Expectations from School Health Education towards Vision 20:2020

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Abstract

This paper discusses the expectations from school health education if the dream of attaining vision 20:2020 is to be a reality. The paper looks into the rationale for school health education, the status of school health education as well as expectation from school health education. The precede model which identifies multiple factors that influence health related behaviours has been discussed. It brings into focus the predisposing, enabling and reinforcing factors as they can help to bring about the desired behavioural change through school health education. Conclusions have been drawn and recommendations made.

Few people argue against the premise that achieving prevention is preferable to attempting cure. A history of common sense would show that every society believe "an ounce of prevention is worth a pound of cure". Also no country, no matter the degree of its affluence does not see the logic behind keeping a healthy citizenry, when the citizens of a nation are healthy, the economy which is the cooperate responsibility of the people is indirectly affected to the affirmative. Therefore, school health education is expected to lay learning process through which individuals or groups voluntarily adopt behaviours beneficial to health, its goals are therefore, both curative and prevention, that is, to reduce morbidity, mortality and health promotion (Ajala, 1998).

Health education which aims at changing an individual's behaviour in a way that will lead to protection, promotion and maintenance of his health and thus, the health of his family and community, can take place in different settings including the school. Of all these settings the school has been identified as having the greatest and most lasting impact on people and society. Therefore, Mayshark, Shaw and Best (1997)

pointed out that due to increased knowledge about individual health, large groups of responsible people are now convinced that significant gains in health in the future can best be achieved through health education in the school setting. Health education in the school can be achieved through various activities in the school, notably through formal classroom instructions on health, provision and maintenance of healthful school environment and provision of health services such as: health appraisal, immunization, referrals, emergency treatment and record keeping etc.

Rationale for School Health Education

The goal of education cannot be separated from the goal of health education since both endeavours are concerned with the upliftment of the individual's physical, mental and social make-up, for effective functioning of the society. The quest for knowledge, for rational thinking and purposeful societal living which is the focus of general education cannot be meaningful without an abundant health of body and mind of the learner (Eke, 1998). Therefore, the school as a custodian of general education has both legal and moral responsibility to provide for the learner, experiences that promote good health. Lucas & Giles (1976) and Jellife (1984) summarized the benefits of health education in the school to include:

(a) Providing a firm foundation for healthy habits of later years
(b) Enabling the child to improve health practices in the home and community
(c) Enabling the child to benefit maximally from the academic and other programmes of the school.

School health education is therefore preventive, promotive, advising and educational. It changes perceptions, values, attitudes and behaviours for healthy life.

Status of School Health Education

Concern for health of the school child is not new in some parts of the world as attested to by Mayshark et al (1997) who gave isolated examples of school health activities in Europe and America in the 19th century where these countries still enjoy front line recognition, the Nigerian school child is yet to get full benefits of these activities. It does not mean that school health education is non-existent in Nigeria; many evidences show that the health of the school child in this country has been of little concern to the government, health and school authorities and the general public. Nigerians regard school as only a place of academic pursuits and nothing more and therefore place minimal priority on school of health education. An array of research findings show continued haphazard status of health education in the school. Eke (1987) carried out a research in which the perceptions of 105 secondary schools health education/science teachers drawn from 11 states of the federation were sought on the status of health education/science in their various schools and states, in terms of: (a)

curricular provisions (b) time allotment and (c) attitudes of non-health teachers in their schools towards the subject.

The results revealed an alarming (51.4%) of the schools give partial or no recognition to the subject on the curriculum. In time allotment, only (39%) of the schools allot partial or no time. Further the study reported a high response (60%) of indifference and negative attitudes among non-health teachers in the schools that were studied. The results leave no doubt that health education in Nigerian schools is a neglected subject.

Expectations from School Health Education

Samuel (2010) quoting Summonds (1974) opined that health education can be delivered through at least five key organizational vehicles: (a) educational institutions (ie, public and private schools, colleges and universities; (b) health organizations (including voluntary health agencies, health departments and other official agencies); (c) health facilities (eg, hospitals, clinics, ambulatory care centers); (d) media organizations (newspaper, radio, television); (e) employment settings (business and industry). Each of these five vehicles has a distinctive organizational mandate, addresses a unique population and has specific types of organizational resource to employ. Thus the might each try to strive toward and indeed to achieve separate types of health education outcomes. Ideally, the outcomes of health education implemented in each of these settings should be complementary any to, and synergistic with the outcomes of health education implemented in other settings.

The mandate of educational institutions is to provide education about numerous subjects considered important to the community. The populations that educational institutions address range in age, developmental abilities, and impressionability from kindergartens to university youths. These groups are very healthy in relation to most other population groups; although they face distinct health risks at various levels. In terms of organizational resources, no other delivery setting even approximates the magnitude of means available for providing education about health. Given the organizational mandate of schools, the characteristics of the populations' they serve, and the type of resources they could make available, we can expect five distinct but related outcomes from school health education if vision 20:2020 is to be realized.

School health education is expected among other things (a) Increase understandings about the philosophy and science of individual and societal health (b) To increase the competencies of individuals to make decisions about personal behaviours that will influence their health (c) Increase their skills and inclinations to engage in behaviours that are conducive to health (d) Strategically integrate with other school and community health promotion efforts (e) To increase the skills of individuals to maintain

and improve the health of their families, and the health of the communities in which they reside.

Nowhere else can we expect to help individuals systematically to understanding health as a variable entity, to appreciate sensations associated with variations in health, to understand the functions of health for the individual and the society, and hence develop conscientiously a dynamic sense of value for health. School health education should be able to ensure that individuals understand how health is influenced by various factors within four health categories viz human biology, environment, lifestyle and health care organization. It is also expected that, health education in schools can help individuals and collectively; can control the various factors that influence their health. School health education is also expected to ensure that individuals have skills to understand new health issues as their life interest as conditions change, as knowledge about health changes, and as social circumstances change.

One of the fears associated with health education is that it interferes with individual freedom by attempting to modify individual's life styles. Actually, the goal of health education is just the opposite – to gurantee the individuals freedom of choice regarding his own health by giving him reliable information on the need to make decisions about how he wants to live. If one accepts this proposition, the one of the functions of health education in contrast to changing behaviour, one would increase the competencies of individuals to make valid decisions about personal behaviours that can influence health. The effectiveness of health education programmes would be determined in part by the quality of the processes by which participating individuals made their decisions, not by the actual decisions made.

There is a vast difference between deciding to engage in behaviour that is conducive to health and actually engaging in it. For one thing, certain skills and inclinations may be required by the individual in order to practice the behaviour. Example, if an adolescent boy called Edet studies about diabetes mellitus in school and subsequently learnt through discussion with her parents that there is a distinct familial history of the disease on both parents side, tending to be obese, he decides to reduce the amount of sugary food he takes daily. Thus he must be skilled in determining which food contains high and low amount of these substances. These means he must be good in interpreting ingredient labels on food packages. He must be skilled in knowing how to maintain adequate levels of vital nutrients; at the same time he is decreasing his intake of foods that contain high amounts of sugar. In addition he must be skilled in responding to flashy media encouragements to enjoy frequently the very types of foods he is trying to avoid. Also, he must be skilled in responding to his peers when they suggest that he is somewhat odd in maintaining such an uncommon diet, and in responding to persistent enticement to follow them in partaking of the types of food he had decided to forgo. If

he develops these skills, they would expect Edet to be able not only to engage in the behaviours that he decided to adopt, but more importantly to be able to maintain them overtime. Therefore they should expect school health education to increase the skills and inclinations required by individuals to engage in behaviours that are conducive to health. Schools can increase the competencies of individuals to make decisions about health related behaviours, and they can increase the skills and inclinations required by individuals to engage in and maintain those behaviours. The Precede Model (Green, 1974) give insight to other factors to be addressed.

The Precede Model identifies multiple factors that influence health related behaviours and classifies them into three categories:

Predisposing, Enabling and Reinforcing

Predisposing factors: - These include relevant characteristics with which a person confronts the options of adopting a particular health behaviour. Some of these characteristics such as referent group norms and values are difficult to change through school health education, which others (such as demographic variables are unalterable). However, some very important predisposing factors, i.e. knowledge and attitudes, are conducive to change through education. For example, a school health education programme should ensure that Edet is sufficiently competent to determine the extent to which he is susceptible to diabetes mellitus disease; extent to which such disease would affect him physically, emotionally and socially; the potential benefits of engaging in various behaviours thought to prevent such disease, and the cost of engaging in those behaviours. The programme could also be expected to provide Edet with quest to engage in behaviours that might prevent diabetes mellitus disease (Green, 1974). Additionally, if he had the skills required to engage in these behaviours, he might be more pre-disposed to do so. However, the occurrence of these behaviours will be influenced so much by enabling and reinforcing factors.

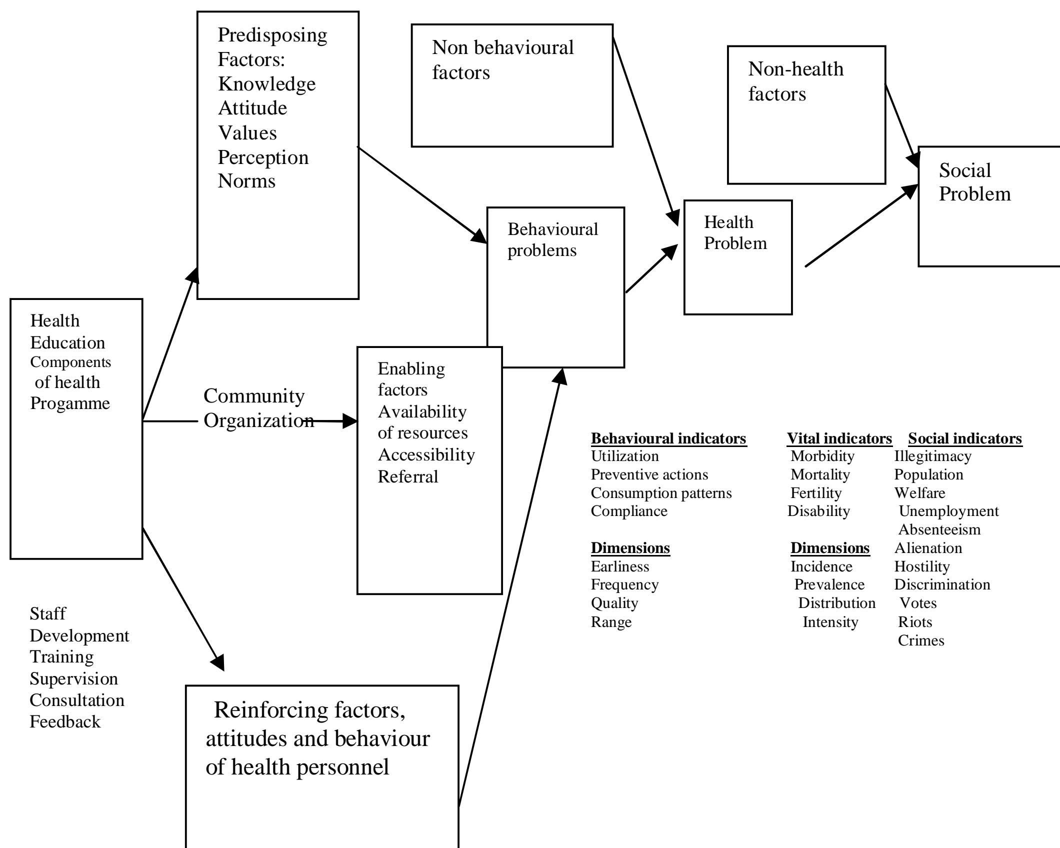
Enabling factors: - encompasses all aspects of availability, accessibility and acceptability of resources. As such they are largely influenced by community organizations; and hence usually are not influenced directly by school health education alone. Example, competent and skilled though, Edet might be, he may not be able to engage in the behaviours he has chosen. His parent might not purchase or prepare the foods that would allow him to reduce consumption of sugary substances. His parents may not know enough about diabetes mellitus and its relationship to diet or they may know about the relationship but be sufficiently motivated to do anything about it. They may wish to do something about it, but appropriate meal alternatives, infact, may not be available; or may not be perceived available. Alternative foods may be available but they may be beyond the purchasing power of the family. The family may be able to purchase alternative foods, but may not know how to prepare them in a palatable way; or

how to prepare them at all. To compound matters the cafeteria lunches provided by the school may not enable Edet to select for acceptable alternatives to reduce his sugar intake.

Thus, in order for Edet to perform the behaviour he has choosen, school health education activities that may have predisposed his choice must be integrated strategically with school and community health in promotion efforts to enable the targeted behaviours. For instance Edets' school could ensure that cafeteria lunches offer alternatives that would reduce the risk of diabetes mellitus pathologies. Perhaps more importantly relevant community organizations could work with school personnel to ensure that Edet's parents understand the relationship between diet and diabetes mellitus disease and have the necessary skills and resources to enable Edet to consume appropriate foods at home. As one method, community adult education class could be coordinated with the school programme to help parents learn how to select and prepare foods that are nutritious, low sugar content; convenient to prepare, appetizing and perhaps less costly than foods they presently serve.

Reinforcing factor: - comprises the perceived consequences of the behaviour or any action of family members, peers, media and others specifically associated to the targeted behaviour, that serve either to reward or penalize the individual for engaging in it. Edet might have been prone to engage and maintain his behaviours if his parents praised him for it, if the media suggested that such behaviours were becoming, if his friends encouraged rather than discouraged him. As with enabling factors, school health education activities are limited in their capacity to address reinforcing factors unless such activities are integrated strategically with community health promotion efforts. Thus, recognizing that behaviours are influenced by important factors beyond the influence of the school alone, we can expect school health education programmes to contribute to enhancing personal health behaviours, but only according to the extent to which such programmes function in concert with distinct school and community health promotion efforts that have been designed to enable and reinforce targeted health behaviours.

THE PRECEDE MODEL



Approximate Relationship among Objects of Interests in the Planning of Health Education

As the illustration about Edet suggested, school health education programmes especially those that are integrated with other community health promotion efforts can provide information to families of participating students, by employing the students as a "common messenger" (Mertberg, 2002), to precipitate healthier familiar behaviours. More importantly they can expect school health education to increase specific competencies and skills that students can use to predispose, enable and reinforce healthy lifestyles of the families they will be responsible for as adults (Ajala, 1998).

Finally, health education delivered in schools is expected to increase the abilities of individuals to analyze the forces of government, economic and social organizations that can influence health. In a participatory democracy it is vital for people to understand the complex issues that surround existing or proposed social actions to protect and improve the health of the population. If people are to make informed wise social choices, they need to be appraised, for instance about the costs and benefits of prescribing the use of saccharin in foods, legislating the usage of seat belts, of fluoridating community water supplies, of regulating into emissions and industrial waste, or of supporting improved access to medical services for the poor and elderly. We must expect schools, perhaps better than any other delivery setting to increase the desires and abilities of individuals to participate effectively in such civic decisions and civic activities that ultimately influence their personal health, the health of their families, and the health of communities in which they reside.

Conclusion

Achieving the above expectations means health education programmes implemented in schools need to be comprehensive. Comprehensive school health education programmes include elements that can be grouped into five general categories; (a) proper goals and objectives; (b) appropriate content; (c) sufficient resources; (d) useful evaluation; (e) effective management. Only when school health education programmes meet such requirements, should we anticipate them to achieve the expectation described. The need to delineate what we can expect as they begin to understand the complexity of outcomes that might be attained; and as we respond to others they might expect outcomes that may be inappropriate for the type and extent of pragmatic inputs provided. However, expecting too much or too little of health education can cripple it. The grandiose expectations for some advocates and practitioners will state health education unnecessary for failure. The limited expectations of others will relegate it to activities which are trivial at best, wasteful at worst. The potential of health education is limited only by its inadequate integration with other sources of influence on health-economic, social, legal and environmental.
The proper understanding and use of health education then, is the context of the several determinations of behaviour and health. Isolating it in the classroom without regard for the family, the peers, the economics and the genetics or environments that will reinforce,

enable and predispose the intended behavioural and health outcomes can only lead to a temporary or partial achievement of these outcomes.

Recommendations

Based on the above discussions, this paper, therefore, recommends that:

1. The public should be sensitized to the health needs and problems of school children and also the benefits of health education in the schools.
2. Governments, Federal and States should review, articulate properly and enforce their positive stand on school health matters.
3. A functional health programme including a healthful environment, provision of basic health services and a compulsory health instruction be established equally in both urban and rural schools.
4. Government should mandate inter-departmental effort in the administration of school health programmes.
5. Teachers should be reoriented towards their role in school health and also, prospective teachers in training be exposed sufficiently to school health needs and problems and their expected roles in performing solutions. All are in keeping with the spirit of expectations from school health education toward vision 20:2020.

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