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DISSEMINATION OF THE EDUCATIONAL PROGRAMME "NON-SMOKING IS A NORM" INTO SCHOOL PRACTICE

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Abstract: *The primary prevention programme "Non-smoking is a Norm" has been completed after a period of five years, and its evaluation both as a pilot study in schools in Brno and in a broader test study throughout the Czech Republic has come to a close. Its broad practical application is now being conducted with its inclusion either in school curricula or in the specific educational programmes of individual schools that have expressed an interest in using it in health education. It is being used as a tool in the primary prevention of risk behaviours, primary oncological prevention and the prevention of cardiovascular disease by providing comprehensive healthy lifestyle education.*

Key words*: drug prevention, school oncological prevention, health education, risk behaviour, school preventive programme*

Introduction

The programme "Non-smoking is a Norm" has been completed and tested in a pilot study at ten schools in Brno and a broader test study at fifty schools throughout the Czech Republic. Following evaluation and an assessment of its effectiveness, efforts will be directed at supporting the practical use of the programme within a specific educational programme in Czech schools. The programme is currently being disseminated into wide-ranging practice. The programme is offered to schools by means of training held within the framework of drug prevention education at pedagogical-psychological centres, by the National Institute for Further Education within its annual programmes for training teachers in health education, by Regional Hygiene Centres, and at individual schools within the framework of teachers' preventive activities and work. Every school has to draw up a Minimal Preventive Programme every year that corresponds to certain prescribed requirements. The educational programme "Non-smoking is a Norm" helps implement risk-factor prevention. It makes a particular contribution to oncological

prevention, the prevention of cardiovascular disease, and health education, primarily in relation to the observation and promotion of a healthy lifestyle among schoolchildren.

How should preventive education aimed at a target group be conducted? How should such a programme be drawn up and how should it then be implemented in practice? When is such a programme effective? A number of authors have considered these questions. Here we would mention the approach taken in Holland under the title "ABC in Health Education and Health Promotion".

The introduction and implementation of the programe of prevention

Health education can be unplanned, spontaneous and unsystematic, or targeted with a systematic approach thought out in advance, including planning, an analysis of the current situation, the preparation of a targeted programme of prevention, its authentication and evaluation, and the progressive dissemination of prevention. Three basic stages can be identified in preventive work, loosely based on H. De Vies, author of "ABC in Health Education and Health Promotion" (De Vries, 2008).

This ABC of health education and promotion is comprised of:

1) stage A – Analysis of the problem
2) stage B – Behavioural change
3) stage C – Continued prevention

A – Analysis of the problem

1) Identification of the health and social problem that needs to be targeted, including epidemiological studies. This also takes in social diagnostics, i.e. what determines the perception of people's problems, their needs, their quality of life, etc. This must be done in such a way that it is clear what the priorities of the shared community are. Also an **epidemiological diagnosis** to determine the specific health problem.
2) This is followed by an analysis of the environmental behaviour and factors that relate to the given health problem. This analysis is known as a **diagnosis of environment and behaviour**.
3) The next step is to **identify the target group**, what group has the greatest share in the risk behaviour. This group will subsequently be guided with a targeted programme of prevention, since it is at the highest risk of developing an illness. The important thing here is to identify the group of the population affected by a problem that those concerned are conscious of and want to resolve and change.
4) An analysis of why people succumb to risk behaviour must also be performed. This step is known as an **education and organisation diagnosis**. If we do not know why people indulge in high-risk behaviour, we cannot draw up the kind of educational programme that motivates them to change. An analysis of the motives leading to risk behaviour must be performed before an educational programme is drawn up. This analysis will include discovering the determinants of

behaviour, such as demographic data, environmental factors (age, socio-economic status, gender, etc.) and cognitive factors such as attitudes, social influences, and expectations of personal capabilities. It is important to know what is influencing behaviour and what convictions need to be changed. For example, a smoker may be convinced of the advantages of not smoking, but doesn't know how to stop smoking. This means that he needs information in order to increase his personal ability. Information about how to stop smoking will increase his level of self-appraisal and reinforce his personal capability and determination to smoke smoking.

5) The next step analyses **how to approach the target group, how to influence it**. This includes careful analysis of the needs of the target group. The same also applies to those who are to implement the programme.

The aim of this analysis of the problem is to gain a clear definition of the problem, and to identify the problem in behaviour that is associated with the problem and the target group that needs to be focused on.

B – Behavioural change

The results of the analysis provide information for **formulating the goals** of the programme of prevention. The choice is made during this phase as to whether the given behaviour needs to be altered by means of education, what type of prevention is necessary, what kind of programme should be selected and how its effectiveness should be assessed in a pilot study.

1) The first step is to discover whether a change in behaviour can be achieved by education, by focusing on regulation, or by means of a combination of both. Passive smoking, for example, can be changed by regulation.
2) A decision must then be made as to whether this is to be a case of primary prevention in the form of education, secondary prevention in the form of early detection, or tertiary prevention – treatment.
3) Creation of the programme, effective intervention aimed at **behavioural change**, the assessment of resources and barriers to implementation. The essential thing is to focus on factors that determine the receipt and processing of information.
4) The programme created **must be tested** and verified, as it is important to analyse whether the programme fulfils the intended purpose and whether it is positively evaluated. This testing must take the form of a comparison of results obtained from a test group and a control group, in order that an ineffective programme is not disseminated. Specialists in various fields associated with behavioural change, such as psychologists, sociologists, health service workers, doctors and teachers, should work together on the programme.

C – Continued prevention

The tested programme is subsequently promulgated according to a strategy in a number of stages, such as dissemination of the programme, its acceptance, its incorporation into regular use in, for example, schools, and its institutionalisation, for example its introduction into all schools.

An ABC scheme in health education:

A

ANALYSIS OF THE PROBLEM

1. needs
2. the individual–environment
3. target group
4. determinants
5. approach

B

INTERVENTION AIMED AT BEHAVIOUR, CREATION OF THE PROGRAMME

1. goals
2. methods
3. testing

C

CONTINUED PREVENTION

1. co-operation between experts
2. dissemination of the programme
3. tactics and strategies

The goal of health education is behaviour change

Psychosocial determinants of behaviour directed at health

The basal content of educational programmes of prevention is **behavioural change**, for example an endeavour to stop smoking, eat healthily, observe the principles of good nutrition, keep healthy eating habits, ensure you get enough exercise every day, etc. There are many socio-psychological theories about how to achieve behavioural change, such as those elaborated by A. Bandura in his work Social Cognitive Theory (1986), by Ajzen in his Theory of Planned Behaviour (1991) and others. These authors agree that behavioural change is achieved via a **plan – planned behaviour**, which can be influenced and measured.

Attitudes - plan - behaviour

De Vries (2002) created the I-Change model, which incorporates a number of socio-cognitive models in which behaviour is the result of a plan, planned behaviour and the capability of the individual. In changing a plan in behaviour, he considers work on three main factors, given as the ASE Model, important.

The ASE Model
A – ATTITUDES
S – SOCIAL INFLUENCE
E – SELF-EFFICACY

Attitudes express the view of the individual on the positives and negatives of certain behaviour, the pros and cons in two dimensions – cognitive, such as the acceptance of rational viewpoints, and affective – how he likes the materials with which he is working, how attractive the models used in intervention are, etc. It is important to differentiate rational and emotional convictions about the newly adopted behaviour.

Social influences can be described as the process by which people directly or indirectly influence the ideas, feelings and action of others. This includes social norms, adoption of the behaviour of others, social pressure, and social support. A. Bandura's theory of social learning introduces the term **observational learning** as an important determinant of behaviour. People, and children in particular, learn about smoking by watching and observing their contemporaries and their parents when they smoke. They imitate these models. Direct social pressure is exerted here by their parents, their contemporaries who smoke and, frequently, the media. Social norms have played a significant role in the prediction of limiting smoking, but less so than in the prediction of the beginnings of smoking.

Self-efficacy or capability expresses the **individual's expectations relating to his ability to implement the desired behaviour**. It does not reflect his true skills, but rather his convictions about these skills (if he is convinced that he will stop smoking, then he will probably achieve it). This relates to his conviction about his ability to behave in a certain way in a certain situation. Behaviour is determined by capabilities and the desired behaviour.

A plan for change can be characterised as meaning that **people plan to change their behaviour**. This process goes through the stages of contemplation or rumination about change, active behaviour, and maintaining this behaviour or returning to the old behaviour in the case of failure. Planning includes **the ability of the individual to turn a plan into the desired behaviour**. Planning one's action becomes a strategic goal of prevention. Action planned in this way might be (in the case of giving up smoking, for example) a visit to the doctor, removing ashtrays from the home, telling one's friends about one's plans to stop smoking, etc. This model has been implemented successfully in Holland in preventing smoking.

Behavioural change

There are two aspects to behavioural change:

1. The individual aspect, where it is important to focus on attitudes, social influences and perceived abilities – the expectation of one's own personal capability as to whether one can achieve the desired behaviour.
2. The environmental aspect, which is influenced by social, economic, political, cultural and legislative factors. Change is possible only if these factors are also changed.

These two aspects are not mutually exclusive. The important thing is a good understanding of the two aspects.

According to socio-psychological theories, a change in behaviour from the individual perspective occurs in four stages:

1. the acquisition of information
2. the acceptance of this information
3. the decoding of this information
4. a response in behaviour, new behaviour, an attempt at new behaviour

A preventive programme must, therefore, be prepared in such a way that it **initiates behavioural change**. The message or information must be attractive to the recipient and must respect the specifics of the target group. Among adolescents, for example, use should be made of comics, video recordings, peer methods, work in groups, role-playing, the deduction of clear conclusions, the use of persuasion in an unforced form, no-smoking posters, etc. Information received is processed on two levels – a central cognitive level and a peripheral affective level, where more attention is devoted to the attractiveness of the programme. Personal ability to make change can be supported and increased by exercises in assertive behaviour, training techniques and skills for saying no, role-playing, etc. The active engagement of the target group in the programme is also important. A specimen programme is drawn up on the basis of this model, and is then tested on the target group. The further dissemination of the programme takes place only after testing on a pilot group to see if the programme is effective. Experts in various areas must be engaged in the project. The creation of a project team must include a number of co-operating groups. See image 1 below.

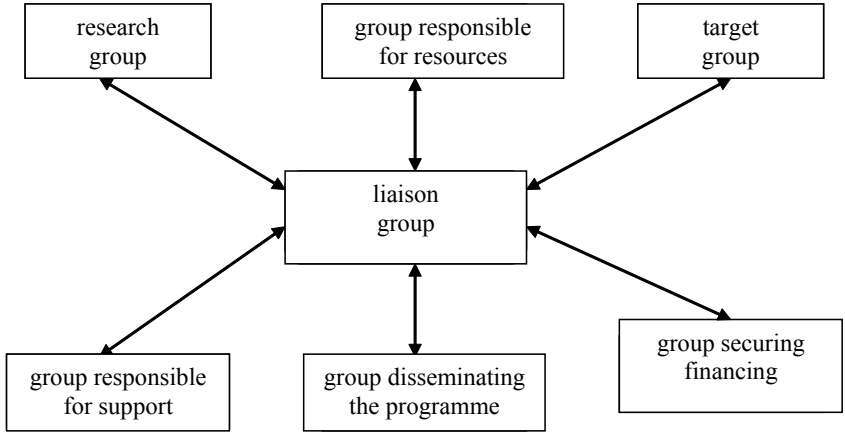

Image 1. The composition of the project team

Health promotion is an ever-repeating never-ending process. According to the actual conditions and the given situation, it is possible to begin with an analysis, to continue with the drawing up of intervention aimed at the given behaviour, and to end with an endeavour to disseminate and continue the programme. It is, however, no less important to note that **health promotion and its planning is a continual process.**

Dissemination of the programe „Non-smoking is a norm“

The programme “Non-smoking is a Norm” is offered to schools for use in health education at the primary level. It is currently being used in 440 schools throughout the Czech Republic, notably in schools in districts such as, for example, Česká Lípa, Nový

Bor, Pardubice, Chrudim, Lanškroun, Ústí nad Orlicí, Přelouč, Tábor, Hradec Králové, Litoměřice, Terezín, Vlašim, Trutnov, Brno, Slavkov, Žďár nad Sázavou, Moravský Krumlov, Zlín, Vsetín, Opava, Bohumín, Nový Jičín, Karviná, Bruntál, Ostrava, Frýdek-Místek, Hodonín and Břeclav. During its introduction into practice, we applied the approach given above in the ABC in Health Education according to H. De Vries, see below. Stated here are details on the analysis of the problem, the creation of the preventive programme, the testing of its effectiveness, and the specific dissemination of the programme "Non-smoking is a Norm".

The ABC scheme in non-smoking education and support for a healthy lifestyle within the programme "Non-smoking is a Norm":

A
ANALYSIS OF THE PROBLEM

1. Needs	(smoking, initial experimentation)
2. The individual–environment	(the norms of society)
3. Target group	(7–11 years of age)
4. Determinants	(analysis of motives)
5. Approach	(the needs of the target group)

B
INTERVENTION AIMED AT BEHAVIOUR,
CREATION OF THE PROGRAMME

1. Goals	(to delay initial experimentation, becoming a no-smoker)
2. Methods	(a programme of education/prevention, regulation at the state level, restricting smoking in public)
3. Testing	(control group and test group)

C
CONTINUED PREVENTION

1. Co-operation between experts	(teachers, psychologists, doctors)
2. Dissemination of the programme	(pedagogical-psychological centres, the National Institute for Further Education, Hygiene Centres)
3. Tactics and strategies	(institutionalisation)

In the first part of problem analysis we discovered that it is appropriate to focus on younger schoolchildren in view of the recommended approach to the prevention of smoking, which recommends beginning intervention two or three years before the risk behaviour appears. In our region in the Czech Republic, in view of the fact that the first experiments with smoking occur at an age of around ten, this means beginning prevention at the age of seven, i.e. in the first year of primary school. The target group is, then, children aged seven to eleven – young schoolchildren at the primary level. The clear definition of the problem is that the aim of intervention is to delay initial smoking among children (experiments with cigarettes) until a later age, to restrict passive smoking, and

the acceptance of a conscious decision to become a non-smoker. The programme also aims to increase knowledge and influence attitudes and behaviour, and applies the methods of interactive work, group work, discussion, motivational stories, role-playing, etc. We have checked that it is positively evaluated. This check was conducted by means of a comparison of the results recorded in a test group and a control group in order to avoid the dissemination of an ineffective programme. This programme is the result of co-operation between experts in a number of fields – educationalists, psychologists and doctors, and is being disseminated by the National Institute for Further Education, pedagogical-psychological centres and hygiene centres. Teachers are trained in the use of the programme and take part in a workshop where they are awarded a certificate and register their guarantor, who sends feedback about the programme's introduction into teaching at the specific school in question. The programme has also been assured by a team of colleagues, see image 2.

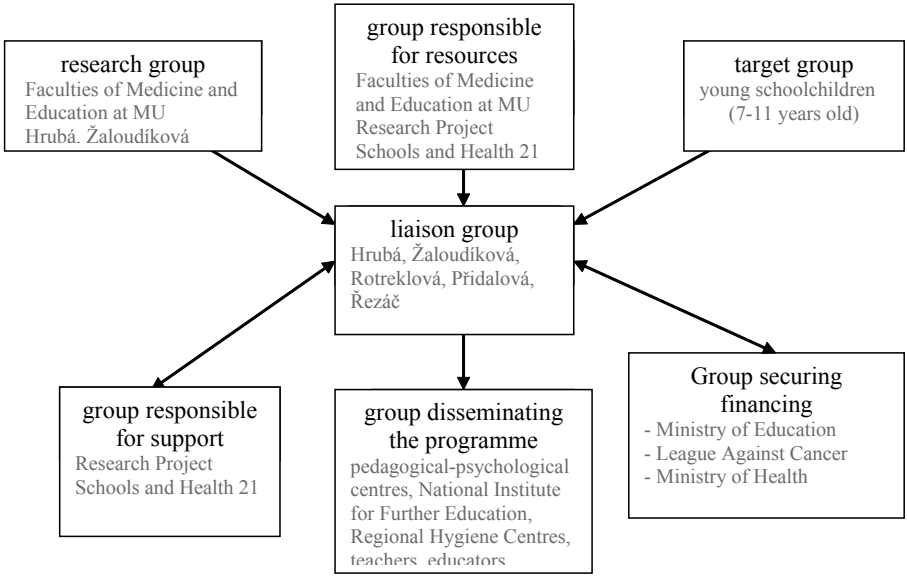

Image 2. Team assurance of the project of non-smoking education and health promotion "Non-smoking is a Norm":

The first information about the implementation of the programme in schools is already available to us. Teachers generally implemented the programme over the course of two months and informed parents of the programme at class parent meetings. Co-operation with parents mostly took the form of discussions on smoking in the home, and eighty percent of parents gave it a positive assessment and expressed interest in its continuation in higher school years.

They used motivational stories and video recordings, and created individual characters for dramatisation themselves. They frequently connected the subject matter of elementary teaching with other subjects such as reading, art, physical education, music

and maths. They also looked for some of the terms used on the computer and in encyclopaedias, applied the programme at open-air school and connected the programme with the projects Children's Day without Injury, Fruit at School, Healthy Teeth, Earth Day, and drug prevention. More than half of teachers put the children's work in their school portfolios. They like the form of interactive work throughout the entire programme. Within the programme, not merely the cognitive dimension, but first and foremost the affective aspect must be supported and developed in order to make the programme attractive for children so that they look forward to it and take a positive attitude to the subject. Children are, however, most strongly motivated towards a certain type of behaviour by their parents – social learning models.

In conclusion it should be said that the aim is to support primary prevention and create a programme to promote health and a healthy lifestyle that can be used in schools to increase the health literacy of primary school children.

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DISEMINACE EDUKAČNÍHO PROGRAMU „NORMÁLNÍ JE NEKOUŘIT“ DO PRAXE ŠKOL

Abstrakt: Primárně preventivní program Normální je nekouřit byl po pěti letech dokončen a jeho evaluace uzavřena jak v pilotní studii na školách v Brně, tak i v širší ověřovací studii v celé ČR. V současné době probíhá jeho rozšíření do praxe zařazením do kurikula školy, respektive do konkrétního školního vzdělávacího programu jednotlivých škol, které projevily zájem využít jej ve výchově ke zdraví. Uplatňuje se především v primární prevenci rizikového chování, primární onkologické prevenci a prevenci kardiovaskulárního onemocnění, a to komplexní výchovou ke zdravému životnímu stylu.

Klíčová slova: protidrogová prevence, školní onkologická prevence, výchova ke zdraví, rizikové chování, školní preventivní program