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Health education assumptions and models and their implementation in the Polish educational system

Introduction

Health education is a relatively new term in Polish academic literature, however, issues connected with health protection have been present in the Polish educational system for a long time. Originally, this study was defined as "health upbringing", which constitutes the integral part of human personality, involving among others: the production habits indirectly or directly, shaping attitudes aimed at boosting the health and developing interests in the issues related to the structure and functioning of the human body (Demel 1968). This term is still in use. In the 1970s health pedagogy was developed.

According to Mazurkiewicz – its author – health pedagogy provides a theoretical base for health education offering the fundamental methodological basis. The subject of its analysis is the process of upbringing to health and teaching health, the essence of which is developing one's competence through "providing the information, shaping a system of values and behaviours connected with health" (Kapica 2001). Currently we are observing a wide interest in the issues dealing with health protection. As a result, more and more faculties such as 'health studies' are created at universities, the role of which is to educated highly qualified staff, who deal with health promotion in the broad sense. It has been several years since the increase in research studies in the scope of health sociology and psychology started to be observed. Also, for several years one can observe increasing interest in research in the field of health, sociology and psychology, as well as in the impact of the disease on the processes of teaching and education. This tendency involves the educational system. Since 1992, some schools have been 'promoting health', and their aim is to organize an environment supporting healthy lifestyle among children and teenagers and also the local community (Brzenska 2012). The new core curriculum of general education from 2008 indicates the increasing role of health education. The curriculum assumes that 'the important task of any school (apart from upbringing) is health education' (Woynarowska 2012b). Joining the 'health education' model to

the curriculum of physical education in lower and upper secondary schools / 'junior high school and high school' / opens a new stage in school's health education in Poland (Bogacz 2009).

Health education and its goals

There are many definitions of health education. Over the past few years psychologists, sociologists, and public health specialists have brought a new interdisciplinary dimension to health education. Health education is the right of every human being, especially a child, because it allows obtaining competence in protection and improvement of one's and other people's health. That is why health education favours:

– positive adaptation to developmental changes,
– development of one's interests,
– prevention of disorders and risky behaviour (e.g. using psychotropic substances) for health and development.

Systematic health education in schools is considered as the most profitable and long-term investment in a healthy society (Nakijma 1993). According to T. Williams, health education is a process which makes people take care of their own health and the health of the society they live in (Williams 1988). Health education is understood as the process in which a person uses knowledge in an effective way – it means that they make a decision and act where the following outcomes matter for themselves or the society they live in (Andruszkiewicz, Banaszkiewicz 2008).

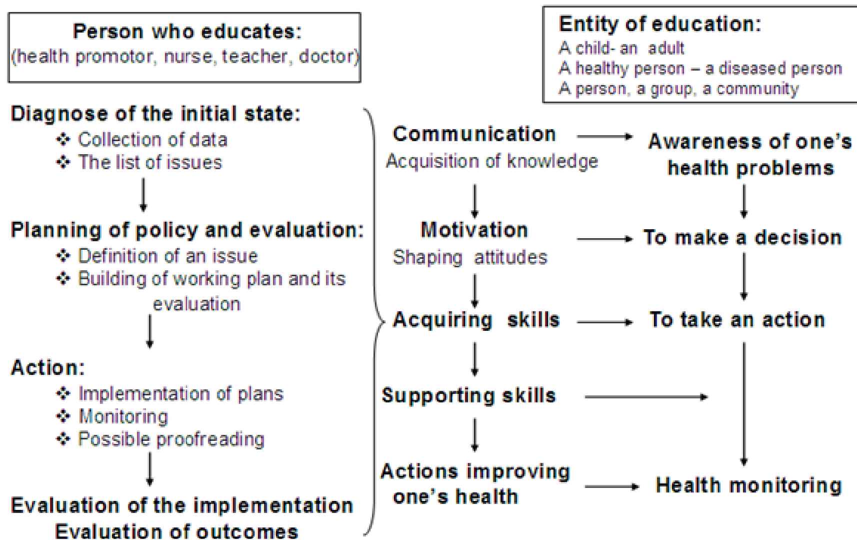

Fig. 1. The process of health education (source: Andruszkiewicz, Banaszkiewicz 2008)

However, it should be mentioned that health education is not only a didactic-educational process conducted at educational institutions (formal education), but also consists of social activities that have influence on people's behaviour (Krawczyński 2003). It is essential that health education should not only mean institutional forms of acting. Health education of adults is based on the activity of an individual, on self-improvement. They can also take advantage of various educational solutions (for example the University of the Third Age). It is crucial that health education is a lifetime process which embraces all stages of people's live. Next stages are connected with different perception of the world, changing priorities, preferences and increasing experience influence on everyday activity, including risk behaviour as well as aspects which do not concern health issues (Szewczyk 2000).

Health education understood in a traditional way embraced mainly education which boiled down to teaching of various aspects of health. However, aims of health education and its expected effects should be differentiated according to the needs of the given group of people (Woynarowska 2010a, 2010b, 2012a). Nowadays, according to the widespread belief, relaying of knowledge concerning health cannot be the main goal of health education. There is a risk that excessive amount of information can contribute to lack of understanding and general discouragement.

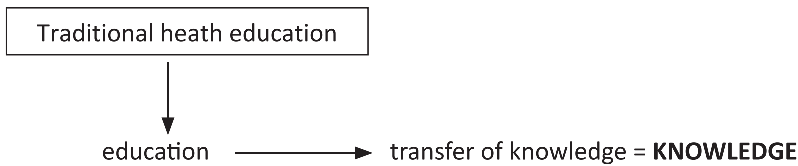

Fig. 2. The goals of health education in traditional approach (source: Andruszkiewicz, Banaszkiewicz 2008)

The main goal of health education should be 'building' people's competence. According to J. Skrzypczak, shaping particular qualifications in a given field means to provide people with a certain amount of knowledge, which should be understood by them. It also means to support people in using their qualifications in a proper way and developing a motivation to act accordingly (Skrzypczak 2000).

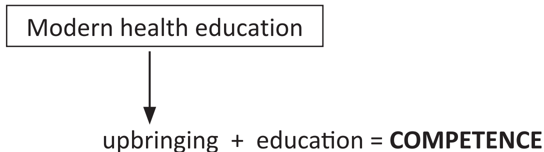

Fig. 3. The goals of modern health education (source: Andruszkiewicz, Banaszkiewicz 2008)

The universal function of health education is exerting relatively permanent and positive change in the human activity. The new, differentiated goals of health education were presented in the comment to the curriculum 2008, which includes helping students in:

- gaining knowledge of themselves and the course of their development,
- understanding what is health, which determines why and how to care about it,
- developing a sense of responsibility for their own and other people's health,
- enhancing self-esteem and confidence in their abilities,
- developing personal and social skills conducive to well-being and adaptation to daily life,
- preparing to participate in the activities for health and creating a healthy environment at home, school, workplace and community.

Achieving these objectives requires, however, various actions taken within the program of teaching, child care and school prevention program. This process is long and requires the involvement of students and their parents, because the effectiveness of health education depends on whether the children transfer what is taught at school into their daily lives (Białek 2011).

Conditioning of health education

Implementation of the health education program should be adjusted on the one hand to cognitive recipients, their age group, social and cultural conditions, as T. Parsons noted in his research (Woynarowska 2012a). Effective health education should have the characteristics of universality and the program should be based on prior analysis of the problems of the group, community, or culture. Culture of the community, influencing an individual's behaviour, is also influenced by the so-called "standard of health", i.e. the way in which somebody meets their health needs (Tobiasz-Adamczyk 2000). According to the PZH research, among the most important issues in the field of health education young people list: sexual maturation, nutrition, substance abuse, mental hygiene and disease prevention (Miller, Supranowicz 2002).

One of the learning outcomes of health education is to form positive habits (behaviour) conducive to maintaining health in good shape. According to Łuszczyńska (2004), health behaviours of individuals are classified as relating to health or those that have documented health effects. In these terms, we can talk about behaviour:

- related to health,
- focused on health, which means consciously taking steps to protect and preserve the health,
- health risk, both conscious and unconscious actions that have a negative impact on health.

Implementation of pro- or unhealthy behaviour is therefore a matter of choice among many possible patterns of behaviour. At the core of these individual choices are values mainly recognized by people, and the hierarchy of values, mutual submission and place health occupies in the hierarchy (Puchalski 2004, Andruszkiewicz, Banaszkiewicz 2008). There is no doubt that the culture of the society affects the implementation of a number of behaviours that make up the typical lifestyle. A classic example is the patterns of diet, which is usually conditioned by a tradition,

customs and tastes formed in the process of socialization. The composition of meals, the amount of meat and its kind are typical of certain groups (cultures) and are passed down from generation to generation. Similar considerations are, among other things: spending free time, caring for personal hygiene or attitude towards drugs. Another important factor in human life style is also the role of the media, functioning independently of culture, which are more often a health education tool, where education is realized e.g. in the form of social campaigns (Włoszczak-Szubzda et al. 2007, Purchałka, Brzenska 2012).

Łuczyńska (2004) classifies the health behaviours:
- health-promoting behaviours (regular exercise, proper diet)
- preventive behaviour, for detecting disease.

An important issue is the theme that accompanies the delivery of the health education because it may affect the formation of permanent habits or result in just a temporary modification of behaviour. Those themes may include:
- desire to maintain good health and well-being (welfare of one's own),
- willingness to adapt to the prevailing patterns of behaviour in the group (the need for approval),
- willingness to try new "things",
- fear of disease and its consequences.

Behaviours relevant to health in accordance with the guidelines of the WHO and the European Union are now included in the list of recommended indicators for monitoring. Therefore these issues are constantly updated and controlled, influencing health policy undertaken by the Member States.

Features of contemporary health education

In recent years, significant changes in the design and implementation of health education have been introduced in the school. The basis for these changes was the plan to include a holistic health model, which assumes that:
- every human being is a whole, but also part of the wider society and nature,
- there are complex relationships between humans and the environment and human health is affected by many factors simultaneously.
- Among the factors that have the greatest impact on human health we should distinguish: lifestyle, the group everyday behaviour, typical reactions and certain personality traits, the environment (physical and social), and human biology (age, sex, genetic factors). Currently, it is believed that the main determinants of health are socio-economic factors, because they depend on the lifestyle and environmental conditions. Inequality (income diversification, level of education, housing, etc.) are the cause of health inequalities, which can be observed already at school.

Key features of the modern approach to health education are:
- taking into account all dimensions of health (physical, mental and social), and the factors determining them,

- using different circumstances: both formal and informal educational programs,
- taking into account the interests and needs of young people in the field of health education,
- striving for consistency of information from various sources,
- creating patterns on the part of adults – parents, school staff and members of the local community,
- creating conditions to practice healthy behaviours at home and at school,
- active participation of students in the planning and implementation of health education.

Health education content, in current practice, has been focusing on physical health issues - health, care and prevention of injuries and somatic diseases. A new element of health education is to pay special attention to the psychosocial health and development of life skills. Life skills are understood as the ability to enable positive behaviour adaptation om a person who effectively deals with the tasks and challenges of everyday life. This is one of the fundamental differences between traditional education and its modern dimension, where knowledge and skills are a key effect of education. A similar approach has been implemented in some EU countries, for example in the UK, for a long time the subject of "personal and social education" has been realized; in Ireland – "Social, Personal and Health Education". A reflection of these changes is the introduction of the new general education core curriculum listing the skills that will be practised, depending on the stage of training in various subjects. These skills are also the foundation of the educational curriculum and school prevention program (Woynarowska 2012b).

In today's education (including health) the role of the teacher has changed and the focus on learning/teaching has shifted. The teacher is a guide (adviser), who oversees the development of the students. Teachers no longer play the role of "experts" – they limit evaluation, comment in their own words and have the courage to say "I do not know, but I'll check and answer your question". That means a teacher has the right to lack certain knowledge and to learn from the students. The role of the teacher is to organize the learning process. It is also important for teachers to model the desired attitudes and health behaviours, because, according to the theory proposed by Bandura, people learn by observing the behaviour of others, especially the significant persons. The student, in turn, is treated as a partner, whose knowledge and experience are the basis for further development. According to current trends in contemporary health education, the prevailing methods of teaching / learning should be activating methods, which can be defined as a way of teaching in which teachers do not provide ready-made knowledge, but only create the conditions for self-learning. An example of such a method is an educational project, which is now an important element of Polish education.

The place and the status of health education in contemporary education

The new core curriculum of general education opens a new stage in school-based health education in Poland. The history of health education in Polish schools is quite long, but its implementation did not include the actual needs of the students. In the core curriculum of general education, health education appeared for the first time in 1997 (Ministry of Education). However, it was not granted the schedule and hours for implementation in the timetable. In 1999, the reform of the educational system introduced the educational path "health education" in primary and lower secondary schools.

Since 2002, as a result of the next reform, this educational path has been included in all types of schools. In 2007, the work on the new core curriculum was established to remove the educational paths, including "health education". It is recognized that health education will be implemented across multiple subjects at the same time, with the leading role in the field given to physical education (Bogacz 2009). In the preamble of the new core curriculum for primary schools and lower and upper secondary schools it is written that "the important task of school is also health education aimed at shaping students' habits of caring for their own and other people's health and developing the ability to create an environment conducive to health." This record, for the first time in the history of education in Poland, has given health education high rank among the school's tasks (Woynarowska 2008, 2012b). The currently functioning model of school health education, health promotion, i.e. the content included in a number of items, with the important role of physical education, is in line with the recommendations issued by the World Health Organization (Nowak 2012, Woynarowska 2012b).

Tab. 1. Curriculum, which includes health education content

SUBJECT	Primary school		Junior high school	High School
	grades I–III	grades IV–VI		
Social education	X			
Environmental education	X			
Technics classes	X	X	X	
Physical Education	**X**	**X**	**X**	**X**
Ethics	X	X	X	X
Polish Language		X	X	
Foreign Language		X	X	X
Science		X		X
Social Studies			X	X
Geography			X	X
Biology			X	X
Chemistry			X	X
Physics			X	
Safety Education			X	X

Source: Woynarowska 2008 (junior high = lower secondary/ high = upper secondary)

Curriculum for health education is included in the core curriculum, which has been recorded by requirements. It specifies the learning outcomes at the end of that stage of education. In the basic records, the so-called base line curriculum has been accepted, which means that the content of the curriculum will not be repeated in the next stages of education (so far the spiral curriculum has functioned). As a result of program changes, the contemporary school requires the answer to two basic questions: how to effectively implement the current model of health education, and how physical education can play the leading role in health education. We conclude that the new model requires school health education: participation in the implementation of all teachers, coordination at the level of individual schools or departments, the use of different occasions and situations (trips, class parties) as well as the commitment and creativity on the part of physical education teachers. It is also necessary to monitor the course of the implementation of health education in the new instalment in the education system (Woynarowska 2012a).

The reform of education and its implications

The inclusion of the Health Education unit and a number of requirements in this area of curriculum for Physical Education, at all levels of education, is an undoubted success and has historical significance. It creates an opportunity for a gradual improvement in the implementation of health education. It can also trigger the increase in prestige (personal, professional and social) of Physical Education teachers. Changing the implementation of the Physical Education classes, which allows students to choose the form of classes, may contribute to long-term reduction in the number of students exempted from such classes or students which are frequently skipping classes (Woynarowska 2008, 2012b). The new core curriculum also reveals a problem with the competence of Physical Education teachers, their resistance to learning new issues as well as the obligation to adjust the appropriate Health Education textbooks. Undoubtedly, the changes in governing the Polish school should be evaluated positively because they offer many benefits, e.g. determining the duration and the number of hours spent on health education, and extension of the issues to be dealt with in the classroom, including psychosocial health topics as well as life skills training. The network of health promoting schools is developing, which will also have a positive impact on achieving the objectives of health education.

Conclusions

Changes which follow from the modern health education have to stabilize its position among the subjects taught in school. Also development of ready-made patterns of education and introduction of the various stages of education will improve the quality of health of the Polish population. But in order to do so, one should create an environment in which knowledge and skills gained in school can be applied

in everyday life. What is therefore particularly emphasized is the need for training, training of life skills, developing the appropriate habits and their gradual consolidation. The reform of the education system, which took place in late 2008, introduced a number of new issues, but to be able to speak of a success in this case the implementers – that is the teachers – should be allowed to acquire relevant competencies. Of particular importance is the cooperation with the local school community, as well as the parents, who should continue and complete the tasks in education in the health of children, started by the teachers.

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Health education assumptions and models and their implementation in the Polish educational system

Abstract

According to World Health Organization (WHO), health is defined as physical, psychological and social well-being, and also education (upbringing, training and learning itself). Those are terms which are mutually overlapping because the proper knowledge and health behaviour are essential for a person to be in good shape, as is the proper attitude towards the subject of development of the human organism.

Health education is a process within which a man not only learns what health is or what pathogenic factors are, but also shapes a kind of habits which can reduce the risk of developing certain illnesses in the future. Health education can be run in a formal way (in schools, kindergartens or any other educational institution) and also as informal education, using i.e. hi-tech and media. In the educational system, the new core curriculum (2008) appears to reflect the role of health protection. The curriculum assumes an increase in the course content dealing with health and its comprehensive participation in the process of teaching.

Issues connected with health areas appear in such subjects as: Biology, Chemistry, Physical Education and foreign languages. That new holistic approach to health education is aimed at forming aware and health-oriented people. In the new core curriculum, health education becomes "an important mission of the school". In the following study, a model assumption of health education is presented at the particular stages of education.

Key words: health education, educational models, reform of education

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