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Health education in schools

Edukacja zdrowotna w szkołach

INTRODUCTION

Health education, is one of key methods of realising health promotion programmes. The starting point for teacher's activity is a thesis: education as a health condition [Demel 1980]. It assumes that health is a group of somatic and psychosocial features, which constantly change and develop under the influence of achieving an educational goal. Education process can protect it, reinforce it and develop it to the higher approachable for an individual level. According to this thesis, health is not a goal itself, but a mean and a condition, which enables human being to use all the possibilities to make life more satisfying, productive and better [Woynarowska 1995]. Such an explanation makes the school an environment of practical realisation of health education programmes.

Although there is a common agreement about the meaning of health education at schools, there is still no effective idea of organisation and realisation of those goals. However there are conditions to create a modern health education system in school environment. In 1998 health education has been included in general education programmes and educational paths¹. We also possess much health education programmes addressed to both teachers and students. Those programmes are definitely useful for a teacher, because they include detailed classes scripts, didactic help sets, very often audio – visual and methodical guides.

GOAL, METHOD AND RESEARCH ORGANISATION

Different needs referring to health education and its complex conditions bring to life many questions of diagnostic nature. One of the questions is: what social and material conditions does contemporary school possess and how deeply does the school use health education theories or health education programmes?

Method of diagnostic poll together with interview method and data analysis has been used to collect necessary information. All data has been subjected pedagogical analysis by inspection sheet's mediation.

Research has been conducted in 46 elementary schools from the PSSE activity area in Racibórz. Interviews with schools' headmasters and teachers had a form of directed conversation. Documents' analysis included didactic and educational programmes' analysis, school committee's protocols, class registers, extra-school registers and data obtained from school medical care staff.

¹ Minister of National Education decree from 15 February 1999. Referring to general education programmes. (Dz. U. Nr 14, poz. 129)

Table 1. Structure of analysed schools

Kind of school	N	%
Rural schools	22	48
Small urban schools	17	37
Large urban schools	7	15
Total	46	100

Source: Self-research

* less than 500 students

** more than 500 students, explanation refers also to following tables.

RESEARCH RESULTS

2.1 Realisation of health education programme

Among 46 analysed schools, 21,7% did not realise any health education programmes and 89,9% did realise it although they had different assumptions. 67,4% of schools realised only chosen issues of health education programme using prepared educational programmes like „Siedem kroków – elementarz”, „Czas przemian”, „Śnieżnobiały uśmiech”. These schools delimited health education to using suggestions offered by institutions co-operating with schools. That way has been chosen by 86,3% of small rural schools and 57,1% of large urban schools. Both, rural and urban schools initiated elements of project “Health Promoting School”. It could be observed mainly in urban schools; in 17,6% of small urban schools, in 14,3% of large urban schools and in 4,5% of rural schools. These facts prove that schools realising health education issues choose their own, local and possible means. Fact that schools prefer to use already prepared programmes is very interesting. What is important, that the most of programmes focus only on chosen health education issues, which does not constitute an exhaustive base for students health knowledge, which, if obtained, should help him to successively form a mature personality, aware of the meaning of good and favourable choices referring to his own and other people's lives.

Both, in headmasters' and teachers' opinion, health education realisation does not cause any problems. However issues connected with addictions prophylactics and sexual education seem to be too difficult for them. It might be result of lack of such methodical competence as dialogue, active listening, psycho-education, and negotiations. Wide factual knowledge is essential in this point.

Many teachers transfer their duties in the area of health education, promotion and protection on medical care, identifying periodical examinations with education process. Methods of realisation health education are mainly lectures full of biomedical data. That brings to life a conviction, that facts and information are enough to make students understand meaning of health, ways to protect and to appreciate it. However, up-to-date approach claims that health education process has to make student to use that knowledge effectively – to think, to wonder, to make decisions and activities referring to health and to become more and more competent about it [Lutowski 1994].

Table 2. Realisation of health education in elementary schools

	Elements of health education		Health Promoting Schools		No realisation	
	N	%	N	%	N	%
<i>Rural schools</i>	19	86,3	1	4,5	2	9,1
Small urban schools	8	47,0	3	17,6	6	35,3
Large urban schools	4	57,1	1	14,3	2	28,6
Total	31	67,4	5	10,8	10	21,7

2.2. Teachers' knowledge of health education programme

Chances for achieving success in school health education increase when teachers who realise it, are earlier informed about programme plans, goals and assumptions. Introduction of teachers into programme details and bases enables deeper identification of students' and environment's heart needs, better predicting and eliminating difficulties and problems. It also makes an opportunity to discussion,

makes all education process more real and links programme with school life [Williams 1989]. However such activities are time consuming and usually teachers are just acquainted with the health education programmes in the beginning of the school year without any deeper involvement. In 92,5% of rural and large urban schools and 81,8% of small urban schools introducing health education programmes took place this way. Such situation makes impossible teachers and students to participate actively in planning educational goals in the area of health promotion and protection, because they are already planned. That might be connected with lack of effective methods to estimate health education effects in investigated schools. None of these schools used this kind of pedagogical examination. Most of teachers identified effects of their educational activity with students' achievements in competitions and olympics. This result indicates that teachers do not realise that they not only influence on students' cognitive competence but also on their values, motivation, attitudes, behaviours and habits.

Summing up we can say school input into health education is not satisfying. Schools do not realise all necessary stages of health education process starting from student's health needs and finishing at lack of estimating education effects.

Simultaneously, in almost every kind of school (except one rural and one large urban school) issues teachers' committee discussed connected health education. Fewer schools organised arranged school committee discussions focused exactly on health education [40%]. They were mainly schools realising "Health Promoting Schools" programme. That proves that health education has and should have its own place in school programme. That creates perspectives and chances to effectively develop health education theories and to embrace more and more students with educational practice.

2.3. Health education organisational schemes

Essential condition of correct health education programme realisation at school is co-ordination of its course. Headmaster, selected teacher or team can play role of process coordinator. Investigated schools had different variants of health education process coordination. The most common organisational solution was the one, where headmaster together with team was responsible for the process. Such solution was used in case of 45,4 % rural schools, in 42,8 % of large and 35,3 % small urban schools. Team consisted of biology teachers, physical education teachers, pedagogist and school nurse. Variant with one person coordinating the process was occurred much rarely in case of urban schools. Headmaster as a coordinator occurred in 28,6 % of large and 29,4 % of small urban schools. Single teacher at this position occurred much rarely for example: biology teacher in 11,7 % in small urban schools and 4,5 % rural, physical education teacher 5,8 % in small urban schools and 4,5 % rural] or school nurse 6,5 %. Such situation is probably caused by the fact that those specialists are formally better prepared to health education teacher in comparison with the others. In large urban schools that variant did not occur at all.

Part of schools, both rural and urban did not have any coordinator. Such situation took place in 40,9 % of rural schools, 28,6 % large urban schools and 5,8 % of small urban schools.

It seems like about ¼ of investigated schools realised health education programme without proper coordination, which probably influenced educational effects concerning health. We should notice that in small schools, where teachers often meet, role of coordinator does not have to be exposed. That fact is proved, because 40,9% of rural schools does not have a coordinator. What is interesting; 28,6% of large urban schools also does not have one, although relations in such schools are more formal and delimited.

2.4. Participation of school medical care unit in health education realisation

Participation of school nurses and hygienists in health education programme is impressive. Realising it is a part of their regular duties. They participate in planning the programme, realise it, estimate the effects, help to choose the most appropriate educational content, methods, materials, initiate and support different forms of activities promoting health. They also organise classes, help students' organisations in pro – health activities and are headmasters' advisers regarding physical and psychical environment' hygiene [Woynarowska 2000].

In examined schools, both rural and urban, medical care staff participated in health education programme. None of the schools maintained lack of medical staff' commitment. In this area we can notice an improvement in comparison to recent years. Since lack of participation in health education process has been reported by 50% of headmasters, mainly in rural schools [Golinowska 1995].

2.5. Cooperation with parents

Parents are responsible for custody and child's education and they can not feel relieved from it when child starts attending to school. It also concerns health education.

Parents' role has twofold character:

1. to support knowledge obtained in the class,
2. in case of competent knowledge, to participate in realisation of chosen topics [Woynarowska 1997].

In all of examined schools, a cooperation with parents delimited to parents – teacher periodical meetings, where parents were superficially informed about school's plans referring to health education. However they were not actively encouraged to participation in it. Information they obtained from school hygienist referred only to balance-sheet results and school medical care activities. What is interesting; such situation refers also to schools realising European project "Health Promoting School", whose main assumption is to make school, family and all society corporate [Woynarowska 2000]. Summing up that part of our considerations, we can say that schools do not use the possibility of cooperating with parents in the area of students' health protection and promotion. It might be result of lack of parents' interest. School should organise seminars, workshops concerning understanding new programmes for parents and encourage them to participation in classes and school tours. That could help them to understand programme goals and actively participate in their children' health education [Young, Williams 1990].

CONCLUSIONS

Presented analysis of empirical data allows to state that schools in our country do not take an opportunity of health education programmes. There are not enough ideas; not necessarily equal; organisation and common introducing health education to schools.

1. Programme realisers are not competent enough to plan classes referring to health issues. This objection refers to the fact that educational content is not adjusted to current and future student's health needs and that there is no estimation process referring to changes and effects caused in student's personality by health education.
2. Teachers in they work take an "expert" position. They usually use traditional education methods, which results in students' passive participation. However modern health education approach respects the rule to look at individual at holistic way.
3. There is not enough cooperation between schools and parents, which should become responsible for health education programmes and realise it together with teachers. School should be interested in parents' attitude towards their activities and make parents to understand how strongly they influence their children in case of forming attitudes, value system, and convictions referring to health.
4. Mentioned problems with realising modern health education programmes demand system solutions and many experts' cooperation. Main goal for teachers, parents and local community is to create schools that would become a healthy place to live, to learn, to relax and to grow up.

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RECAPITULATION

Health education is one of the main methods of health education realisation. Health as a group of somatic and psychosocial features constantly changes and develops under the influence of achieving an educational goal. Education process can protect it, reinforce it and develop it to the higher approachable for an individual level. Therefore school becomes an environment of practical realisation of health education programmes. Different needs referring to health education and its complex conditions bring to life many questions of diagnostic nature. That article constitutes an attempt to answer questions like: what social and material conditions does contemporary school possess? How deeply does the school use health education theories or health education programm?

STRESZCZENIE

Edukacja zdrowotna jest jedną z kluczowych metod realizacji programów promocji zdrowia. Zdrowie jako zespół cech somatopsychospołecznych podlega zmianie a także doskonaleniu pod wpływem wychowania zamierzonego. W procesie edukacji tkwią siły zdolne je zabezpieczyć, utrwalić i podnieść na najwyższy, dostępny dla jednostki poziom. Zatem szkoła staje się środowiskiem praktycznej realizacji programów wychowania zdrowotnego. Zróżnicowane potrzeby na edukację zdrowotną jak i złożone jej uwarunkowania skłaniają do poszukiwania odpowiedzi na wiele pytań, głównie diagnostycznej natury. Praca jest próbą odpowiedzi pytanie: jakimi warunkami społeczno-materialnymi, będącymi istotnymi determinantami efektów edukacyjnych, dysponuje współczesna szkoła oraz w jakim stopniu wykorzystuje ona propozycje teorii wychowania zdrowotnego, akty legislacyjne jak i programy edukacji zdrowotnej ?