ANALYSIS OF HEALTH EDUCATION CURRICULUM AS A BASIS FOR CREATION OF SCHOOL EDUCATIONAL PROGRAMMES

Leona MUŽÍKOVÁ

Abstract: *This contribution comes out from the content analysis of curriculum documents, programs and projects of health support and from results of the questionnaire survey covering the group of more than 500 head teachers of the Czech elementary schools. The acquired information allows us to form a model of health education that can be a starting point in creation of school educational programs in the educational field Man and Health of General Educational Program for elementary education. At the same time, the author points out that there are limits and difficulties connected with creation of school educational plans in this field, specifically in the health education field of study. A demand of openness of this model is emphasized with respect to changing terms of realization in pedagogical practice.*

Key words: *curriculum, health education, elementary school, school educational program*

Theoretical basis

Contemporary Czech school system goes through a process of curricular reform, whose part is implementation of a new concept of heath education to schools of all levels. Therefore the paper is focused on assessment of curricular frame of health education in Czech Republic, comparison of acquired information with knowledge from abroad and verification of Czech elementary school system readiness to realize the new concept of health education.

The term *health education* is considered in the broad sense of the word as a part of educational system and in narrow sense of the word as a specifically defined education branch specified by *educational documents*. Health education should guide to health consciousness and behaviour of citizens. In this context the term *health literacy* is often used that characterizes „cognitive and social skills that determine motivation and ability of individuals to obtain access to health information, to understand it and use it to development and preservation of good health“ (Holčík, 2004: 120). Health literacy could be a precondition of *healthy lifestyle* (healthy way of life). By Liba (2005: 5) “balance of mental and physical load, a purposive movement activities, well-balanced diet, harmo-

nic relationships among peoples, responsible sexual life, rejection of addictive drugs, responsibility in work and life, personal and work hygiene etc.“. Healthy life style is projected into *quality of life*, which expresses general satisfaction with life and feeling of personal well-being, mental harmony and life-contentedness.

Besides the term *výchova ke zdraví* also the term *zdravotní výchova* is used in connection with health education in Czech Republic. This is the term for a special branch of medical sciences and Czech health care, targeted on preservation of health of individuals and population groups of the society (Provazník, Komárek, 2005). We accept this terminological differentiation and the term *výchova ke zdraví* (health education, in the sense of education towards health) is used in accord with the framework education program (VÚP, 2005) as an official name for one of branches of the Czech *system of education branches* that are determined by the government for realization of basic education in accord with *School act* (MŠMT, 2006b). In more general sense *health education* is understood as “part of effort to support health and improve health state of existing population“ (Průcha, Walterová, Mareš, 1995: 283).

Research, whose results are shown in this paper, belongs to the curriculum research field. The term c*urriculum* is here taken as a basic pedagogical category defined by Průcha, Walterová and Mareš (2003). In level of theoretical basis, this research is grounded on two partial concepts – *the projected form of curriculum* as presentation of really planned projects of education contents (i.e. education programs, teaching plans, education curricula or standards) and *the implementation form of curriculum* comprising the education content introduced to education subjects (Průcha, 2002).

Research tasks dealing with problem of *the projected and implemented curriculum* are investigated rather frequently (e.g. Maňák, Janík, 2006). The most frequent method used in *research of the projected curriculum* is probably content analysis of curricular documents, mainly education programs. The corresponding curriculum is studied as a text, which characterizes a relevant concept of education, its goals, content and other constitutive elements. Research worker role is to carry out interpretative analysis of the text. For *research of the implemented curriculum,* observations are usually considered as the most suitable method, but more often interviews and questionnaires are used. Curriculum participants (head teachers, teachers and pupils) are inquired by means of those research methods and so conditions or circumstances of curriculum realization are found out. In the both cases the curriculum is analyzed by the research worker, usually by using a category system that can discover curriculum structure and also its possible characteristic features.

Research problem

The research is focused on verifying implementation of goals of the national program *Health 21* to real conditions of Czech schools. Implementation process for goals of the national program *Health 21* is realized contemporary with the curricular reform of the Czech school system; by the reform a new education branch is introduced – health education.

Our task is, among others, to describe health education curricular intents and put contentual effect on health education implementation at elementary schools. The partial project of our research intent, whose results are presented here, is built on content

analysis of the project form of health education curriculum (i.e. on frame educational documents) and is used for explorative verification of Czech schools readiness to the new concept of health education on school program education level.

Methodology

The research of the projected form of curriculum was based on the non-quantitative content analysis method of texts (Gavora, 2000). The basic set of Czech curricular documents comprises *Standard for basic education* (1995), educational programs for basic schools (*Basic school, General school and National school*, in Czech *Základní škola*, *Obecná škola* and *Národní škola* (MŠMT, 2006a), *Framework educational program for basic education* (VÚP, 2005), *School act* (MŠMT, 2006b). Sources from abroad are represented by international comparison of physical education and health education (Pühse, Gerber, 2005) and works of the authors Wiegerová (2005), Liba (2005) and others.

The research of the implementation form of curriculum was focused on evaluation of initial conditions for implementation of the new concept of health education to elementary schools and on insight into topical issues of health education realization in our system of basic education. In our research method we used a structured questionnaire with closed, half-closed and open questions. 1000 head teachers of fully organized Czech elementary schools were included in our research set of respondents, 536 of them responded to the questionnaire completely. After finishing data collection in the years 2005/2006 we analysed obtained answers.

The results of analysis of the questionnaire answers to closed and half-closed questions were published sooner (Mužíková, 2007), so we do not show them here. The answers to open question were evaluated by *content analysis* on boundary of open-coding approach (Strauss, Corbinová, 1999). In categorizing of answers we were inspired by methodology described by Janík (2005).

The questionnaire survey was completed by non-standardized interview with pedagogical workers of pilot schools. This method completed set of information obtained by the questionnaire survey.

Research results of the projected form of health education curriculum

More detailed analyses of educational documents have been already published (Mužíková, 2006a, 2007), so here we only sum up crucial pieces of knowledge:

The initial conceptual document for formulating pedagogical goals of health education at elementary schools is *Standard of basic education* (MŠMT, 1995). It defines *health education* as one of educational branches also with the branch *Physical education and sport* with the educational branch *Healthy lifestyle*. This conceptual document has been essential for *educational programs for basic education* that are still valid (but finishing), namely *Basic school, General school* and *National school* (MŠMT, 2006a).

The most frequent program is for *Basic school* that has been implemented in most Czech schools.

By the current *School Act* (MŠMT, 2006b the above mentioned educational programs will be stepwise substituted *Framework educational program for basic* (VÚP, 2005). Continuously updated versions of the framework program are curricular documents on State-level and they define general frame of individual stages of education. The framework educational program is obligatory for creation of *school educational programs* (MŠMT, 2006c) i.e. the curricular documents of higher level. By School Act, those programs are created by each of school individually based on its factual conditions.

The framework educational program for basic education has introduced nine educational branches, with *Man and health* among them. The educational branch *Man and health* comprises the educational branches *Health education* and *Physical education* (with *health education for physical education*). Health education is also a part of educational field *Man and his world* outlined for the 1st level of basic school education.

The education branch *Health education* is specified in Framework educational program as follows: "Health education provides basic knowledge on preventive protection of human health. Pupils learn to develop and protect health state actively, within all health education components (social, mental and physical), and to be responsible for it. By its educational content it is directly connected with educational branch Man and his world. Pupils improve their hygienic, nutrition, working and other habits of preventive health care; they develop ability to refuse harmful substances, to prevent injuries and to face perils in everyday and extraordinary situations. They gain deeper and broader knowledge on family, school and contemporaries, on nature, people, human relationships and they learn to consider own activities from health needs viewpoint and from a teenager perspective and to decide in favour of health. Considering individual and social dimensions of health, the education branch *Health education* is closely connected with the cross-section topic Personal and social education" (VÚP, 2005: 72).

After implementation of the framework program to basic schools (since September 1, 2007) the *health education* topics should be taught at the first level of basic schools integrated with other education subjects, at the second level of basic schools either as a separate education subject or integrated with other subject(s) by *the appropriate school education program*.

In this way, legitimacy of the branch *Health education* is confirmed by incorporation to curricular documents of basic educational system codified in the valid School act. Contents and goals of *Health education* have been boosted by the World Health Organization program *Health for all in the 21st century* program and by elaboration of this program into the national version approved by the State authorities.

Based on knowledge from international sources (Pühse, Gerber, 2005, Wiegerová, 2005, Liba, 2005 and others) curricular concepts of health education were sorted to several conceptual models; their detailed specification has been already published (Mužík, Mužíková, 2007). Here we give only an overview:

1. Health education is considered in complex context, in the curriculum it is specified as a separate educational branch and usually is taught as a separate subject. Its content is interconnected with physical education, which is interpreted as education to movement activities within healthy lifestyle. Sport performance and competitiveness are not dominant elements of physical education. This model is preferred in Finland and USA.
2. Health education is explicitly connected with other subjects. Usually it is declared that health education has penetrated all subject (e.g. in Poland, Greece, Slovakia), or health education topics are included in individual subjects, e.g. in natural history, civics (e.g. in Ireland), or in physical education.
3. Health education is connected with physical education and in this sense it is also composed in the subject name (e.g. physical education and health education). Physical education is not focused on sport performance, but on health support (in Europe e.g. Sweden, in other parts of the world Australia, China, Japan, South Korea, New Zeeland).
4. Health education is a part of physical education subject that follows so called health oriented goals, but health education is not explicitly specified in the curriculum. It pays usually attention to basic hygienic rules, injury prevention etc. Many topics of health education (e.g. principles of health nutrition, prevention of socially pathological phenomena, sexual education etc.) are dissolved in other learning subjects or are not included in the curriculum at all. (This model was accepted in Europe in England, Belgium, Lithuania, Hungary, Germany, Norway, Portugal, Austria, Spain, Switzerland, and Turkey, in other parts of the world in Brazil, Hong Kong, Ghana, Israel, Canada, and Tunisia).
5. Health education is not explicitly included to the curriculum and is only a general goal of physical education, focused mainly on physical capability and sport performance (e.g. in Byelorussia, Denmark, France) or it is predominantly focused on movement relaxation (the Netherlands, Nigeria). Such interpretation of physical education and health education probably do not fulfil function of more complex education to health, when goals focused on health are probably only declared (but this speculation we can not prove).

We can conclude that majority of the above mentioned countries takes importance of health education within basic education. Health education is in some cases realized in the separate subject, but more often in the subject connected with physical education, which changes its former sport orientation to "health supporting" one (Mužík, Mužíková, 2007).

The results have demonstrated that in comparison with other countries Czech Republic has a good starting position for health education implementation to schools. In Czech Republic pedagogical requirements for health education are defined not only in accord with modern international concepts but also with needs of pupils and the society. The projected curriculum form enables to implement health education of individual schools by the internationally applied model described in paragraphs 1, 2, or 3 (chosen by the school educational program).

Research results of the implemented form of health education curriculum

The content analysis of answers obtained from head teachers of elementary schools to open questions of the questionnaire and informal interviews with pedagogical workers of pilot schools have brought the following results related to the implementation form of health education curriculum.

1. Questions to issues solved by authors of school educational programs in the present time:

a) How will be health education implemented and who will be responsible for it?
- Will health education be implemented as a separate education subject?
- Will prescribed topics be taught in integration with one subject or with more subjects?
- Will prescribed topics be taught in form of projects or block education?
- Will teaching be a combination of the above mentioned variants?
- What is qualification for teachers, will be a possibility to complete it?

b) How will be health education supplemented?
- Will health education penetrate all school education processes?
- What facultative subjects, voluntary subjects, interest forms will be offered?
- How will physical education be oriented?
- By what parameters will health education and physical education be evaluated, how will pupils be evaluated and marked?
- What other educational forms will be organized (courses, excursions, discussion meetings, programs, projects)?
- How will cooperation be ensured of individual teachers, mutual cooperation of teachers and pupils and cooperation within group of pupils?

c) How will the health education process be supported at individual schools?
- Will teachers be an example for pupils?
- Will suitable social atmosphere and school climate be created?
- How will personal and social education of pupils be carried out?
- How will health education be interconnected with environmental elements?
- What will be the form of cooperation with parents, community, institutions and others?
- Will pupils´ nutrition be guided (a diet in school dining rooms, out-of-school eating, drinking and eating regime of pupils)?
- How will free time be influenced?

d) What other problems connected with health education implementation can emerge?

2. Impulses directive for creation of school educational programs:

a) Determination of basic educational forms of health education
- If health education is taught as *a separate subject,* it should be secured by qualified

teachers (in the present time there are no graduates of the health education branch and number of graduates specialized in family education is very limited).
- If health education is realized by *subject integration,* education topics must be elaborated into relevant school subjects. Participating teachers should be adequately educated in respective topics.
- If *education in blocks* is preferred (mainly at the first level of elementary schools), it is suitable to use inter-subject relations.
- If compulsory education is supplemented by a *facultative subject*, compulsory and facultative topics must be specified.
- If health education is *integrated* with *physical education*, the existing physical education should be changed towards "health supporting" physical education (see Mužík´s contribution in this book).

b) Determination of additional forms of health education
- Preparation and realization of *preventive programs* are part of health education – above all for prevention of smoking and drug addiction (e.g. minimal preventive programs).
- Realization of *projects supporting health* is suitable (e.g. Health-supporting school, Health weeks, Health days, Healthy teeth and others).
- *Other forms of physical education* can be recommended, with healthy balance program (regular short time for exercising, movement activities in relaxation pauses, physical education groups, outdoor courses and stays, healthy physical education as an optional subject and similar suitable forms.
- Health education learning can be supplemented by one-shot educational forms - *educational excursions* to specialized workplaces (free-time centres, environmental education centres etc.), *discussions* with professionals (medical specialists, health care workers, psychologists, police staff members, social workers etc.), discussions with ill or drug-addicted individuals (e.g. HIV positive persons, drug users, smokers) and similar ones.
- *Project days or thematic days* should be organized (e.g. the theme "Man protection in extraordinary events") and *training of modelled critical situations.*
- Engagement of pupils in *environmental actions* is needed.
- Offer of *leisure activities at school* can be enhanced (e.g. school clubs or groups interested in health topics - healthy nutrition, first aid, healthy lifestyle, hygiene, etc.).

c) Specification of health education forms going beyond the school environment
- Offer of *leisure activities* out of school environment (expeditions, outdoor stays and similar activities).
- Intensified *cooperation with parents* (support and recognition of the healthy lifestyle in families, reduced smoking and alcohol consumption, offer of leisure time activities for parents and children together – e.g. actions supporting mutual experience of parents and children, parents and children etc., lectures and courses for parents focused on health education support at schools and in families).
- Formation of *advisory centres* for parents and children.

- Real forms of *cooperation with public*, community representatives or specialized institutions and with pediatrists.

d) Focusing on psycho-social area
- Necessary *cooperation* of individual teachers and school employees, because health education program should be projected into the whole education process at school.
- Increased attention paid to *teacher-pupil communication*, focused on creation of *positive psycho-social climate* at school (pupil's reliance and willingness are missing very often in discussion of problems with teachers).
- Special attention given to *integration of handicapped children*.

e) Determination of material conditions
- Provision of necessary *specialized materials with description of methods/instructions* for teachers.
- Provision of *learning materials and aids* for pupils.
- Probably *equipment of a specialized classroom or training, adaptation of school* (e.g. for physical relaxation pauses).
- Reservation of sufficient *financial resources* for real fulfilling of the health education program.

f) Influence on pupils nutrition
- Focusing on *the nutrition and drinking regime* of pupils in lessons and time spent at school.
- Systematic education of pupils to *proper nutrition habits* in their daily regime.
- Modification *of menus in school dining rooms* (adaptation of school dining menus to needs of obese and/or weakened pupils).
- *Cooperation with parents* in the nutrition field.
- *Health nutrition courses* organized for interested person.

Summary and conclusion

The analysis of educational documents confirmed legitimacy of health education in Czech basic schools and enabled evaluation of the projected curriculum level in relation to concepts from abroad. Based on the research focused on implementation form of the health education curriculum, disputed questions were specified and real topics for creation of school education programs were formulated. Comparison of the projected and implemented curriculum levels discovered difficulties in realization of health education in existing conditions of Czech schools. Indispensable precondition of successful implementation of the health education school program is its open character and flexibility reflecting current situation in school environment and also out of schools.

Health education implementation will always depend on:
- attitude of pupils, teachers and other school employees to health education,
- personal change at schools,
- cooperation with parents,

- current situation at schools, in community, society,
- local occurrence of social-pathological phenomena,
- change of legislation,
- other less predictable factors.

The above mentioned problem questions and collected issues for creation of school educational programs are only starting basic points for further studies of the projected and implemented forms of health education curriculum, with a respective going beyond to result or effect level (see Průcha, 2002).

Literature

1.GAVORA, P. *Úvod do pedagogického výzkumu.* Brno: Paido, 2000.

2.HOLČÍK, J. *Zdraví 21. Výklad základních pojmů. Úvod do evropské zdravotní strategie Zdraví pro všechny v 21. století.* Praha: Ministerstvo zdravotnictví ČR, 2004.

3.JANÍK, T. *Znalost jako klíčová kategorie učitelského vzdělávání.* Brno: Paido, 2005.

4.LIBA, J. *Výchova k zdraviu a škola*. Prešov: Pedagogická fakulta PU, 2005.

5.MAŇÁK, J.; JANÍK, T. (eds.). *Problémy kurikula české základní školy.* Brno: MU, 2006.

6.MUŽÍK, V.; MUŽÍKOVÁ, L. Physical Education and Health Education on the Educational System in the Czech Republic and other Countries. In ŘEHULKA, E. et al. *School and Health 21 (2)*. Brno: Paido, 2007, s. 549–560.

7.MUŽÍKOVÁ, L. *Výchova ke zdraví v současném základním školství.* Rigorózní práce. Brno: Masarykova univerzita, Pedagogická fakulta MU, 2006a. 104 s.

8.MUŽÍKOVÁ, L. K realizaci výchovy ke zdraví na základních školách. In KNECHT, P. (ed.) *Výzkum aktuálních problémů pedagogiky a oborových didaktik (v disertačních pracích studentů doktorských studijních programů).* Brno: Masarykova univerzita, 2006b, s. 88–101.

9.MUŽÍKOVÁ, L. Health Education from the Primary School Head Teachers Perspective. In ŘEHULKA, E. et al. *School and Health 21 (2)*. Brno: Paido, 2007, s. 103–110.

10.PROVAZNÍK, K.; KOMÁREK, L. *Manuál prevence v lékařské praxi : Souborné vydání.* Praha: Univerzita Karlova – 3. lékařská fakulta, SZÚ Praha, 2005.

11.PRŮCHA, J. *Moderní pedagogika.* Praha: Portál, 2002.

12.PRŮCHA, J.; WALTEROVÁ, E.; MAREŠ, J. *Pedagogický slovník*. Praha: Portál, 1995.

13.PÜHSE, U.; GERBER, M. (Eds.). *International Comparison of Physical Education: Concepts, Problems, Prospects*. Oxford: Meyer & Meyer Sport, 2005.

14.Rámcový vzdělávací program pro základní vzdělávání (se změnami provedenými k 1.9.2005). *VÚP v Praze [online]*. c2004-2005 [cit. 8.srpna 2006]. Dostupný z World Wide Web: <http://www.vuppraha.cz/index.php?op=sections&sid=367>

15.Sdělení MŠMT k učebním plánům vzdělávacích programů ZÁKLADNÍ ŠKOLA, OBECNÁ ŠKOLA a NÁRODNÍ ŠKOLA (od 1. 9.2006). *MŠMT ČR [online]*. 2006-04-18 [cit. 1.srpna.2006]. Dostupný z World Wide Web: <http://www.msmt.cz/_DOMEK/default.asp?ARI=104043&CAI=2701>

16.Standard základního vzdělávání, čj. 20819/95-26, ze dne 22. 8. 1995. *MŠMT ČR [online].* 1995-08-22 [cit. 6. října 2005]. Dostupný z World Wide Web: <http://www.msmt.cz/Files/HTM/Standard_ZV.htm>
17.STRAUSS, A.; CORBINOVÁ, J. *Základy kvalitativního výzkumu : postupy a techniky metody zakotvené teorie.* 1. vyd. Boskovice : Albert, 1999. 196 s. ISBN 80-85834-60-X.
18.WIEGEROVÁ, A. *Učitel – škola – zdravie*. 1. vyd. Bratislava : Regent, 2005.
19.Zákon č. 158/2006 Sb., kterým se mění zákon č. 561/2004 Sb., o předškolním, základním, středním, vyšším odborném a jiném vzdělávání (školský zákon), ve znění zákona č. 383/2005 Sb. *MŠMT ČR [online].* 2006-05-03 [cit. 1.srpna.2006]. Dostupný z World Wide Web: <http://www.msmt.cz/_DOMEK/default.asp?ARI=104088&CAI=3255>.

ANALÝZA KURIKULA VÝCHOVY KE ZDRAVÍ JAKO VÝCHODISKO PRO TVORBU ŠKOLNÍCH VZDĚLÁVACÍCH PROGRAMŮ

Souhrn: Příspěvek vychází z obsahové analýzy kurikulárních dokumentů, programů a projektů podpory zdraví i výsledků dotazníkového šetření provedeného na souboru více než 500 ředitelů českých základních škol. Poznatky dovolují vytvořit model výchovy ke zdraví, který může být východiskem při tvorbě školních vzdělávacích programů ve vzdělávací oblasti Člověk a zdraví dle Rámcového vzdělávacího programu pro základní vzdělávání. Autorka současně upozorňuje na limity a úskalí při tvorbě školních vzdělávacích programů v této vzdělávací oblasti, resp. ve vzdělávacím oboru výchova ke zdraví. Zdůrazňuje potřebu otevřenosti modelu s ohledem na proměnlivé realizační podmínky v pedagogické praxi.

Klíčová slova: kurikulum, výchova ke zdraví, základní škola, školní vzdělávací program