

THE CZECH PUBLIC'S OPINIONS ON HEALTH EDUCATION IN PRIMARY SCHOOLS

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Abstract: *The paper deals with the Czech public's opinions on health education in primary schools. The results have been obtained by means of representative sociological research into health and healthy lifestyle. The research was joined by the author of this paper within pursuing the School and Health for the 21st Century research plan and was carried out in cooperation with the Medical Information Centre and the INRES Agency. The research involved 1606 Czech citizens aged over fifteen and was representative in terms of age, gender and regions of the Czech Republic. Its results helped to identify main reasons for dissatisfaction with health education in primary schools among the Czech public, revealing that the primary factors leading to dissatisfaction are the extent of classes, educational content and the teacher's personality. The findings inspire a range of concrete ideas for improving the quality of the Humans and Health educational area and show which spheres of health education and family education should attract most attention.*

Keywords: *health education, family education, primary school, education*

Introduction

The Czech educational system is currently undergoing a curricular reform, which involves deepening a new concept of *health education* and launching it within all school stages. This innovated course of study has become an integral part of the educational system and is defined by educational documents.

Health education should promote health awareness and improve people's behaviour. In this context, the term *health literacy* is frequently used to describe "a cognitive and social skill determining individuals' motivation and ability to get access to health information, understand it and take advantage of it to improve and maintain their health."

Health literacy should represent a precondition for *healthy lifestyle* of a particular population. According to Liba (2005: 5), healthy lifestyle involves "a balance between psychic and physical strain, deliberate physical activity, rational diet, harmonious relationships among people, cautious sexual life, refusing addictive substances, responsibility in work and life, personal and work hygiene etc." Healthy lifestyle affects the quality

of life, which reflects the overall satisfaction with life and overall feeling of personal ease and spiritual harmony.

The *Standard for Basic Education* (1995), representing a fundamental document of primary education (which is in the centre of attention in this paper), defines the educational field of health education in primary education and classifies it, together with physical education, within the *Healthy Lifestyle* educational area.

The same document also determines existing *educational programmes for primary education* (2006): the *Primary School* (1996), the *General Primary School* (1997) and the *National Primary School* (1997). The majority of Czech schools pursue the *Primary School* programme; however, the above educational programmes are gradually being replaced by the *Framework Educational Programme for Basic* (i.e. primary and lower secondary) *Education* (FEP BE) (2005, 2007¹), which represents a national curricular document and defines a general framework for individual educational stages. All schools are obliged to observe this document when creating their own *school educational programmes*; these serve as curricular documents at school level and are designed by each school according to its specific wishes and needs.

The term *curriculum* is perceived as a fundamental pedagogical category. In the broadest sense of the word, it is defined as a “set of problems related to answering questions: why, whom, in what, how, when, under what conditions, and with what expected effects educate”; in the narrow sense of the word it is understood as a curricular document or as educational content (Maňák, Janík, Švec 2008). The term *health education curriculum* is therefore understood as educational content of the educational field of health education.

The theory of curriculum distinguishes between different curricular lines, concepts and forms. This paper focuses on the *projected form of curriculum*, which is according to Průcha (2002) represented by educational programmes, educational plans, syllabi, educational standards etc., and on the *realised form of curriculum*, which is the subject matter passed on to pupils by concrete teachers in concrete schools and classrooms.

The above mentioned *Framework Educational Programme for Basic Education* introduces nine educational areas, among them also the educational area of *Humans and Health*. This area includes health education and physical education (which also comprises remedial physical education).

The educational field of health education is within the *Framework Educational Programme for Basic Education* defined as follows:

“The educational field of **Health Education** provides pupils with fundamental information on the human body as related to preventative health measures. Pupils learn to actively promote and protect health in all its forms (social, emotional and physical) and to be responsible for their own state of health. In its educational content, this field is closely linked to the educational area of Humans and Their World. Pupils reinforce their hygienic, nutritional, work and other preventative healthcare habits, expand their ability to refuse harmful drugs, avoid injuries and deal with personal threats in everyday and emergency situations. They expand and deepen their knowledge of family, school, peer group, nature, humans and interpersonal relationships, and learn to see their activities through the prism of the health-related needs and prospects of a growing young individual and to make decisions beneficial to their health. In view of the individual and social

¹ Up-dated version of the FEP BE.

dimension of health, the educational field of Health Education is closely linked with the cross-curricular subject of Personal and Social Education.” (FEP BE, 2005: 76)

On research into the realised form of health education curriculum

Research into the realised form of curriculum can be based on a wide range of research approaches and methods; the commonly recognised research method into this area is *observation*, which can be either direct or mediated (e.g. by means of a lesson video-recording – the so called video-study). Due to the fact that observation is both time-consuming and financially demanding, it is commonly substituted by *survey*, more typically in written than oral form.

So far, there have not been many research projects into the realised form of curriculum at the level of education in the Czech Republic relevant in respect to the topic of this paper. Marádová (2007), who has been engaged in studies of this area for a relatively long time, carried out a questionnaire survey accompanied by interviews in 2004–2006. Its aim was to gain information about implementation of health education in contemporary primary education from the lower and upper primary school teachers’ perspective. The respondents’ answers (380 lower primary school and 417 upper primary school family education teachers) indicate that “... to the question asking about the thematic area of health education pupils are most interested in, most teachers (76%) stated that that of family and sexual education. ... However, the teachers include this topic into education with certain constraint, and in the overall evaluation it occupied the position of the least favourite topic” (240).

Research projects lead by Mužíková (Mužíková 2006a, 2006b, 2007; Běličková 2008; Hloucalová 2008) analysed head teachers’ opinions about the ways of realisation of health education in schools. The findings obtained from 536 head teachers of comprehensive primary schools and 148 semi-comprehensive primary schools confirmed that the status of health education as an independent educational field is in many schools rather low and the projected form of health education curriculum is not fulfilled in an expected and appropriate way.

Other findings about health education are based on research projects by Žaloudíková (2003, 2004). Even though the attention was paid especially to the result form of curriculum², some of the findings can also be related to the realised curriculum. The research, among other things, points out that the respondents (pupils, teacher trainees and teachers) miss sufficient information about most threatening factors to human health, and health prevention of serious diseases. The author also explores the child conception of health and diseases, but the outcomes have not been published yet.

Partial findings about health education can be also found in a study by Hajerová-Müllerová, Doulik and Škoda (2005) whose aim was to assess changes in the child conception of drugs. Similarly, many other authors focus on partial health education topics, but a complex research into its curriculum is still absent.

Research problem

The research presented in this paper was motivated by results of a questionnaire survey which was carried out in 2005–2006 and dealt with existing implementation of health education according to the *Standard for Basic Education* (1995). The results were

² In the area of pupils, students and teachers’ health risks awareness.

obtained by analysing responses to closed and semi-opened questions. The research addressed a sample of primary school head teachers. The survey results have been already published (Mužíková 2006a, 2006b, 2007); therefore we present only a summary of the most important findings.

- The head teachers were not sufficiently familiar with current requirements for health education as defined in the *Standard for Basic Education*. The majority of schools had not designed thematic plans for health education; most head teachers stated that “health education penetrates school education as a whole”.
- Only 20% of schools were well equipped with didactic aids and materials for health education. The head teachers claimed a lack of financial resources was a major cause of this unsatisfactory state.
- Even though the *Primary School* educational programme, implemented in 96% of the selected schools, integrates health education in upper primary school within the educational field of family education (and within the subject of family education), nearly two thirds of schools did not interconnect the two educational fields in practice.
- Only 13% of schools employed a qualified teacher of family education, in the rest of the selected schools family education was taught by teachers without required qualification.
- Nearly all head teachers found the results of the implementation of the *Minimal Prevention Programme* useful. There were various educational activities organised in schools within health education; nevertheless, they were mostly one-off discussions, competitions etc.
- At the time of the survey, nearly one third of head teachers were not acquainted with the *Health 21* programme (approved by the Czech government resolution No. 1046, 2002); the same percentage admitted being informed only partially.
- Most head teachers claimed they considered health education important and they would enable teachers to obtain further education in this area.

The above results have revealed that health education is not implemented in concordance with the projected form of curriculum presented in the *Standard for Basic Education* (1995) in many primary schools, and thus inspired us to carry out an additional research survey. The aim of this research was to find out Czech public’s opinions on the current level of implementation of health education in primary schools and to identify main reasons for satisfaction or dissatisfaction with this educational field in Czech schools.

This research was carried out in cooperation with the *Medical Information Centre* and the *INRES Agency*.

Research sample

Czech public’s opinions were obtained from the sample of 1606 respondents; individuals were selected randomly by means of quotas. The sample was representative of the Czech population over the age of fifteen. Representativeness was derived from

the population of the Czech Republic aged over fifteen.³ It can be argued that the results stated below are representative of the Czech population aged over fifteen in terms of gender, age and region.

Other signs, which were not representative but were observed within the research, included education, marital status, number of children, size of the respondent's residential municipality, occupation, net monthly family income, attitude to religion and type of accommodation. Cases where statistical significance was proven are pointed out. Nevertheless, due to the fact that these data are not representative, the revealed statistically significant correlations can be interpreted only as tendencies.

Research method

The research was designed as a sociological one and was based on questions proposed by the author of this paper and commented on by competent workers of the research organiser. The survey was carried out by means of a standardised guided interview between an interviewer and a respondent.

Data were gathered by 350 *INRES Agency* interviewers across the whole of the Czech Republic. The *INRES Agency* was also responsible for visual and logical inspection, coding and computerising the data; results tabulating was performed by the workers of the *Institute for Health and Healthy Lifestyle Studies* and interpretation of the results by the author of the questions (and this paper).

The data were statistically processed by the SASD 1.3.0 program (statistical analysis of social data). One-factor analysis and contingency tables for the selected signs of two-factor analysis were processed. The correlation level of selected signs was defined by means of χ^2 method and other testing criteria, applied according to the character of signs. This analysis served as a basis for subsequent data interpretation.

The respondents' answers were recorded in a written form; answer sheets were verified in a pre-research. Each sheet completed by a respondent was logically and visually inspected – the focus was placed on logical relations and information credibility. The sheets with non-functional illogical links and incomplete sheets (when the respondent refused to answer the questions and decided to end the interview leaving a part of the sheet blank) were excluded. These sheets were placed in the “non-respondents” category.

The assessed items often contained continuous answers, which had to be transformed in such a way that would enable making a clear summary of the main results. The continuous answers were divided into partial statements, and thus the character of the transformed variable signs changed from a continuous into category form.

Research schedule

The research project was designed in September and October 2007 and was subjected to objecting in the beginning of November 2007. The pre-research verifying the research techniques and formulating the questions to be asked involved a sample of 240 respondents and was carried out in November 2007. Simultaneously, all interviewers were instructed.

³ See the *Population Structure of the Czech Republic by Major Age Groups in 2006*. (31 Dec. 2006) Prague: Czech Statistical Office, 2007.

The actual survey was organised across the whole of the Czech Republic at the turn of November and December 2007. Gathering the answer sheets, their visual and logical inspection and computerising the obtained data was accomplished in December 2007. The next step involved adjusting the data, their basic mathematical and statistical analysis, processing frequency and selected contingency tables, and primary data interpretation including objecting a signal report by the author of this paper.

The results were interpreted by the author in the beginning of 2008.

Results

The opinions of the representative sample of Czech citizens on the quality of health education in primary schools were surveyed by means of open questions. The research was carried out in 2007 and addressed 1606 respondents aged over fifteen.

The answers to the question “In your view, what are the main strengths of current health education in primary schools?” can be neither categorised nor statistically processed. The overwhelming majority of respondents stated “I have no idea”; “I don’t know that health education is taught in schools”; “I don’t have enough information” or they did not answer at all. Only 29 respondents (1.8%) stated that healthy lifestyle was promoted in their school and the school paid attention to neatness, changing shoes and hands washing, or that “everything was o.k.”.

The question “In your view, what are the main weaknesses of current health education in primary schools?” was specifically answered by 689 respondents (42.9%); 917 respondents (57.1%) stated they did not know, did not have enough information, could not answer the question etc., or gave no answer.

The number of 689 specific answers was subjected to content analysis, which established the following categories for placing the concrete answers. This procedure led to identification of main reasons for dissatisfaction with the quality of health education:

- a) **Extent of education** – typical answers: few lessons, insufficient extent, few lectures, few outdoor stays etc.
- b) **Educational content** – typical answers: health education is uninteresting, too theoretical, suffers from a lack of materials and aids, without conception, not sufficiently focused on prevention etc.
- c) **Teachers’ quality** – typical answers: teachers are under-qualified, have bad attitude to classes, are not an example to pupils etc.
- d) **Pupils’ attitude** – typical answers: children are not interested in this subject, are not serious about it, take it as a game, do not take advantage of what they have learned in practice etc.
- e) **Family support** – typical answers: family does not respect what is taught at school, bad attitude of the parents, not respecting health habits in family etc.
- f) **Financial expensiveness** – typical answers: a lack of money on classes, inappropriate materials and aids, expensive courses etc.
- g) **Other reasons** – examples: there is a need to improve children’s habits, drinking regimen, low quality of schools canteens etc.

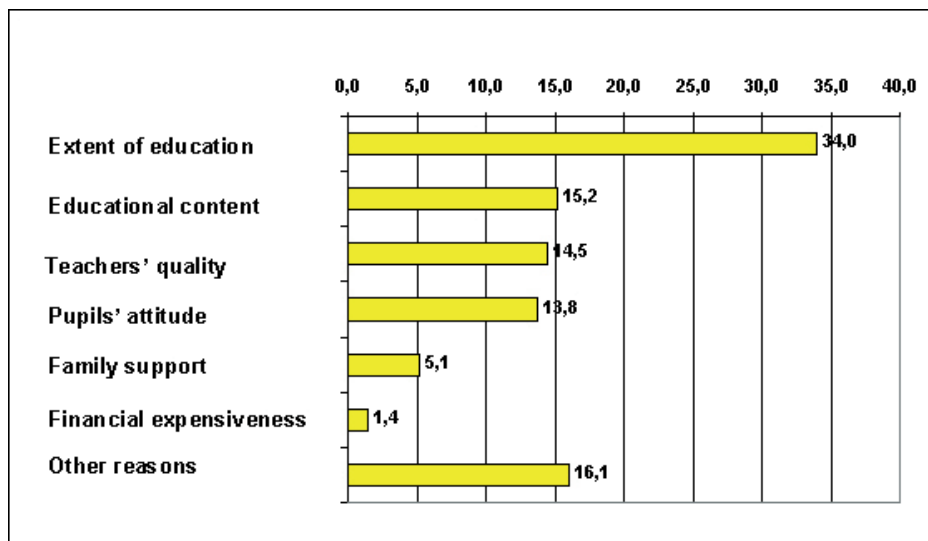
The most common reason for dissatisfaction with health education (34% of responses) is the insufficient *extent of education* (see Table 1 and Graph 1). The frequency of answers related to *educational content* (15.2%) and the *quality of teachers* (14.5%) is quite identical; a sum of statements within these two categories indicates that 29.7% of respondents are not satisfied with the *quality of education*. Pupils' attitude to health education is criticised by 13.8%, family support by 5.1% and financial expensiveness by 1.4% of respondents. Other reasons do not matter from the viewpoint of the realised form of curriculum.

Correlation analysis of the frequency of answers within particular population groups ($p < 0.05$) performed by means of two-factor analysis generated these statistically significant results:

The low extent of education is more frequently pointed out by women, students and the single, but in particular by *young people under the age of 24*. Men more often than women opt for the "I don't know" answer. This answer is also statistically more frequent in respondents aged over 55.

Category	Absolute frequency of the answers	Relative frequency of the answers (%)
Extent of education	234	34,0
Educational content	104	15,2
Teachers' quality	100	14,5
Pupils' attitude	95	13,8
Family support	35	5,1
Financial expensiveness	10	1,4
Other reasons	111	16,1
Total	689	100,0

Table 1: Reasons for dissatisfaction of the Czech population with the quality of health education



Graph 1: Reasons for dissatisfaction of the Czech public with the quality of health education

Due to the fact that there is a statistically significant difference in the frequency of answers between young population aged 15–24 and older age groups ($p < 0.05$), the answers of the former group were separated and interpreted independently. What is more, the answers provided by the young age group are of a greater information value for assessing the present implementation of health education, since most of its respondents experienced health education which was supposed to be realised in concordance with the *Standard for Basic Education* (1995) during their compulsory school attendance.

Respondents' answers were categorised and quantified separately for groups aged 15–19 and 20–24. The obtained rates were for illustration compared with the statement frequency of the entire research sample of respondents aged over 15 (see Table 2 and Graph 2). A statistically significant difference in the frequency of answers ($p < 0.05$) between both selected groups of young population was proved in two individual categories: the extent of education and the quality of teachers.

Young respondents in particular object to the *low extent of health education* (44.5% and 37.5% of answers). The lessons were supposed to be integrated within the subject of family education from the sixth till the ninth grade of primary school; the extent being one class a week. (In lower primary school, health education topics are integrated within several subjects, especially biology and science.) The views of young generation seem to confirm the already presented finding from a previous research (Mužíková 2006a) that two thirds of selected schools failed to sufficiently integrate health and family education.

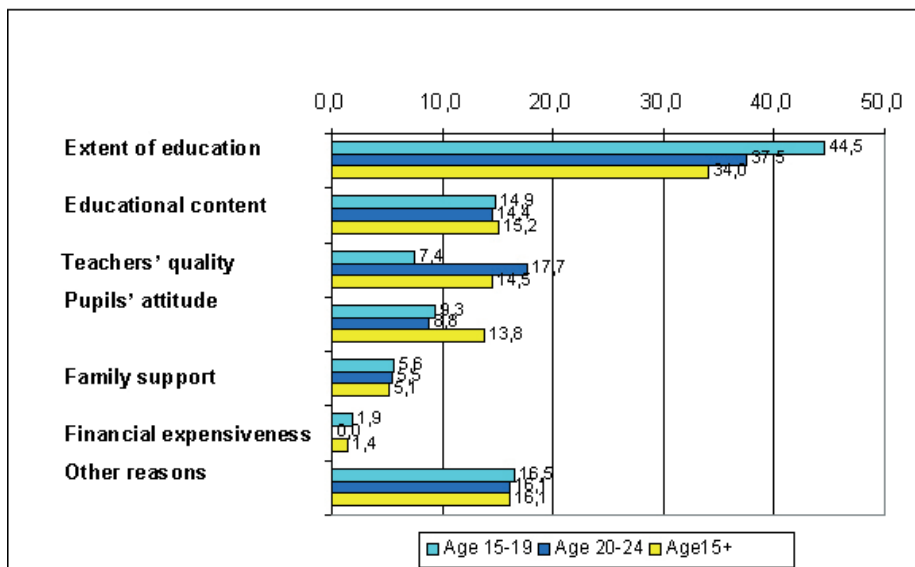
The *educational content* appears to be a relatively frequent reason for dissatisfaction too (14.9% and 14.4% of answers). A statistically significant difference ($p < 0.01$) was shown up in the category of *teachers' quality* – their qualification or attitude towards health education (7.4% and 17.7% of statements). This result again corresponds with the previous research finding stating that teachers qualified in family education (and thus also in health education) taught only in 13% of schools at the time of the research. On the other hand, the difference in dissatisfaction between the youngest group (7.4% of statements) and the next group aged 20–24 (17.7%) may indicate improving quality of health education teachers. This result could reflect increasing qualification of teachers in the area of health education, in particular thanks to education of school prevention methodologists and other ways of involving teachers in further education.

The frequency of other answers is not sufficient for assessing the implementation of health education.

When compared with the entire population, the young generation is less critical of the pupils' attitude towards health education (9.3% and 8.8% of statements). Criticism towards the family attitude is more or less constant within all observed groups (approximately 5% of statements). The other critical statements concern especially educational conditions and correspond with the results presented in the previous chapter.

Category	Age 15-19	Age 20-24	Population 15+
Extent of education	44,5	37,5	34,0
Educational content	14,9	14,4	15,2
Teachers' quality	7,4	17,7	14,5
Pupils' attitude	9,3	8,8	13,8
Family support	5,6	5,5	5,1
Financial expensiveness	1,9	0,0	1,4
Other reasons	16,5	16,1	16,1
Total	100,0	100,0	100,0

Table 2: Reasons for dissatisfaction of the young population of the Czech Republic with the quality of health education (% of statements)



Graph 2: Reasons for dissatisfaction of the young population of the Czech Republic with the quality of health education (% of statements)

Findings and conclusion

The research gathered 1606 answers from a representative sample of respondents. Due to very low public awareness of health education and its educational content it failed to identify the reasons for satisfaction with the quality of health education.

The main reason for dissatisfaction with the quality of health education in primary schools is the low extent of education and the way this educational field is taught (i.e. educational content and teachers' quality). These results confirm the findings obtained by the analysis of head teachers' views (Mužíková 2006a, 2006b, 2007). This finding should be taken into account especially in teacher training.

The observed socio-demographic signs of respondents – gender, education, place of living etc. – do not have a significant influence on satisfaction or dissatisfaction with

health education. The only exception is respondents' age; when compared with the entire population, statistically significant differences were shown up especially within the population aged 15–24. This result confirms that in spite of paying an increased attention to health education in schools over last years, the quality of education is perceived as rather low.

The obtained findings urge us to make a comparison between the projected and realised form of health education curriculum but we do fully realise that such a comparison can again lead only to descriptive results. Therefore, we will attempt to define concrete starting points for implementation of health education within the school educational programmes.

NÁZORY ČESKÉ VEŘEJNOSTI NA VÝCHOVU KE ZDRAVÍ V ZÁKLADNÍM ŠKOLSTVÍ

Abstrakt: Příspěvek seznamuje s názory občanů České republiky na výchovu ke zdraví v základním školství. Výsledky byly získány na základě reprezentativního sociologického výzkumu k problematice zdraví a zdravého způsobu života. Výzkum, do něhož se zapojila autorka příspěvku v rámci řešení výzkumného záměru *Škola a zdraví pro 21. století*, byl realizován ve spolupráci s Lékařským informačním centrem a agenturou INRES. Výzkumu se zúčastnilo 1606 občanů České republiky ve věku nad 15 let. Soubor byl reprezentativní z hlediska věku, pohlaví a regionů České republiky. Výsledky pomohly identifikovat hlavní důvody nespokojenosti české populace s výchovou ke zdraví na základní škole. Dokumentují, že stěžejními důvody pro nespokojenost jsou rozsah výuky, obsah výuky a osobnost učitele. Získané poznatky poskytují řadu konkrétních podnětů pro zkvalitnění práce ve vzdělávací oblasti Člověk a zdraví. Ukazují, na kterou oblast tělesné výchovy a výchovy ke zdraví je třeba zaměřit hlavní pozornost.

Klíčová slova: tělesná výchova, výchova ke zdraví, základní škola, výuka