THE VOICES OF CHILDREN IN HEALTH EDUCATION.

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Abstract: One of the main objectives in health education in the New Zealand national curriculum is that students should be helped to take responsibility for their own health. However, most decisions about health programmes in primary schools are made by adults.

This paper reports findings from a study which sought the views of primary children about their knowledge of health and their preferences for health education content.

Children knew more that adults probably realised, but had little say in what they studied. Older primary children knew about controversial topics like drugs and sexuality.

However, there were many gaps in their knowledge and they wanted to cover these in health lessons.

There are, therefore, implications for school health programmes.

INTRODUCTION

Health education is an important part of the New Zealand national curriculum. *The New Zealand Curriculum Framework* (Ministry of Education, 1993) points out that "health is vitally important for personal and social well-being and achievement" and that children can be helped "to take responsibility for their own health ..." (p. 16). The study reported in this paper was an exploration of whether there was any evidence that New Zealand primary school students possess knowledge of their own health and concerns that might influence their health education, and thus meet the above objective of a degree of autonomous decision-making about their health. Did the students have viewpoints about their health and health education? If so, what were their voices saying? From where did they get their information? What did they want to know? Did their views differ from those of their teachers and parents? What do their views mean for the design of health education in school?

In recent years, international researchers have demonstrated that primary school students do, indeed, have numerous views on their own health and what they think is important for them to know. Their views often differ from those of adults (Wiley & Hendricks, 1998), so if it is adults who make health decisions on behalf of children, there may well be missed opportunities in health education. Aggleton, Whitty, Knight, Prayle, Warwick and Rivers (1998) argued that, "Now more then ever, there is a pressing need to know what children and young people think about health issues, and how these ideas map out what teachers, youth workers, school nurse, parents and adults believe" (p. 213).

In terms of school curriculum, decisions about what should be learned, and how, are also made predominately by adults. This matches an historical trend to deny children's voices because they are regarded as ill-formed and immature (Lloyd-Smith & Tarr, 2000; Qvortrup, 2000; Smith, Taylor & Gollop, 2000). Children have been seen as objects in need of adult direction to socialize them. Recently, arguments have been made that children should be viewed as social beings who can think about many aspects of their lives and express views and preferences, rather than as a voiceless group. James and Prout (1997) argued that this view is changing and children are no longer seen as incompetent or innocent as was once thought, and they suggested that a new paradigm is emerging in which children's contributions are taken more seriously. In line with this, in New Zealand, Harrall and Hallewell (2001) have claimed that children's voices should be heard because they are capable of worthwhile thought. Smith and Taylor (2000) have shown that children's views are embedded in their own family, school, neighbourhood, and wider society.

Several health educators (for example, McWhirter, Wetton & Williams, 1996; Williams Wetton & Moon, 1989) have shown that many children are able to put their health knowledge into context so that it has meaning, reflect on what they want to learn, be critical about what they are required to learn and not learn, and tell adults what they want to learn more about.

There is, however, a challenge to researchers in how they obtain children's views. Progress has been made with various research techniques including

artwork, puppetry, theatre, drama, stories, picture cards, conversations and photography (Gollop, 2000; Mayall, 1996; 2000; O'Kane, 2000; Jones & Tannock, 2000). Hence, there are many ways of gathering evidence that might prove useful for designing health curriculum programmes, that take into account the perspectives of children.

One of the major issues to emerge in recent research cited above, is that there are differences between the views of adults and the views of children; furthermore, adults such as parents and teachers make enormous assumptions about what they think children know and are interested in knowing regarding health. Aggleton, et al. (1998) found clear adult – child differences in views about children's health, risk-taking, ill-health; attitudes and behaviour towards health and health promotion relevance. They found that adults known to children influenced their health views. However, there were other strong influences such as the media (especially television) which provided children with more information beyond what adults such as parents and teacher believed children knew.

A clear trend in the research is that children knew far more than adults thought. This advanced knowledge applies to aspects of health that might be considered controversial, such as violence, drugs and sex. It is these more controversial aspects that are the focus of this paper.

Research Method

This study was an exploration of students' views about their own health and health education: What do primary school children know, think? What they are concerned about, and want to learn about their health while at school? Of the major themes to emerge, two have been selected to report in this paper: first, drugs, alcohol and tobacco; and second, sex information and sexual behaviour. These were chosen because they are aspects of health which exemplify differences in adult-child perceptions and knowledge, more starkly than aspects such as exercise, eating habits and food and personal hygiene.

There were two principal methods of data collection; a draw-and-write technique and conversational interviews.

- A draw–and-write illuminative technique, developed by Wetton (1972). This technique was designed to examine children's drawings to understand how they explain and construct ideas. Teachers were trained to administer two tasks. The first was to draw 'what makes and keeps you healthy' and the second was to draw 'what makes you not so healthy.'

Data were collected from a Year 3-8 sample drawn from six classes in an urban Year 1-8 school of about 300 students. The sample was: Year 3 (n = 23), Year 4 (n = 27), Year 5 (n = 25), Year 6 (n = 28), Year 7 (n = 20), Year 8 (n = 39). For the purposes of this study, children in years 3-5 were considered as "younger", while those in years 6-8 were categorized as "older". The sample covered a wide range of socio-economic levels; the school's SES mean was mid-level (Decile 7) and contained a range of ethnicities.

- Conversational interviews. Unstructured conversations were held with small cross- sectional groups of about five children in each of the six classes. In total there were 12 groups, one group of boys and one of girls from each of the six classes. The focus was upon their drawings (above) – what they had drawn, why, and the meaning of the drawings. Because the children in each group knew each other, and the researcher conducting the interview was familiar to them, it was assumed that they would contribute openly.

The data from the drawings and conversations were classified into numerous specific categories, and then recombined into broader categories: body care and personal health, physical activity and safety, ingestion and inhalation, and mental and social health. Draw-and-write data provided the raw material for the discussions with groups of about five students in each class, but the real essence of what children thought about health education and the issues with which they were grappling became more evident during the conversations. The discussion encouraged students to elaborate upon their drawings and therefore provide additional data not evident in their drawings. The conversations provided a setting in which the children could talk freely about health issues that were connected to the drawings but often ran a long way beyond them into the more controversial aspects that are covered in this paper.

Data were also collected from the teachers of the six classes and the parents of the focus group children, through interviews and a questionnaire. The focus was upon their views of health education, what should be taught at school and reactions to their children's views on health. These data are not reported in any detail since the emphasis is upon children's voices.

Findings

This section reports some of the findings regarding, first, children's views about drugs, alcohol and smoking (DAS) and second, sexual issues.

In this study, at the younger level (Years 3-5), a third of the children mentioned drinking and smoking. There were many more mentions in the older group, and by Year 8, most of the children spoke in depth about access to hard drugs and alcohol, and several had already acquired the smoking habit. What may be deduced from these findings is that some very young children have experience of, and knowledge about, drugs, alcohol and tobacco, whether it be from their peers, older siblings, parental habits or other sources, such as television and other media.

In the study, seven of the 11 boys in Years 7 and 8 talked about hard drugs, being in vehicles when drugs and alcohol were present, being at parties and night clubs where pills were slipped into drinks, and of the pressures exerted by their peers and older people. A Year 7 boy stated:

> My cousin had only just got his driving licence and he was going out to a party, and he invited me along, but I said no 'cause I was scared that I was going to get drunk and also, he was going to be driving the car after drinking.

Some of the Year 7 and Year 8 girls were very aware of teenage drugs that were being marketed, and had already been pressured into trying them by their peers. A Year 8 girl stated:

> Like, you can walk into this shop and there's all these different types of smokes. It's like alcohol. They are getting these new things like Stingers and KGB, and they are like, the kids our age, just love them and think they are so nice, but really they are not good for us.

Issues about pressures and queries about drugs, alcohol and tobacco

An important issue is the source of children's information and the pressures they may experience. Drugs, alcohol and smoking (DAS) were mentioned in conversations by many children and appeared to be a high priority in children's health concerns and issues. With the younger children, the high profile of DAS in a variety of media may have been an important influence in their interest. For example, the statements of the Year 3 boy cited earlier revealed that television was a factor.

Children were also aware of and concerned about the pressures on them to engage in drug behaviour. One Year 4 girl worried about what to do if a parent offered her a drink and a Year 4 boy said, *"Like, when you are a teenager, people, like, some other teenagers will try to get you to try drugs or things like that."* Some Year 8 boys were particularly concerned about peer pressure and drugs. One boy suggested, *"At high school you get offered lots of drugs like marijuana and dope,"* and another suggested that a lot of pressure is exerted by secondary school students on younger children, even before they get to secondary school. Year 8 is a time when the transition to secondary school is imminent, and these conversations indicate that these children were well aware of what they were likely to be confronted with in the near future, and were concerned about how they would deal with these pressures from older teenagers.

The findings of Orme and Starkey (1999) in exploring young people's views on drug education in schools were that adolescents do indeed have drug related concerns and issues, but are often unwilling to talk to parents and teachers about them. Children as young as Year 5 in this study revealed that they were unsure of talking to adults they knew because they did not know whether they could trust them, and that most certainly, they would get into trouble. A Year 5 girl stated:

> Who to talk to ... if you've got huge problems and you can't talk to your parents because you're too scared to, and all your friends might take it the wrong way, and you think that if you talk to your teacher, then the teacher will tell your mother, and then you will be in trouble or the teacher will take it to your parents. So, who can you talk to?

Some of the parents and teachers of the younger children expressed their surprise to find issues of DAS raised by the children at such an early age, and had not thought that they really came within children's personal experiences. Year 3 and 4 teachers made the observation that these issues were not really a part of a young child's repertoire, and they blamed television. Only one boy in this study actually revealed that smoking had become habitual, and an issue for him was how to stop. This was a valid point, since most programmes currently taught in schools are preventative in nature and do not recognize the possibility that some children may already be addicted to some form of drug behaviour.

Issues about sex and behavior

The appropriateness of sex education in primary schools has been a controversial and sensitive issue for many years in New Zealand. The fact that it was brought up spontaneously by the children during this study indicates that there is an interest in sexuality at a younger age than many adults might have thought likely.

While the younger children (Years 3-5) made no mention of sexual issues, many older children did. Sixteen of the 31 older children (Years 6-8) wanted information about sexual issues, particularly about sexual relationships and safety. Interestingly, the parents and teachers of these children also had the expectation that children should learn about various aspects of sexual health. Seventy percent of the 34 adults took this view. Even parents with younger children wanted them to learn about changes that occurred in the body, the private regions of the body in relation to appropriate and inappropriate touching, preparation for puberty, preparation for parenting and aspects of relationships, emotional health and HIV/AIDS. One parent pointed out that many parents have difficulty addressing some issues with their young adolescent and suggested that, *"for those parents who don't feel comfortable talking about the birds and the bees, sex education at school is very important. It is very relevant that children learn it correctly and do not get the wrong idea."*

Some of the children in Years 7 and 8 raised issues pertaining to personal and sexual relationships, sexual orientation, safe sex, teenage pregnancy and access to counselling services. Although it was unspoken, the impression gained in the interviews was that some of the more mature Year 8 boys may have been sexually active, and that they wanted information, and saw the conversation as an ideal forum. On the other hand, there were others, particularly two boys, who were less physically mature, who had absolutely no interest in the conversation about relationships. The group setting raises the possibility of some children exaggerating for effect. The differing levels of maturity within one class group has the potential to create problems for teachers, and a careful assessment would be necessary to ensure the appropriateness of sex and sexuality education taught in the classroom.

One Year 8 boy suggested that he was interested to know about sexual protection, because, *"you see these ads and movies about sexual protection and that is a very important area that we need to know about."* The Year 8 girls spoke about learning about relationships, and being able to talk through relationship issues. Even among those students who seemed interested in the topic of sex education, there was a big difference between some girls in Year 8 who were more concerned about social issues, and three boys who continually referred to the physical acts of sex and information they needed in relation to them.

Another Year 8 boy brought up the issue of sexual orientation, same-sex relationships and the issue of HIV/AIDS. Confusion about identity was raised by one boy and the humiliation of dealing with comments like, *"You're gay"* and, *"If you are doing it with someone who has got AIDS, you can get AIDS."* Perhaps not surprisingly, some misconceptions were evident during the conversations about same-sex partnerships. For example:

> *Boy 1: You don't need protection for same sex because there is no chance of getting pregnant.*
>
> Boy 2: *Do you think the only reason you have safe sex is to prevent pregnancy?*
>
> Boy 3: *Safe sex is probably more important to prevent the transmission of disease ...*
>
> Boy 1 *Can gay women get pregnant?*

A Year 7 boy thought that they should learn about the consequences: *"Like if you get yourself pregnant, like if you are 15 and you're pregnant, what um ... how can it affect you?"* Contrary to the popular view of adolescent egocentrism, this was a deviation from thinking about self, to thinking about the consequences for others.

The manner in which health education is taught

The above findings indicate that the children in this research had their own views about DAS and sexuality. What then, did they think about how health education was taught?

Several of the older children in this study referred to the manner in which health was taught and indicated that this concerned them. Some said they realized that health was, *"a big programme"* (Year 5 girl) and that, *"teachers should listen to what we have to say, like, I mean, you might want to learn about food and nutrition, but there are certain other things that you want to know."* Similarly, a Year 7 girl suggested that many of them did not see the importance of some of the less obvious health issues because they were never addressed at school. A Year 8 girl also raised a similar issue, suggesting that because food was always talked about, many of them had come to think of health only in terms of nutrition, and that they actually wanted to go beyond that, *"to the other stuff that we really want to learn."*

Many children had the view that most of the messages they received about health were negative. They wanted reasons and explanations. One Year 8 girl pleaded, *"instead of telling us what not to do, tell us why."* They also wanted to be consulted about what they already knew and what they wanted to know. A Year 8 girl pointed out that *"teachers don't actually ask us what we know, they just tell us what to do."* This suggests that health knowledge and messages continue to be delivered to children in a traditional manner which fails to take into account students' prior knowledge. Such a method concentrates more on the delivery of facts and the obeisance to rules.

What many of these children were intimating was that health education, in its present state, was not addressing their real needs and interests. School health content was still seen as that selected by the adult and delivered to the child. A final conversation with Year 8 girls gave a good summation of children's thoughts. The girls were asked if they viewed health as being mainly about exercise, food and smoking?

> *Girl 1:* *No, I see it as like, school, and relationships, as well as changes at puberty.*
>
> Girl 2: *Like everyone, when they think of health, think of food...*
>
> Girl 3: *Like all of us do because the teachers don't really tell us anything else, so we think fruit and vegetables.*
>
> Girl 1: *And we need to look beyond that to the other stuff that we really want to learn. They should tell us, not just the main points about health, but the other points as well.*

The evidence from this study indicates that children have a wider concept of health than might have been supposed by adults. The findings showed that by the age of 9-10 years, many children had been dealing with some difficult issues, and they had questions that needed addressing. They were also beginning to recognize that these issues could affect their personal health and well-being if they did not know who they could approach for advice and help. One year 5 girl revealed, *"People who have had trouble may not be able to tell anyone, so they might keep it inside and it all builds up and you start coping with it in difficult ways."*

Discussion and implications

In this section the above findings are related to other research on children's views on personal health and health education. Attention is drawn to implications of the findings for teachers, parents and others in health education policy in New Zealand.

One of the findings was that children were more knowledgeable about drugs and alcohol than might be supposed. This is in line with other research. Porcellato, Dugdill, Springett and Sanderson (1999), in their study of primary children's perceptions of smoking in Liverpool (UK), found that although many children aged between four and eight years of age had a negative disposition towards smoking, they had already developed the attitude that it was an acceptable adult behaviour. Many had experiences of smoking if family members smoked, and thought it was likely they would also become smokers in the future. This begs the question about the appropriateness of current drug and alcohol programmes in schools, particularly the level at which they are introduced. Research by McWhirter *et al.*, (2000) aimed to bring about change in the way drug education is delivered. Above all, a new approach to drug education was recommended, based upon what children knew and what they had already experienced within their own social context. Porcellato *et al.*, (1999) argued that intervention strategies concerning smoking needed to change since attitudes and beliefs about smoking had already been established and experimentation was under way, even with many very young children. Currently, prevention programmes in drug education in most New Zealand primary schools tend to be delivered to children as late as Year 7 and 8.

The results from the present study are similar to those by Porcellato, Dughill and Springett (2002) who found that the rationale given by children for not smoking varied within each year and gender group. A notable difference was that while Porcellato *et al.*, found that children generally focused on the physical rather than the social effects of smoking, this study found that a few children recognized the social consequences and some were beginning to debate the social issue. For example, a Year 3 boy pointed out that it was *"alright for dads to smoke, but not mums. It is not good for mothers to smoke"*.

These results can also be set alongside a British newspaper article just a few years ago (*Daily Express*, March 16th, 2002) which reported that by the age of 13 years, 21% of children had been offered glue and other solvents; cocaine 8%; crack 9%; heroin 7%; ecstasy 7% and cannabis 23% (Department of Health). In New Zealand, this knowledge about DAS may well be attributed to the high profile of advertising on television in the past few years, and the fact that many children live in environments where adults engage in DAS behaviours. This concurs with an American study (Hahn, Hall, Rayens, Burt, Corley and Sheffel, 2000) of kindergarten children's knowledge and perceptions about alcohol,

tobacco and other drugs. It was found that out of 126 five and six-year-old children, more than half were knowledgeable about these matters.

The finding in this study that many children from Years 3 to 8 made some reference to DAS is a very serious issue. This certainly has implications for the curriculum and at what level teachers and parents might begin to introduce drug awareness education.

As was found in this study, an American study by Hahn *et al.*, (2000) found that children were knowledgeable about DAS because of the high media profile, and, also because of their use in the home. Children in this present study seemed aware that tobacco was a drug, and they also often referred to close family members who they saw daily practicing the habit of smoking. Close association with those who smoked cigarettes or drank alcohol seemed to prompt concerns by some children, such as why people did it. They were also aware of marijuana, because, as one boy stated, *"Smoking is drugs, and ... there are these other kinds of smokes." This raises the question of when is the appropriate time to raise the more sophisticated issues surrounding drugs.*

The influence of other people on children was evident in this study, as it was a British study by Procellato *et al.*, (1999) that revealed that parents had a major impact on young children's drug perceptions and behaviour, but this was later superseded by peer influence. Taylor (2000) found that a successful method of dealing with adolescent health issues and concerns was through the use of drama. Issues such as DAS could be put into context, and issues and concerns recognized and addressed. The finding that many children indicated that they often received negative messages about health raises the issue of instilling fear into children. This was also found by Roberts, Smith and Bryce, *(1993) who suggested that since many of the preventative programmes taught in schools dealt with the major killers, such as DAS, children were picking up a strong message of fear. This may require careful consideration in the future when selecting appropriate programmes for use with children and how they are dealt with in the classroom.*

The source of children's knowledge should be of interest to adults and policy makers. In New Zealand studies, Thomson (1997) found that children had actually experienced some the matters they raised and McWhirter *et al.*, (2000) suggested that medical and other drugs are prevalent in young people's lives today, and that information and access to them may well come from a variety of sources. These findings challenge the views of teachers reported earlier. This raises the issue of the need for intervention in schools, an approach recommended by Denscombe (2001) to bring about smoking cessation among young people. Thomson's (1997, p. 10) finding that many of the young people interviewed in a New Zealand study said they had never had any drug education during their time at school indicates that even preventative education may be lacking in many schools on the dangers of DAS.

The findings in this study suggest that there is a need for a continuing commitment to drug education in the primary school, and that programmes should not merely employ the preventative approach, but also be open to the need for intervention. Any programmes have a need to be appropriate for age and circumstances (Starkey & Orme, 2001), and above all, that children are consulted and their voices heard (Thomson, 1997; Blackett-Ormsby & McKie, 1999; Starkey & Orme, 2001).

There were wide variations in children's knowledge of sexual matters. In terms of intervention, Jordan, Price, Telljohann, and Chesney (1998) suggest that during the early years of adolescence "education and skills-based training in recognising, defining and taking the proper actions regarding their sexual behaviour should guide the sexual health programmes" (p. 296). Lawlor, Marsden,,Sanderson and Simmonds (1999) identified that there needed to be more time given to sex education in the curriculum, with a need for appropriateness, cultural appropriateness and sexual health counsellors in school. The point made by both Year 7 and 8 boys indicates that maybe there is a need for sexual counsellors even at primary school level. It has been demonstrated that young people in early adolescence required information about "access services [and] emergency contraception ... ." (Taylor, 2000, p. 169). It was clear in this study that although some students were ready for this approach, others were probably not.

One problem in providing sex education in primary schools is the matter of who should teach the classes. It has been shown that teachers may be reluctant, due to the presence of very young children in the school. Most primary school teachers are not trained to teach sexuality, and many have said they do not feel comfortable teaching sex education. Sieg (2003) found the same to be true in her study in England, where teachers talked of the barriers to teaching sex and relationship education. As a consequence, there may be a reliance on public health professionals visiting and teaching. The programmes are, then, seen as something outside the core curriculum. Hence, they may be missed if the school programme is too full, and if the programme is one-off in nature a child may be absent on that day. There is a real need to deal with children's questions, to allay some of their fears, and to work through many of the misconceptions they may have. In a recent article about the continuing obstacles for sex and relationship education (SRE) in English schools, Sieg (2003) argues that if the prevalence of teenagers' pregnancies and sexually transmitted infection is to be reduced, then a more adequate programme of SRE needs to be offered in schools. Sieg further points out that schools are considered a safe environment where young people can:

> Clarify their knowledge, values, attitudes and skills in relation to sexuality, love and sexual relationships, thereby encouraging them to adopt sensible and mature positions from which they make their sexual decision and relationship choices (p. 36).

The concerns which some of the Year 7 and 8 boys raised in this present study suggest that they wanted to be given more information about safety in a sexual relationship, and about the moral dilemmas of relationships. However, some felt that teachers rarely gave them the full picture, or indeed, what they really wanted to know. Sieg (2003, p. 39) points out that SRE has the potential to become, "an education for life and not merely warns young people about risks of HIV, STI infections and unplanned pregnancies, but also assists them in developing healthy and rewarding sexual lifestyles and relationships."

According to Jensen (2000, p, 146), traditional health knowledge on its own increases students' worries and feelings of powerlessness within the health area. If the purpose of health education is to enable children to deal with issues in their own lives, then appropriate adults need to hear what they are saying and incorporate real issues which are of concern to them, and facilitate the learning of skills and strategies so that children may be able to intervene in their own lives and take positive action. They cannot do this on their own. Gadin and Hammarstrom (2000) pointed out that children should be more active participants in the democratic decision-making about health curriculum content.

Conclusion

This study set out to explore with children whether there was any evidence that primary school children were in a position to influence their own health education and meet the objective of a degree of decision-making about their health. The evidence showed that they do possess knowledge that can contribute to classroom health lessons and curriculum design. Children in this study spoke about a range of health issues and concerns, and they did so in a more sophisticated and informed manner than perhaps adults like parents and teachers might expect. The children very ably articulated health issues and concerns, and pointed out that the health education they received did not address all of these issues. It was found that as children progressed through their primary years they became increasingly interested in current and topical issues of a more controversial nature, and they realized that these issues might very well affect them or those they knew. They also progressively began to recognize that their own health behaviour had consequences for themselves, as well as others. They wanted more information about things that were beginning to impact upon their own lives. They had many questions, but showed signs of anxiety when they did not always get answers, particularly during their health lessons.

This study has illustrated the importance of consulting with children about the teaching and learning of content in the curriculum. As Wetton and Moon (1988)argue, if teachers dismiss children's views and knowledge as immature then parents and teachers may very well miss "the critical factors in a successful health education programme" (p. 60). This present study found that children did have views that they wanted to express, and these views were worth listening to. The children wanted to be more than just passive recipients of health lessons designed solely by adults on the basis of only what adults thought children should be learning. It seems, therefore, that there is an opportunity for children to be participants in the construction of a more appropriate curriculum that might bring their own interests and concerns to the fore.

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