

Health: Education, promotion and application in the primary school setting

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“My personal recollections of health education are limited to an adolescent memory of a session at boarding school about “Our Changing Bodies”, accompanied by a feeling that whatever exposure I had to health issues at primary school apparently made little impression!”



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When considered in the light of what I have recently learned about the ‘history’ of health education, these experiences during the latter half of the 1960’s, suggest a traditional and apparently outdated view. In the context of health education this approach focused on the ‘transmission of knowledge’ and was characterised by an emphasis on physical health which ignored the other aspects of wellbeing which are evident in more recently accepted definitions of health.

Health

When asked to define what I understood by the word health, I came up with: “A sense of physical, emotional and spiritual well-being.” After further class discussion with my peers, all of whom had begun with similar ideas, I expanded my personal definition to include “... a balance of physical, emotional, intellectual, social and spiritual well-being.”

This view obviously sees health as more than just “freedom from disease” and is consistent with definitions offered, for example, in the original Health Education Syllabus (Ministry of Education, 1985, p.4) which describes health as “... a state of well-being ... [it] encompasses physical, mental and social health.” This definition is developed further in the New Zealand Curriculum Framework (Ministry of Education, 1993) and the current Draft Health and Physical Education Curriculum document to include the spiritual and emotional dimensions. The New Zealand Framework replaces ‘mental’ health

with ‘intellectual’ health.

Shirreffs (1982, cited in Greenberg, 1992, p.3) goes so far as to suggest that health, which he defines as “a quality of life involving social, mental and biological fitness ...” is a function of an individual’s “adaptations to the environment.” It is clear that this definition ignores spirituality and does not identify emotional health as a discrete component.

Others go still further and include what could be seen as less obvious elements such as self-awareness and vocational health (Horowitz, 1985, and Eberst, 1985, cited in Greenberg, 1992, p.3). What is common to all of these interpretations, and indeed to most others I have read, is recognition of what Greenberg (1992) calls the ‘multidimensional’ nature of health. This view is also reflected in the World Health Organisation’s 1947 definition (cited in Kinloch, 1985) which states that “Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (p.19).

My own interpretation of the word health sits quite comfortably with Greenberg’s (1992) concept of a “quality of life that is a function of social, mental, emotional, spiritual and physical health” (p.3), although my use of the word balance needs expanding to acknowledge differing values individuals may place on each of these components (Greenberg, 1992). Health is dynamic.

Health Education

These definitions in themselves, suggest a change in focus when you

consider health in an educational context and imply a move away from the traditional emphasis on personal hygiene and prevention of disease. The Health Syllabus (Ministry of Education, 1985, p.4) describes health education as “the process through which people develop the understandings, skills and motivation to act in a responsible way for their own health and the health of others.” Similarly the Curriculum Framework (Ministry of Education, 1993) discusses the way in which:

this area of learning enables students to learn about and develop confidence in themselves and their abilities ... [and] helps them to take responsibility for their own health and physical fitness and to acknowledge their part in ensuring the well-being and safety of others. (p.16)

Greenberg (cited in Greenberg, 1992) considers health education to be “a process in which the goal is to free people so that they make health-related decisions based upon their needs and interests as long as these decisions do not adversely affect others” (p.30). He emphasises the need to combine the teaching of health knowledge with the associated skills of decision-making and problem solving. Tones (1995) subscribes to the theory of health education as empowerment which nonetheless has a similar aim, which is to equip learners with the necessary skills to empower, or ‘free’, them to positively influence their “environmental circumstances.”

In a discussion of the changing emphasis of health education in the New Zealand Curriculum, Scratchley (personal communication 1997) describes a process by which teachers “through a positive approach to health and lifestyle [can] help children to acquire the information and skills necessary so that they are more able to make informed decisions about their health behaviours and actions.” Although this would seem to support Tones’ view, Scratchley has

pointed out that perhaps children do not always have the choices which this model implies. Similarly, she also refers to a desire for children to have not only the knowledge, understandings and skills, but also the potential and willingness, to make changes¹.

Placing these definitions alongside my own developing understandings of what is meant by health education prompts me to ask “What are the desired outcomes?” I see health education as a process designed to provide children with health knowledge, promote understandings and encourage critical thought. These goals must however be bedded in a skills-based framework which will help children to take action to positively influence their quality of life and encourage them to acknowledge their role in ensuring the well-being of others.

Health Promotion

Butler (1997) has categorised current approaches to health education according to their varying philosophies: behaviour change; cognitive-based; decision-making; freeing/functioning and social change. His explanations of the characteristic features of these approaches highlight the emphasis that most place on individual choice.

The World Health Organisation (cited in Lloyd, 1994) has defined health promotion as “the process of educating people about health issues in order to enable them to, increase control over, and improve, their health” (p.29) Tones (1995, p.69) describes health promotion quite simply as a “combination of policy and education” and points to public health policy as its ultimate goal.

Butler (1997, p.157) discusses health promotion in terms of a “broad-field that draws from the concepts of holistic health, self-care and disease prevention” and focuses on the part that this has to play in promoting individual and community health behaviours which impact on the “health of whole populations”. He also presents a range of definitions, all of which refer in some way to a potential for

improving personal ‘health’ at the same time acknowledging a level of external influence.

It is important to note that despite some interpretations, there is a distinction to be made between the terms health education and health promotion which should not be used interchangeably. Tones (1991, p.134) has devised an equation to demonstrate the relationship between these concepts: “Health Promotion = Health Public Policy x Health Education”.

Health Promoting Schools

The idea of the school as a “health-promoting environment” (Tones and Tilford, 1994) is identified by Tones (1996) as the “off-spring of WHO’S (1984) creation of the health promotion movement as a whole” (p.41), which was given increasing emphasis throughout the 1980’s. The World Health Organisation’s School Health Initiative (1995) elaborates on the potential that schools have for reinforcing more broad-based community health initiatives and underlines the link between health and education.

The concept of the health promoting school implies an integrated approach to health education and health promotion, involving the school in a partnership with the wider community and ensuring that the healthy behaviours and choices being promoted are reflected in all aspects of school life. It encourages schools to take a much broader approach to health. This requires a primary focus on establishing a healthy school environment, conducive to the acquisition of skills, knowledge and understandings. Problem solving and crisis management then become a necessary secondary focus.

It is important to consider what constitutes a health promoting school. Schools are required to reflect the different needs of their students and communities. This requirement, to respond on a much more personal and individual level to the particular health needs and issues of the school’s community, acknowledging cultural diversity, is one of the major strengths of the

health promoting schools model.

The following three major components (Lloyd, 1994) are important aspects for the health promoting school to consider: healthy community participation; healthy school environment; and healthy classroom. These also require:

- commitment and support of management; planning and the allocation of roles
- a stimulating and well-balanced programme (the formal curriculum)
- a supportive safe social, physical and psychological environment (the hidden curriculum)
- the acknowledgement of feelings, attitudes, values and health-promoting behaviours of those involved
- positive and productive health promotion links with outside agencies, the family and the community

At the heart of the health promoting school is a recognition of the importance of "collective and social action" (Lloyd, 1994, p.2) which will reinforce the individual's choices. Tones (cited in Lloyd, 1994, p.3) encapsulates this concept of the centrality of the educational environment to the promotion of good health when he states that "Even empowered individuals will find healthy choices difficult to make in circumstances which are not conducive to health."

Putting It Into Practice

Obviously individual schools and those people responsible for their governance and administration will apply these guiding principles in different ways. Each school's unique setting will determine the emphasis and key features of its health promotion policy and will focus on the issues of major concern to that school. As one local school principal put it: "health pervades the whole school".

In the context of this particular school's policies, it is interesting to note the attention paid to what may be seen as less obvious aspects of health promotion: risk management, trauma education, regular

testing and maintenance of school equipment and buildings to ensure the safety of the physical environment as well as its aesthetic appeal. In a sense this exemplifies the need to model in a more general way, the healthy and safe behaviours being promoted through the formal health education curriculum. This same school principal also identified other areas for consideration: the establishment of protocols for dealing with the administration of medication, immunisation or sick children at school; and the development of policies supporting school initiatives in response to issues such

plans to include abseiling in the activities were dropped when it became apparent that a trained instructor was not available.

On another occasion at a different school our group of student teachers was reminded to use the footpath rather than cut across the driveway. As a parent I have always been conscious of using pedestrian crossings and modelling safe crossing techniques, particularly in the vicinity of schools.

School A models and reinforces a healthy attitude to food and nutrition by offering shared lunches



as bullying, healthy food, respecting others and vandalism.

It is also essential to consider staff development, both on a functional level such as requiring that all staff have a basic first aid qualification and with respect to personal and professional growth.

While on teaching practice at a local intermediate school I was involved in three incidents which have become more meaningful in the light of my new understandings. All in some way involved risk management and health promotion demonstrating this school's commitment to the safety and wellbeing of its students while also protecting the safety of staff responsible for them.

As preparations were progressing for the annual school camp,

rather than lollies as a reward and sells only 'healthy food' in its canteen.

In terms of fostering self-esteem and good relationships at School H, positive cards are handed out for a range of positive behaviours and recipients are publicly acknowledged at a weekly school 'Positive Assembly'.

It is clear that schools can incorporate health education and health promotion in a myriad of ways but their commitment as a whole institution must be genuine and consistent. The principles must be embodied in the school's mission statement and its goals reflected in the school's management plans. These issues of governance and administration can then provide a

basis for the effective delivery of an integrated and interactive health education programme.

Goals

The goals of a health promoting school should reflect its commitment to the concept of a healthy school, taking into account the physical, social, emotional, spiritual and intellectual aspects of health and the needs of students. Based on what I have observed and read, and on my discussions with colleagues, I believe that a health promoting school should aim to:

- provide a safe, pleasant and stimulating environment which is conducive to learning;
- equip children with the knowledge, understandings and skills to make informed decisions in relation to their own health;
- sensitise children to their role in ensuring the health of others and their responsibility to future generations (in terms of environmental issues);
- maintain and enhance links with the public and community health sectors;
- help children to achieve a positive self image and to realise their potential as whole human beings; and
- foster good relationships between students, staff, parents and caregivers and the wider school community.

This seems to be a tall order and begs the question of just how schools might go about achieving these goals and reinforcing their identity as health promoting institutions. The following represent some possibilities:

- establishing policies which regulate and detail how their aims will be achieved and reviewing these regularly;
- allocating funding to the implementation of these policies;
- providing a range of relevant and contextualised learning experiences which employ a variety of teaching approaches;
- regular monitoring of the safety of the school buildings and environs and maintenance of

equipment;

- staff training, professional development and support;
- encouraging participation of staff, students and their families; and
- inviting participation of and consultation with community and other relevant organisations.

The Healthy Schools-Kura Waiora framework (Ministry of Health, 1995) categorises this range of possibilities according to five main action areas aimed at promoting the health and well-being of students and staff:

- building on policies;
- creating school environments;
- developing personal skills;
- strengthening local community involvement;
- coordinating school health activities.

Conclusion

It is clear that in order to develop personal understanding of the potential for promoting health in a school setting, one must first understand what is meant by the terms health, health education and health promotion. Health education should provide children with opportunities to construct their own knowledge and develop the skills necessary to apply this knowledge and their new understandings to make informed decisions. Health education and promotion should be supported "from the top" and implemented throughout the school with the support of the local community.



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¹ Since this was written a new Draft Curriculum Health and Physical Education has been released for discussion and trialing. This places strong emphasis on a socio-ecological perspective.

