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Around Europe

School Health Education in Sweden*

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Introduction

In the autumn of 1973 I made a study tour in Sweden and Finland as a medical Fellow of the Council of Europe to investigate school health education, with special reference to human relationships and personal responsibility for health. This paper is a personal view of my findings and opinions of school health education in Sweden.

*Based on a report to the Public Health Division of the Council of Europe, 4 December 1973.

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Historical Background

Sweden has a well-established tradition of social commitment with a broad and progressive educational system, and health education forms an integral part of the school curriculum. A study of the development of sex education shows how a relationship between doctors and teachers can influence government and how a continuous assessment of results can modify methods. In the early part of the century some doctors and commentators drew attention to the lack of knowledge about sex in the population,¹ and this led in 1933 to legislation to provide compulsory sex education in all secondary schools. But it was not until three years later that training was made available to teachers.

Sex education became obligatory in all school grades in 1956; it was accompanied by an official handbook for teachers and a

guide to the number of hours to be spent on each topic. The teaching was didactic; the children were told what was right and what was wrong and opportunities did not exist for teachers themselves to discover—or even discuss—their attitudes to the situation.

Nevertheless, it was soon common knowledge that all was not well with sex education in Sweden. The incongruity of a country on the one hand having high rates of abortion, divorce, and sexually transmitted diseases, yet on the other hand providing sex education for all school children, produced the predictable reaction in many countries to keep away from any attempt to follow the Swedish lead. But in 1964 a Royal Commission was set up to investigate aspects of sex in relation to education. This reported in 1969² and led to fundamental changes in teaching methods which have become non-didactic, with new curricula and new teaching material. Teachers now have opportunities to examine their own and their pupils' attitudes, and they will have opportunities for further training. Of course, many older teachers found it difficult to change their established traditional methods nor were they prepared to question their attitudes.

I noted with considerable encouragement that these new attitudes were in accord with my own work in health education.³⁻⁶

Responsibility and Organization

Health education, though not a school subject, has a recognized place in legislation. The National Board of Health and Welfare (Socialstyrelsen) is responsible for the co-ordination of health education efforts in the country in general, while the National Board of Education (Skolöverstyrelsen) provides all teaching on health matters at school.

All aspects of the educational system are covered by legislation and in the last five years a new curriculum has been developed: in addition to imparting knowledge and skills, teaching must promote "the development of responsible members of society." The school is not only officially stated to be an integral part of the community but it is charged to work "in co-operation with the home." Education is based on a compulsory nine-year all-ability comprehensive system, starting at the age of 7, in which all subjects and topics are regulated by content and time. Health education is dealt with by various teachers under a variety of topics; the following are considered appropriate—ergonomics, physical education, family and society, in addition to biology, hygiene, and sex education. All teachers receive some training in health education and they have to spend five days each year in extension study programmes which often include a health related topic. The National Board of Education produces the curriculum and the teachers' guides, which indicate objectives and outlines. Audiovisual aids and a list of recommended textbooks are available.

Basic concepts of health education are introduced at the junior level by the discussion of safety in the home and on the road and in the next three years are extended to include an introduction to hygiene, human biology (including sex), concepts of health and sickness, care of the environment, and the place of tobacco and alcohol in society.

In the middle level (ages 10 to 12), all these topics are dealt with in a deeper way and their relationship with society, the home, work, and traffic, discussed. At this stage biology and civics teachers will collaborate with the class teacher. At the senior level (age 13 and upwards) health education comes into at least six subjects—biology, civics, religious knowledge, domestic science, child care, and physical education. Meetings take place between the respective teachers, one or two student representatives, and occasionally the school nurse or doctor before any project is started.

There are four principles of health education in Sweden: (a) it must correspond with age and motivation; (b) all as-

pects must be investigated—biological, psychological, sociological, and ethical; (c) it must be objective in relation to different ethical values and the complexity of contemporary life; and (d) it must have full parental co-operation, the school being seen as an extension of the family. There are frequent teacher-parent meetings.

Contemporary Areas of Concern

Within the National Board of Health and Welfare there is a small Health Education section whose function is primarily to communicate with teachers, social workers, and other interested parties, and which has drawn up a list of topics which it considers to be of concern in contemporary Swedish society: cardiovascular disease; diet and exercise; sex, abortion, and venereal disease; drugs, especially "sniffing" which has recently become popular again among young children and "mellanöl," a medium-strength beer freely available and consumed in ever increasing quantities by young people. The idea is that well-designed material and regular in-service training schemes will help to make teachers aware of these problems.

Evaluation

No attempts have been made to measure the effectiveness of the education programmes apart from the epidemiology figures for gonorrhoea. Whereas the incidence of this disease has increased in the general population in recent years, it has become considerably reduced in teenage boys.⁸ This could well have been the direct result of effective sex education and the increased use of condoms.

Personal Observation

I met people concerned in all aspects of health education in Stockholm and the provinces, from legislators and administrators to teachers, nurses, and doctors. I was also able to spend a considerable time in the classroom and discuss the subject with young people. I attended the first parents' meeting at one school, to which parents of all children in grade 1 (aged 7) had been invited to meet the school staff. Almost all the parents were present, which is usual. The school doctor explained his role and reminded the parents that they would continue to have the most important part in their children's upbringing. He was followed by the dentist and psychologist, and then the parents met the class teacher. Parents are involved from the beginning and are expected to continue working in partnership with the school in order to provide a healthy attitude to life for the child.

I was able to sit in with biology classes dealing with some of the topics of my study. One 13-14-year-old group, 16 in number (the average class size), were being shown contraceptives with discussions on their various advantages and methods of use. Examples were passed around the class and all joined in a full discussion. Another class, of similar age, observed and helped in the dissection of the genital tracts, fresh from the abattoir, of a cow and a bull. The former contained a 3-week-old fetus. This appeared to be especially valuable; the pupils seeing in a most realistic way a well-formed and equivalent size fetus to the human at abortion. The emotional impact on both the boys and the girls was very apparent and this seemed a most realistic method of involving them in considering the consequences of an unwanted pregnancy. In both these classes the pupils left their desks and sat around their teacher in a group.

A third class, aged 12-13, were shown a film on the effects of smoking. This appeared not so successful as the children were unable to identify with the subjects portrayed—the room

had to be darkened—the people in the film were all middle-aged, and the film was not only of foreign origin (German, with Swedish commentary) but obviously not in contemporary mood. The teacher agreed with my comments but told me that no better films were available and that his particular school was not equipped with video-tape facilities. The classroom and preparation room were, however, equipped to a very high standard in every other respect.

I visited a technical high school, where the students were aged 16 to 19. In the waiting room of the medical department there were a variety of posters and pamphlets on aspects of health education such as correct diet, posture, exercise, contraception, and sexually transmitted disease. Pupils are given good surroundings, excellent equipment, and pleasing and tasteful furnishings—everything looked spotless and unmarked, in spite of being 14 years old. There is obvious pride in the surroundings appreciated by the pupils as well as by the staff. Many of the school products are sold commercially in a shop outside the school—these include bread, cakes and pastries, clothes, woven material, and fur coats.

I took the opportunity to have lengthy discussions with school principals and members of both teaching and medical staff on the new problems in contemporary health education. The social framework of Sweden had changed for the first time in many decades.

The growing economic pressures in the western world are also affecting Sweden, though to a lesser degree. Many young people leaving school were finding it impossible to get a job and were therefore staying on for an additional two or three years at school. Middle-aged men, the fathers of pupils at school, were being made redundant and the resentment and social malaise resulting from these factors were finding expression in the young by growing unprotected sexual adventures.

Commentary

To the Swede the notion that health education might reduce the incidence of certain diseases is perfectly acceptable. The relationship between diet, exercise, and health is not only stressed at school but also, in the past year, to the public. Many communities have built sports centres and I visited a well-known example in a provincial city north of Stockholm. A variety of running paths are marked out through the forest and ski tracks on the slopes. P.T. apparatus and an outdoor swimming pool (heated in winter) are nearby and all activities can be followed by a *bastu*—the Swedish equivalent of the sauna. The community had recently started offering “season ticket” facilities to local firms suggesting that regular attendance could help reduce sickness in their staff. The management pay SK 0.40 (approximately £0.40) and the employees SK 0.30 (£0.30) for each visit including a run, some athletics, a swim and *bastu*, followed by breakfast. Even so, this excellent and practical form of health education was not carried as far as the potential allowed. Each table had a large ash tray which the hungry health-seekers were busy filling while partly satisfying their appetite with cigarettes. My suggestion that it would be more appropriate to forbid smoking in the restaurant (and provide an area outside for those who required to smoke) was not greeted enthusiastically.

There are different attitudes to marriage in Sweden. It is virtually unthinkable for a couple to marry before they can afford their own home. This will effectively preclude marriage

before the mid-20s at the earliest and, while they may well be living together before the wedding, their first years of marriage will have a more socially-secure base than exists when privacy has been sacrificed in the parental home.

Hence apparently the Swedish people have been through an educational process in which it is recognized that man should act with responsibility to himself and to his environment, both biological and non-biological. Man requires his environment to be conducive to his own viability and productivity and the fundamentals of health education form an integral part of every Swede's upbringing, both at school and at home.

Relevance to Britain

Ten years ago the Cohen Committee⁹ recommended that health education should be introduced into schools in Britain, and various recent publications have reinforced this view.¹⁰⁻¹² Nevertheless, no policy statement has emerged from either the Department of Health and Social Security or the Department of Education and Science and county education authorities have generally expressed no interest in the subject.¹³

Sweden has evolved a practical system of health education involving the school, the family, and the community, without any large hierarchical and administrative superstructure. Each teacher has a clear notion of the extent of his responsibility and recognized areas of concern, such as sexual behaviour and drugs, are included in education on human relationships and personal responsibility.

Britain could well emulate the Swedish model. This would require active co-operation between the medical and teaching professions, some reorganization of teacher training, and appropriate legislation. In the meantime it would be reasonable for health education working parties to be established in all districts, enabling teachers, doctors, health visitors, health education officers, and social workers to work for preventive care in the community.

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