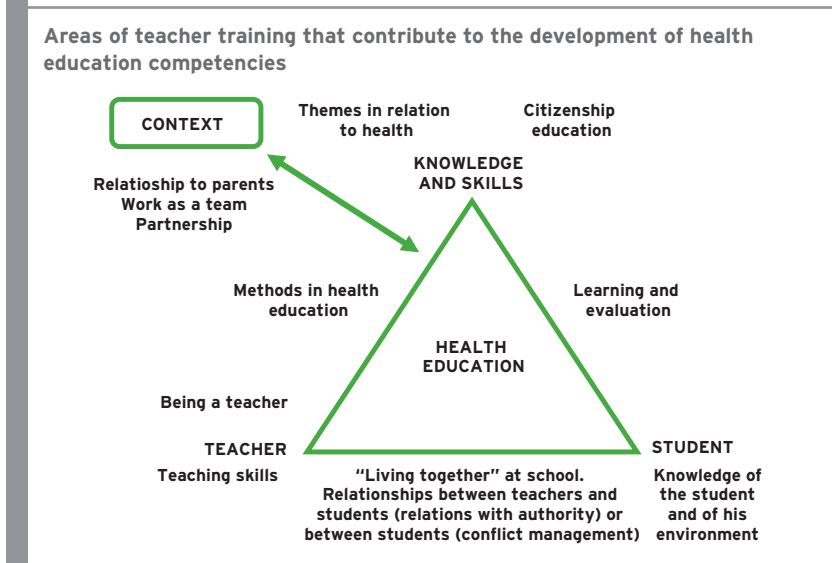
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4. We will not address the issue of training practices that are currently used in IUFM (teacher training colleges). In a previous study (D Jourdan *La formation des acteurs de l'éducation à la santé en milieu scolaire* [Training health educators in the school setting], Toulouse: Éditions universitaires du Sud, coll. École et santé: 401 p.), we examined this question, using a national survey and data from international publications.

5. The issue here is knowledge in the broad sense, defined from an educational (and not merely didactic) perspective: knowledge, expertise and interpersonal skills.

well-being at school (which has been shown to be connected with school success [18]) and to development of students' ability to make choices while exercising freedom and responsibility.

**FIGURE 2**



### Rooted in training specifications

The specifications for initial professional training (Official Bulletin no. 1 dated 4 January 2007) that are used in teacher training institutions are based on a definition of the teaching profession that is based on ten competencies<sup>6</sup>:

- act as a civil servant in an ethical and responsible manner;
- master the French language, in order to be able to teach and communicate;
- master their subjects and have good general knowledge;
- design and implement their own teaching;
- organise class-based work;
- take students' diversity into account;

6. Whether considered in terms of the common core of knowledge and skills or the specifications of the teaching profession, the purposes of education are expressed as competencies. It is useful to explain the logic underlying the decision to define the profession in terms of competencies. The idea of competencies (or key skills) is not in itself a new one, but the definition and usefulness of this concept remain controversial. The term is part of everyday language and for a long time has been used to denote a level of effectiveness in action. The use of the term in French has changed along with the social context, and in May 1968 it underwent a profound change. This period, which saw a rejection of Taylorism, was the first step towards the current model of competency. Competencies are different from knowledge, which is organised according to academic subjects and scientific fields and not according to areas of real-world activity. Knowledge is abstract, formalised and decontextualised. Competencies are also distinct from qualifications, which are often associated with diplomas, are recognised and validated by society and by convention, and once awarded cannot be taken away. A competency is both operational and purpose-driven. It designates a knowledge of how to act in a particular situation, with a specific set of constraints and resources. This competency in action is guided by a certain intention, with a particular end in view. This is a process which can be

- evaluate students;
- master information and communication technologies;
- work as a team and together with parents and partners of the school;
- to maintain training and keep up with new ideas.

In general, the specifications put forward an explicit and organised set of key principles:

- teaching is a skill that can be learned, and it is not sufficient to master subject knowledge in order to succeed in the profession;
- initial training is professional in nature, and brings together work experience with university teaching;
- initial training takes into account changes in practice, the need for a collective framework for professional activity, and the need for partnership;
- reflection about the public service values that are inherent in education is at the heart of training;
- educational research should be accorded a significant role, in both initial and continuing training.

As was indicated in the introduction, the specifications for teacher training contain broad provision for health issues. They state that training for primary teachers (para 1.2) must use a common national framework, based on “official texts that state the non-subject educational commitments of the school, in particular health education and education in environmental issues and sustainable development...”. Health and prevention are issues that call upon the professional competencies of teachers (para 3), both as subjects to be taught along with all non-subject areas of education, and as components of the civil servant’s role (acting in an ethical and responsible way) “to identify students who have difficulties with health issues and high-risk behaviour” and “to take responsibility for students who have disabilities”. Finally, the issue of partnerships, which cannot be separated from health education and addiction prevention, is brought to the fore: working as a team and together with parents and partners (in particular, medical and social work professionals, public services etc). More generally, this stresses the non-subject educational dimension of teachers’ professional practice and emphasises the need for professional

learned. Competencies cannot be supplied ready-made (Jourdan M H *Le management au défi de la promotion de la santé des usagers dans un service d’urgences* [Management of the challenge of health promotion for users in an emergency department]. IFCS [Health Managers Training Institute], Rhône-Alpes region, France - Lyon Public Hospitals). Thinking about professional development for teachers in health education in terms of building competencies has several consequences for training. First, this assumes that the ability to act will not be passed on in an automatic way, but that a process will take place, in which the trainee is the main protagonist. With this in mind, there is no option but to trust trainees, who will “knit” together their various experiences in their own way. Training helps individuals to build competencies, but is not the sole factor. Things that happen in schools and that young professionals encounter at the beginning of their careers are crucial in determining professional identity and building competencies. This broad view of the concept stresses the essential role of support in building competencies. This close relationship between support and training is the basis for several health education and health promotion programmes that are used in schools. Examples are “Apprendre à mieux vivre ensemble à l’école” [Learning to Live Together Better in School] in France, and “Ecoles en santé” [Healthy Schools] in Canada.



practice to be incorporated into the school's collective programme, and for communication with students and parents.

## Health education at master's level

Based on an analysis of the specifications, it is possible to suggest starting points for inclusion of health education in initial university training.

### A process of creating links

Training in health education and citizenship can be a way of bringing the disparate parts of training together, rather than just adding yet more content. All teachers are faced with the issues posed by high-risk behaviour (violence, drug addiction, alcoholism, smoking) and ask questions about their own role and that of schools. Daily life in schools is such that the primary challenge is always crisis management, but the issue of prevention and education in these areas rapidly arises. Dealing with such "live issues" of citizenship with students (in their school-based training) and newly qualified teachers is a way of encouraging them to bring together their various areas of knowledge, both academic (scientific, historical, legal, ethical) and drawn from their experience, which will help them to find their place as teachers. Health education is one of the elements of the common culture shared by all teachers, whether primary or secondary.

### The background of the common core of knowledge and skills [19]

Education in "social and civic skills" approaches these issues (e.g. health, sexuality, road safety, first aid) in addition to the knowledge, skills and attitudes that contribute to health education that are already present in academic subjects. Health education therefore has a role in traditional subjects, via the curriculum, and as a component of citizenship today.

### Guidelines for citizenship education in the school setting [20] and organisation of CESC [21]

The circular of September 2006 [20] lays down the conditions under which a citizenship education programme should be established..., using learning situations that are based in the curriculum, that take place as part of school life, and that are relevant to students' daily lives. This area of education can only be addressed collectively in the school, as this is the responsibility of all, and goes beyond didactic concerns. Its specific nature requires communication with families. In many schools, this area is the basis for true teamwork in the school, led by the CESC.

### Non-subject education (health, environment, sustainable development, road safety, media literacy) and the changing teaching profession

Health education is part of non-subject-based education. This non-disciplinary content is referred to as non-subject-based because there is no academic

knowledge base, and therefore no clearly established curriculum. This type of education is focused on learning citizenship skills and democratic values. It is inarguably part of the current role of schools and of teachers. Including this content across the teacher training process, in initial training as well as continuing training, helps to support a changing profession.

### Contributions from trainers involved in a variety of subjects

One of the specific features of citizenship education, and of its subsidiaries, health and environmental education, is the fact that these cannot be limited to simple absorption of knowledge or the “right way” to think about a certain issue. The purpose is to develop personal, social and civic skills, which will enable students to take their place in the wider debate, as free and responsible citizens. Work with students must incorporate different views of the same issue, the tensions arising from contributions from various disciplines, and learning how to form arguments and debate. Approaching these complex issues in training requires both inclusion of epistemics from a variety of subjects, and a range of insights into the pedagogical and didactic approaches that can be implemented. It is essential to obtain input from trainers from different subjects.

### Variety of implementation methods

The experience of various universities in this area shows that a wide variety of methods can be used to incorporate health education into teacher training. For each example module, the specific competency (in the specifications for teacher training) is given:

- health education within taught disciplines (competency 3). The idea is not to add content, but to highlight the contribution of various subjects to the consideration of health issues, via bodies of knowledge (e.g. historical, legal, biological), students’ learning of personal, social and civic skills (via artistic, literary and physical activities) or the development of attitudes (respecting oneself and others, media literacy, critical skills). For example, in subject-based training, sessions are given over to issues of citizenship in History & Geography (health, drugs, consumption etc.), to the contribution of sciences to citizenship education (health and environmental education), and to the link between physical education and health;
- acting as a servant of the State, in an ethical and responsible manner: experience in modules “Current values in schools” (competency 1). The experience in several universities, in particular in “Current values in schools” modules, shows that health issues are a useful basis for approaching the ethical aspects of teaching. Working with real-life situations means addressing the role of schools (in the public and private spheres), the responsibility of teachers (safety, abuse), their non-subject educational responsibilities (respecting oneself and others, approaches to the law), the challenges of teamwork within schools and relationships with parents and partners;

- “living together” as the subject of a module that is focused on citizenship education and its subsidiaries (various types of non-subject education) (competencies 3 and 9);
- working together in the school: the curriculum and health education and citizenship committee (CESC) **[21]** (competency 9). Modules can be organised that focus on teamwork in secondary education. These would concentrate on prevention and management of high-risk behaviour, on conflict prevention, on quality of life in the school, and on relationships with parents and partners. The institutional framework provided by CESCs (which bring together all members of the school community) is the primary consideration, but space is also allowed for work on the curriculum and on internal regulation;
- module on working together with parents and partners (competency 9);
- identifying and helping to resolve specific difficulties experienced by students in relation to health, disability, social integration (competency 6);
- implementing new legislation (competencies 3 and 10);
- common core of knowledge and skills, in particular “social and civic skills” (Official Bulletin no. 29 dated 20 July 2006). Theme of convergence of scientific disciplines (Official Bulletin no. 5 dated 25 August 2005);
- specific modules:
  - health education and promotion in schools (Official Bulletin no. 45 dated 3 December 1998) (competencies 1, 3, 6 and 9),
  - sex education (Official Bulletin no. 9 dated 27 February 2003) (competencies 1, 3, 6 and 9),
  - first aid (Official Bulletin no. 46 dated 11 December 2003) (competencies 1 and 3),
  - the role of teachers and of partners in the prevention of abuse (Official Bulletin no. 12 dated 22 March 2001) (competencies 1, 6 and 9),
  - prevention of drug addiction (public health law no. 2004-806 dated 9 August 2004, article L. 312-18, the French Government’s drugs, alcohol and smoking plan 2004-2008) (competencies 1, 3 and 9),
  - prevention of violence and peaceful resolution of conflict (Official Bulletin no. 31 dated 31 August 2006) (competencies 1, 3 and 9);
- the challenge of working on this issue with schools that accept trainee teachers **[22]**: the specifications assume that there is an alternating pattern of university- and school-based training. This means that there needs to be strong collaboration between universities and schools that accept trainee teachers **[box 3]**.

**BOX 3****The role of schools in training, as described in the framework document of Orléans-Tours regional teacher training college (for year 2007-2008)**

Training in the general area of professional identity: principals and their teams have a fundamental role to play in training, by enabling trainees to establish themselves as public servants and to find their own place within the school. In particular, the trainee should be encouraged to:

- get to know the school and its policies (the school's educational plans, which are part of a regional plan), its hierarchy, the stakeholders and partners, and how it works;
- become accustomed to the behaviour and position of teachers in the school: rules, duties, rights with respect to students, the administration and colleagues;
- internalise the various different aspects of the profession. This part of training can take the form of meetings with trainees, in which information is given and discussions held. Such meetings can be combined with other meetings and events in school, depending on the trainees' timetable at the teacher training college.

The specifications for teacher training emphasise the importance of involving the trainee in the work of teams within the school. There is a need to emphasise the challenge for trainees of taking part in the school's work on health issues, keeping up to date with the school's educational plans and internal regulation, and in particular to take part in CESC meetings.

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# Conclusion

The journey described in this book has led us from an analysis of the context in which teachers are trained in health education, to practical suggestions as to how this can be implemented. In conclusion, we shall return to some of the main ideas.

As we showed in the first part of the book, the priority of training is less providing students with specific technical skills, and more giving students an awareness of their role in health education, as part of their professional identity (as this is perceived by those involved). In this way, with the resources they gain in training and build with experience, teachers can contribute to the development of their students' skills in the area of health.

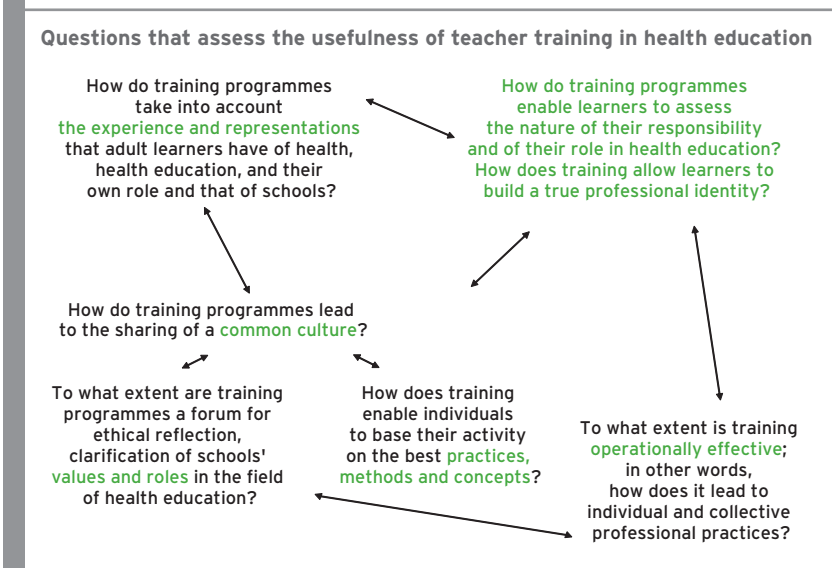
There are several coexisting representations of health education, which are determined by the professional preoccupations of those involved. Enabling trainee teachers to discover other ways of approaching the issue, and to stand back from their own interpretations, is an aim in itself. However, not all representations are of equal value. Taking this diversity into account necessarily entails assessing how far each approach meshes with the purpose of the education system. In other words, in schools, health education primarily draws upon an idea of education, and not information about pressing health issues and ways of preventing these issues, or even health promotion. The main idea is always to enable self-determination.

The two sides of the issue that are presented above do not naturally work together in harmony. Helping trainees to develop of reflection skills can certainly be considered a useful way to achieve this aim.

Health education is a concern that is shared by many different types of professional, from both education and health. Promoting a culture that is common to all stakeholders may help to build synergies that will improve children's education. The aspects that are most likely to be held in common are ethics and shared values. These are the humanistic values that can form the substrate for a common culture. In a changing society, the role of schools needs to be constantly made clear, and must be tailored to the values it is meant to represent and to the current social context. Nobody can dictate a common culture for those involved in health education in schools. It can only be built over time, with training, support and teamwork.

In **Figure 1** we see a summary of the main aspects of training in health education for teachers, in the form of six inter-related questions. Rapid changes in the role of health education in schools, and the change in paradigm that we outlined in the first part of the book, are not without their tensions. In such a context, finding an appropriate form of training involves striking a balance between wide-eyed utopianism and conservative realism. To quote Philippe Perrenoud on this subject: "Training institutions should specify the next

**FIGURE 1**



step in the professionalisation of the teaching profession, using new teachers as the agents of change and basing the process on a strategic analysis of changes in the school system(s) in which they work. If this process is too timid, the opportunity to advance professionalisation will have been missed; if it is overly optimistic, the existing teaching body will resist excessive change. Initial training must prepare new teachers to manage this gap: on the one hand, they must be aware and understanding of why they are there, and on the other, they must be able to defend their own professional identity, not aggressively but assertively, against pressure from colleagues who are more experienced, conservative and cynical"<sup>1</sup>. It is to be hoped that this book will contribute to this process of professionalisation.

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The aim of health education is to help all young people gradually to acquire the resources that they need in order to make choices and exhibit responsible behaviour concerning both their own health and that of others. It therefore enables young people to be effective citizens. The role of the school system is, therefore, to help students to develop this capacity to decide for themselves and to take responsibility for their own health. In view of this fact, health education is not a matter for specialists; rather, it is part of the daily work of adults who are responsible for the education of children and adolescents.

For primary and secondary teachers, health education is one of many tasks. Their training in this area cannot therefore be limited to a series of information sessions about health-related themes. A truly appropriate training system must be carefully integrated with the other aspects of the modern teaching profession, and must be placed at the heart of any plan to redefine teaching. Addressing such “live issues” of citizenship with students is a way of enabling them to draw connections between what they learn academically and their own experience, and thus to create their own identities as teachers.

The purpose of this work is to make explicit the various pitfalls that can arise in health education training, and to offer the reader some tools to deal with them.

It is aimed at all those involved in training, at professionals from various disciplines and working in various institutions, and has been designed to help produce a culture that is common to the various stakeholders, working in the context of a partnership.

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