

EXPERIENCE WITH HEALTH EDUCATION IN BASIC SCHOOL

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Abstract: *The chapter deals with health education as a newly emerging educational field of basic education as well as a subject of curricular research. Within the Czech Framework Educational Programme health education is together with physical education part of the educational area Humans and Health. Curricular research which focuses on health education and physical education uncovers the difficulties of implementing health education into school practice. Research in health education as well as research in physical education indicate that the stated educational fields show discrepancies between the designed form of the curriculum and its implementation in the school practice. Therefore, this chapter focuses on the research findings and suggestions, which can contribute to improving the quality of health education as well as physical education in basic education.*

Key words: *health education, physical education, educational field, educational area, Framework Educational Programme, school educational programme, designed form of the curriculum, implemented curriculum, research in health education, research in physical education*

Introduction

Curricular reforms implemented after 1989 raised in the Czech Republic discussions on the global form of the Czech education as well as on partial aspects of education and training. Curriculum research started to be carried out in various educational areas, educational fields, subjects etc.

Also the emerging training in the field of *Health Education* attracts increasing attention. The motives for research in the field of health education draw upon our own research findings (e.g. Mužíková, 2006, 2008, 2010a, 2010b, 2011; Mužík, Mužíková, 2007; Mužík, Vlček et al., 2010; and so on), as well as upon the current data published by other authors or institutions, e.g. the Research Institute in Prague (Tupý, 2008, 2011), Czech School Inspection (2010) and others.

The development of education in the field of health education after 1989 with the focus on basic education will be outlined in the following text and will be supported by research results. Concurrently, we will focus on *Physical Education*, which in the Czech basic education accompanies Health Education.

1 Health Education as an Educational Field

We understand Health Education generally as a part of *Health Promotion*. According to Holčík (2004) health promotion represents a complex of ideas, tools and methods, which can be called: strengthening, reinforcing, supporting, protecting and developing health with active participation of individual citizens, groups, organisations, and the society as a whole. That is where these are not the matters solely of health institutions, but activities of individuals, groups, organisations, departments, and the society as a whole.

Health Education within the area of education can be comprehended more broadly as a part of the whole system of education and more narrowly as a concretely specified educational field defined by the existing educational documents. Health education should lead to raising the health awareness as well as behaviour in citizens. The term *Health Literacy* is frequently used in this context to define the “cognitive as well as social skill which determines motivation and ability of individuals to gain access to information on health, understand it and use it for promoting and sustaining good health.” (Holčík, 2004, p. 120)

Health Literacy should be a prerequisite for *healthy lifestyle* (or *healthy way of life*). According to Liba (2005, p. 5) it lies in “a balance between psychic and physical strain, deliberate physical activity, rational diet, harmonious relationships among people, cautious sexual life, refusing of 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 well-being, spiritual harmony and life satisfaction.

The term *Health Education* will be used in the following text mainly as an official designation of one of the fields within the Czech *system of fields of education*. The main conceptual document, which constituted the educational field of *Health Education* within the system of Czech Basic Education was *the Standard for Basic Education* from 1995. The aforesaid standard concisely formulated the key educational objectives as well as sets of obligatory educational contents, at the fulfilment of which all the pedagogical activities were aimed. The so-called core curriculum was arranged according to the educational areas and as a whole it defined the content and extent of basic education, which should be obtained by pupils during their compulsory education. The educational fields which created the framework for the selection of the core curriculum as well as the bases for its didactic processing in the educational programmes were singled out within the individual educational areas.

The standard for basic education served also as a tool for self-evaluation of schools. It focused both on ascertaining the effectivity of educational activities as well as on the assessment of pupils' results. By formulating the generally valid framework for basic education the standard became also a suitable starting point for creating the criteria for checking and assessment activities of the Czech school inspection.

The educational field *Health Education* pertained to the Standard for the basic education as a part of core curriculum and was included together with the field of *Physical Education and Sport* into the educational field of *Healthy lifestyle*. The main goal was to recognise the most significant favourable and unfavourable influences,

which can affect human development in the course of their lives including their current physical as well as psychic condition.

The core curriculum of the field of *health education* was divided into the following topics, which were in the Standard for basic education further elaborated on and described separately for the primary school and junior secondary school within the basic school:

- family, home and personality development;
- the fundamentals of psychic and physical hygiene, day regimen;
- rational nutrition;
- prevention of abusing addictive substances;
- the fundamentals of sexual education;
- personal safety;
- physical activity and health.

Another field in the educational area of *Healthy lifestyle*, as stated above, was the educational field of *Physical Education and Sport*. The objective of the training in this field should lead to pupils' acquisition of physical skills, improvement of their physical performance as well as proper body posture and to their attempt at an optimal development of health orientated performance and so on.

In compliance with the new principles of the curricular policy formulated in 2001 in *The National Programme for the Development of Education in the Czech Republic – The White Book*, a new system of curricular documents for educating pupils and students from 3 to 19 years was introduced in the education system. These curricular documents are formulated on two levels – of state and school. The state level is represented by the documents such as *The White Book* and *The Framework Educational Programmes* (in Czech abbreviated as RVP). The framework educational programmes represent an obligatory framework for education and standardise educational content for preschool, primary, and secondary education. The school level is represented by *The School Educational Programmes* (in Czech abbreviated as ŠVP), according to which education is implemented at individual schools. Each school creates their own school educational programme according to the principles stated in their particular framework educational programme. When creating The School Educational Programme, schools can take into consideration specific needs of their pupils, specific intentions and conditions of the school and of the region.

The Framework Educational Programmes represent the central level of the designed form of the curriculum. They define educational objectives, key competences as well as the educational content necessary for reaching the former stated. They define the framework for draft curriculum and formulate the rules for the School Educational Programmes. These programmes define the worth-while and appropriate education for the individual levels as well as fields. They represent the humanistic and democratic values, which are the basis for educating pupils and for the life of schools in the Czech Republic.

We were interested especially in the *Framework Educational Programme for Basic Education* (FEP BE). This document was implemented in schools within the Czech Republic on 1 September 2007 and it is annually updated.

The Framework Educational Programme for Basic Education emphasizes especially those aspects of education which are vital for life in the modern multicultural

society. They are namely understanding of values, the art of communication and cooperation, understanding of global problems, active influence and protection of health, practical activities of everyday life, educating towards independent thinking, acting and educating oneself. Among the nine educational objectives, there is also the following: teach the pupils to actively develop and protect their physical, psychic and social health and to be responsible for it.

The educational content is in the Framework Educational Programme for Basic Education divided into nine *educational areas*. The individual educational areas are formed by the *educational fields* which are related in their content. Health Education is in The Framework Educational Programme for Basic Education incorporated in the educational fields of *Humans and their World* and *Humans and their Health*.

The educational area *Humans and their World* is conceptualised for primary school. It consists of five topics out of which the topic that deals with health education is *Humans and their Health*. This topic makes the pupils get to know themselves on the basis of getting to know the humans as live beings with their own biological as well as physiological functions and needs. They get to know how humans develop from cradle to adulthood, what is suitable and what is not from the point of the daily regimen, hygiene, nutrition, interpersonal relationships etc. They obtain basic instruction on health and diseases, health prevention, first aid, safe behaviour in various life situations, including emergency situations, which threaten life of individuals or even whole groups of citizens. Pupils gradually realise what responsibility every human being has for their own health and security as well as for the security of health of other people. Pupils should come to an understanding that health is the highest value in life of a human being. They are getting the needed knowledge and skills by observing concrete situations, playing roles and solving problem situations.

The educational content is divided into the following topics:

- *human body*: life needs and manifestations, the basic structure and function of the human body, sex differences between a man and a woman, the basics of human reproduction, the development of a human being;
- *partnership, parenthood, basics of sexual education*: the family and partnership, biological and psychological changes in adolescence, the ethical aspects of sexuality, HIV/AIDS;
- *healthcare, healthy nutrition*: daily regimen, drinking regimen, physical regimen, healthy nutrition, disease, minor accidents and injuries, first aid, injury prevention, personal, intimate and psychic hygiene, stress and risks connected with it, influence of commercials;
- *addictive substances and health*: refusing addictive substances, gaming machines and computers;
- *personal safety*: safe behaviour in a risky environment, safe behaviour in road traffic in the role of a pedestrian, a cyclist, crisis situations (bullying, torturing, sexual abusing and so on), brutality and other forms of violence in the media, services of professional help;
- situations of public threat.

The educational area *Humans and their Health* is drawn up for both the levels of basic schools (i.e. primary and lower secondary level). It brings the fundamental stimuli

for influencing health which are introduced to the pupils who then learn to apply them and use them in their lives. The education in this field leads to pupils' learning about themselves as live beings, understanding the value of health, the significance of health prevention as well as the depth of problems connected with a disease or health damage. The emphasis is laid upon practical skills and their application in model situations as well as in every day life of their school. The educational area *Humans and their Health* comprises two educational fields: *health education* and *physical education*, to which appertains the accompanying field of *health physical education*.

The educational field *Health Education* brings the basic knowledge on humans in connection with the preventative protection of their health. It teaches the pupils to actively develop and protect health in all its components (social, psychic, and physical) and be responsible for it. The educational content is directly linked to the educational field *Humans and their World*. Pupils strengthen their hygienic, nutritive, work as well as other health prevention habits, they develop their skills to refuse harmful substances, prevent accidents and face their own being threatened in everyday as well as emergency situations. They extend and deepen their knowledge of the family, school and the community of their peers, of nature, humans, interpersonal relationships and they learn to look at the aforesaid phenomena from the point of view of adolescents and to decide in favour of health. Due to the individual and social dimension of health, the educational field *Health Education* is very closely linked with the cross-curricular topic *Personal and Social Education*.

The content of the educational field *Health Education* is divided into the following topics:

- interpersonal relationships and the forms of cohabitation: pair relationships, relationships and the rules of cohabitations in a community;
- changes in human life and reflection upon them: childhood, puberty, adolescence, sexual maturing and reproductive health;
- healthy way of life and health care: nutrition and health, physical and psychic hygiene, daily regimen, protection against contagious as well as non contagious diseases, chronic diseases and injuries;
- life threatening risks and prevention thereof: stress and its relationship to health, civilization diseases, auto-destructive addictions, hidden forms and levels of individual violence and abuse, sexual criminality, safe behaviour, keeping the rules of security and health protection, manipulative commercials and information, protection of humans in emergency situations;
- the value and support of health: holistic approach to humans in health and sickness, reinforcement of health and its forms, support of health in a community;
- personal and social development: self-cognition and self-concept, self-regulation and self-organisation of activities and behaviour, psychohygiene, interpersonal relationships, communication and cooperation, moral development.

In the educational field *physical education* the pupils are traditionally led, on the one hand, to getting to know their own physical potential and interests but also to getting to know the effects of concrete physical activities on their physical capability, psychic and social well-being. Physical education proceeds from spontaneous physical activities to controlled and optional activities. Pupils are learning to assess independently the level

of their capabilities and to incorporate physical activities into their daily regimen to satisfy their own physical needs as well as interests, for the optimal development of their capabilities and total performance, for regeneration of their powers and compensation of various loads, for the support of their health and protection of their lives.

What is characteristic for physical education is the recognition and development of physical abilities of pupils. Remedial and special compensatory exercises are an integral part of physical education as they can be preventively used for all the pupils or set to pupils with a physical disability instead of activities not suitable for their particular disability.

It is obvious that the FEP BE links physical education with health education in the field *Humans and their Health* much more than other educational documents.

Explicitly health education can be found also in the educational field *Humans and nature*. The educational field of *Biology* comprises the topic of human biology with a limited content of phylogenesis and ontogenesis, anatomy and physiology, illnesses, injuries, prevention, and healthy lifestyle. This topic not only corresponds with the field Health Education but also revises some of the content (e.g. lifestyle). Topics in the field Health Education can also be found in *Chemistry*: for example work safety, emergency situations, natural substances and their significance for the human body, medicaments, dangerous and addictive substances. From the educational field *Humans and the world of Work* we can use as an example the topic of food preparation.

Health Education is implicitly present also in other educational areas and fields, such as the educational field *Humans and Society* or the complementary educational field *Drama Education*.

A significant and integral part of the Framework Educational Programme for Basic Education are *cross-curricular topics*, which try to cover the current world topical issues and create opportunities for involving pupils, make them cooperate and help to develop pupils' personalities especially in the field of attitudes and values. Due to the fact that cross-curricular topics go across the educational fields and have a clear integrational character, they are significant for the support and education for health. Namely, it is the *personal, social and environmental education*.

There is an independent chapter in the the FEP BE which states the material, personal, hygienic, organisational and other conditions for the implementation of the the FEP BE. Even this chapter clearly shows the emphasis on supporting health at schools.

Another useful part of health education at basic schools are also the *programmes and projects for supporting health*, which complement the educational offer and enrich the implementation of the health education curriculum. Below you will find a basic summary of them.

The member states of WHO accepted at their meeting in 1998 the generally known programme *health 21 – Health for Everyone in the 21st century* (1999). The Czech government reacted to the said programme when they approved the national programme called *Longterm Programme for Improving the Health State of the Citizens of the Czech Republic – Health for Everyone in the 21st century (Czech Programme for Health 21)*. The concrete targets of *Health 21* concerning the basic education have the form of a curriculum design and that is how they amend the contents of the curricular documents.

Besides the programme *Health 21* there are the aims of *the National Programme of Health in the Czech Republic*, which is annually contributed to by the subsidy programme *Projects for Supporting Health*. These are overall interventional projects with the aim to favourably influence state of health, health condition, and education to a healthy way of life. Until now about two thirds of the implemented projects for health support were targeted at the child population and they could have been implemented at schools– e.g. *School Supporting Health, Healthy Teeth, School Milk, Fruit and Vegetables Five Times a Day, It is normal not to Smoke, Smoking and Me, Programme against Bullying and Violence at Schools and School Institutions, etc.*

The obviously best elaborated concept among the above stated projects can be found in the project *School Supporting Health* (Havlinová, 1998). The Czech Republic used this project for entering the European network of schools supporting health (ENHPS). Currently the project conjoins more than 40 European countries and within the territory of the Czech Republic several hundred preschool, basic, special as well as secondary schools.

Many schools create their own school or class projects, which stem from the topical needs and conditions of particular schools. These projects frequently use modern methods, such as project teaching and problem solving tasks and they, concurrently, have a motivating effect upon the pupils. The most frequently they are projects like *Healthy Days* or *Healthy Weeks*.

The above stated as well as other programmes are available on the website of the Czech Ministry of Education, Youth and Physical Education¹, The Ministry of Health², The State Health Institution³ and other institutions. A more detailed description as well as the analysis of the individual programmes or projects related to the educational field Health Education can be found for example in the works of Bočková (2005) and Brázdová (2008).

2 Health Education as a Subject of Curricular Research

It must be admitted that the Czech Republic lacks interdisciplinary research that would illuminate the position of health education in relation to other fields of school education. However, the results of the research carried out until now are not negligible.

Since the 1990s research is beginning to define and study the relationship of health education to physical education as well as to family education (e.g. Mužík, Krejčí, 1997; Mužík, Mužíková, 2007; Marádová, 2005). On the level of conceptualisation of the educational content it is rather the position the individual topics should have within the curriculum of health education that is being considered: e.g. problematic nature of life style and quality of life (Csémy et al., 2005; Havelková, Kachlík, Raus, 2006; Pokorná, 2006; and so on), nutrition (např. Rouhová, Pillerová, Havelková, 2001; Procházková, 2006), experience (Krejčí, 2004), physical self perception (e.g. Fialová, 2005), social behaviour (e.g. Prokopová, 2006), socially pathological phenomena prevention (e.g. Kachlík, 2005; Čech, Hanáková, 2008), health risks and primary prevention (Žaloudíková, 2004, 2009)

¹ <http://www.msmt.cz/>

² <http://www.mzcr.cz/>

³ <http://www.szu.cz/>

etc. The publications of Havelková, Reissmannová et al. (2009), Machová, Kubátová et al. (2009) as well as other authors are based on specifically orientated research findings.

The implemented form of the curriculum of health education is the subject matter of the research conducted by Marádová (2007). The results clearly show that majority of the tested pupils prefer topics from family or sexual education. Some knowledge on the implemented curriculum of health education can be found in the research of Žaloudíková (2003, 2004, 2009). The author infers from her research that school does not provide enough information on what is most harmful for health and how to prevent serious diseases. The authors Hajerová-Müllerová, Doulík and Škoda (2005) published a study within which they were assessing the changes of children's attitude to *drugs*.

The research studies organised by the co-author of this text analysed the opinions of almost 700 basic school headmasters regarding the implementation of health education at their schools (e.g. Mužíková, 2006; Mužíková, 2010a). The ascertained findings confirmed that the status of health education as an independent educational field is very low at many schools and that the designed form of the curriculum of health education is not implemented in a suitable way (see the detailed results in the following part of the chapter).

The history of the research in the curriculum of physical education in the Czech Republic started in the 1970s. The first research studies focused mainly on the implemented form of the curriculum of physical education, especially the didactic interaction between the teacher and the pupil. A comprehensive summary of those research studies can be found in the work of Dobrý, Svatoň et al. (1997). In the aforesaid publication you can find research results pertaining to the diagnostic activities of the teacher (e.g. Šafaříková 1980), the influence of various contents upon the didactic activities of the teacher (e.g. Hercig, 1977), the structure of activities of teacher and students (e.g. Svoboda, Kocourek, 1987; Jansa, 1987) and so on.

The research method of the Analysis of the didactic interaction enabled substantiating the relationship between the quality of teacher's activities and pupils' learning results (Dobrý, Svatoň, Šafaříková, 1984). The following research studies regarded the process of influencing the teaching activities of a teacher through immediate feedback information gained via a computer recording of the observed phenomena (Mužík, Uhlíř, 1989; Mužík, Hurychová, 1994; Mužík, 1997) or demarcating the activity profile of a teacher and their professional competences (Karásková, 1994).

In the recent years the research in the curriculum of physical education focuses on more forms of the curriculum (see e.g. Mužík, Trávníček, 2006; Mužík, Janík, 2007, 2009; Mužík, Vlček et al., 2010; and so on). The results of those research studies indicated a discrepancy existing between the curricular demands and the pedagogical practice. These results acted as the stimulus for the subsequent research studies presented in the following parts of the text. Physical education is perceived as an educational field closely connected with health education and belonging into the same educational field as Humans and Health.

2.1 Knowledge on the Implementation of Health Education in School Practice

Health Education, as stated above, is a newly developing educational field. It is a newly drawn up designed form of the curriculum of health education and it needs

to be approached innovatively when implementing health education at schools. We are expecting that the new quality of education in health education will manifest itself in the improved health literacy of the pupils and, subsequently, in their improved health condition.

These curricular schemes put great demands upon the school practice. That is why a question arose whether the Czech education system is well prepared for those demands and whether the increased demands in relation to health education are reasonable – for example when compared with foreign countries. We followed the partial research results gained in 2005 (Mužíková, 2006), which indicated that schools were not prepared to implement a newly prepared health education curriculum into their school practice. The findings could be generalised as follows:

- most headmasters and teachers at basic schools understand the importance of health education, however, they are not sufficiently acquainted with its content and the requirements for its implementation according to the FEP BE;
- a minority of headmasters and teachers do not appreciate health education and are not planning to implement it in the projected form at their school due to the fact that they consider the current status satisfactory. The main reason is the unfamiliarity of the projected form of the curriculum of health education in FEP BE.

These findings were followed by research carried out with a sample of headmasters of Czech basic schools.

2.1.1 Basic School Headmasters' Opinions of the Implementation of Health Education

The aim of the subsequent research was to get a deeper insight into the way health education is being taught at schools as well as a more thorough understanding of the problems that both Czech education and health education face. The research aim was thus formulated: To analyse basic school headmasters' opinions of the implementation of the health education curriculum according to FEP BE. We focused namely on the state of the conditions for training in health education, on the preference of individual parts, ways and forms of education, arrangement of the subject in the implementation of the field of health education, etc.

Research Method

The research method in this part of the research study was written questioning. The questionnaire had four parts: questions regarding the characteristics of the research sample (closed or semiclosed questions), questions upon the implementation of health education according to the Standard of basic Education (closed or semiclosed questions), quantitatively aimed questions regarding the implementation of health education according to FEP BE (closed or semiclosed questions) and qualitatively aimed questions regarding the implementation of health education according to FEP BE (open questions).

To ascertain the significance of differences in the number of the observed quantitative data we used the method of chi-square test. In responses to the open questions we used the method of the content analysis on the threshold of the method of open coding (Strauss, Corbinová, 1999). The answers of the respondents were transformed into

partial statements and processed by computer programme MAX QDA, which enabled their categorising as well as quantification. Our aim was to arrange the statements of the headmasters in such a way that they would, on the one hand, express the number of occurrence of the presented opinions (quantitative standpoint) and, on the other hand, express the sense thereof (qualitative standpoint). This arrangement was later used for deriving the content, extent as well as the nature of the researched phenomena.

The questionnaire was formed and verified during the school year of 2005/2006. It was distributed to schools in the second term of the schools year of 2005/2006, i.e. in the time, when the schools obtained the instructions for preparing their school educational programmes. The research sample consisted of headmasters of Czech schools. The selection of the headmasters was carried out in cooperation with the Czech School Inspection (CSI) using a method of random selection from a list of basic schools in the CSI database. It was the CSI that carried out the distribution and collection of the questionnaires. Then they were submitted to the co-author of this text for processing.

1000 headmasters of basic schools were addressed. The questionnaire was anonymously filled in and returned by 712 headmasters of basic schools (i.e. 71,2% of the addressed headmasters). Further 32 questionnaires were excluded from the sample during the processing for incomplete significant information and 148 questionnaires were put aside as they described only primary level of basic school. That is to say the research sample was created by 532 headmasters of the basic schools with both the primary and junior secondary level. We gathered 7564 partial statements, which were subsequently categorised and quantified.

Results and Discussion

The detailed results have already been published (Mužíková, 2010a), therefore we focus on the main findings corresponding with the implementation of health education into school practice:

More than half of the observed sample of headmasters (56%) considered implementing health education as an individual educational field useful. Most of the headmasters were not sure, though, who would guarantee and teach health education at their schools as they did not have qualified teachers for that.

Many a headmaster in the time of the research (2006) did not know that health education was defined as an independent field in the Standard for Basic Education as early as in 1995 and that FEP BE will enable them to implement health education either as an independent subject or in integration with another subject.

Only 11% of the headmasters of basic schools were considering to implement health education as an independent subject, on the contrary, 44% of the headmasters of basic schools did not plan to implement health education in any particular way. The biggest part of the headmasters (45%) was intending to integrate health education with another subject, most frequently with physical education.

Only one fourth of the headmasters intended to employ a qualified health education teacher in the future. Most of the headmasters focused rather upon a certain specific prevention (smoking, drugs apod.) and did not appreciate duly the complex idea of Schools Supporting Health (Havlíková, 1998). None of the respondents represented any idea of a complex scheme for health education within their school.

Most of the headmasters assumed that they would not soon acquire any didactic materials for health education and would not secure the material, personal, hygienic, organisational as well as other conditions for the implementation of health education as stated by the FEP BE (chapter 10). The most frequent reason was lack of financial means.

When asked which forms of education the school would use to implement health education, 474 basic school headmasters answered, i.e. 89,1% respondents (10,9% respondents did not answer). Most of the headmasters answered the question using several different statements, altogether 1526 statements were gathered. These statements were divided into categories defined on the basis of the content analysis of the answers and then quantified (see Fig. 1).

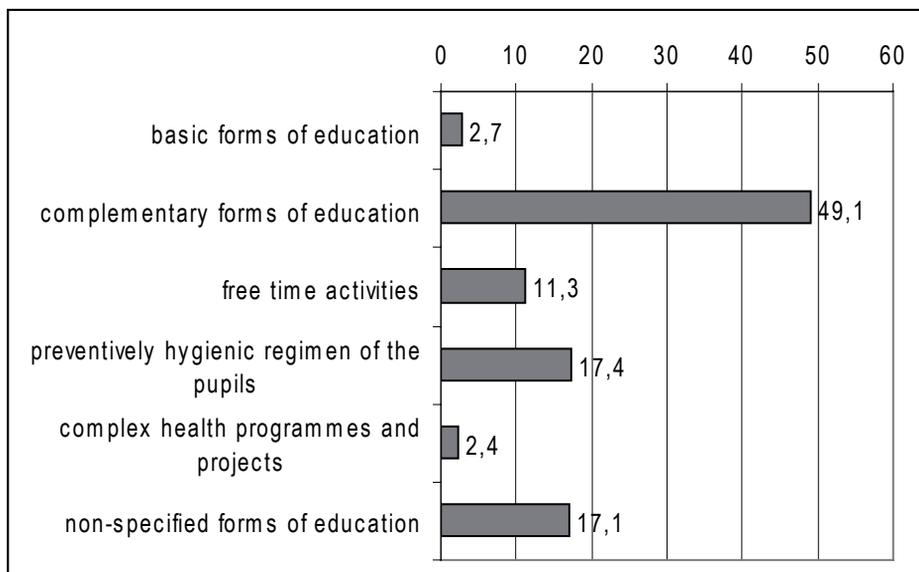


Fig. 1 Preferences in the forms of education in Health Education as stated by the heads of basic schools (% statements)

Very low frequency was observed in the headmasters' statements focused on the basic forms of education. Only 2,7% of the headmasters stated that health education would be implemented in the form of an independent subject or an optional subject.

Almost 50% of all the statements concerned the accompanying forms of education, such as school projects of health support (14,1% statements), projects with the themes of healthy lifestyle, physical activity, nutrition, sexual education, AIDS prevention, smoking, alcohol, drugs, addictions, bullying, emergency situations, ecology and so on. Some projects were not specified in more detail though (there was written only: projects, thematic projects, school and class projects). Second most frequent amending form of education were meetings with experts (12,5% statements), most frequently with doctors, further short-term courses and seminars (7,9% statements), such as the traditional skiing or swimming course, first aid courses etc. Relatively low frequency (less than 3% statements) showed one-off competitions.

11,3% statement of the respondents referred to leisure-time forms of education. The most represented (5,2% statement) were the school clubs (usually sports) and hobby groups (e.g. health, first aid and so on). Unfortunately, these groups are attended by a low percentage of pupils.

Relatively highly represented (17,4% statements) were the headmasters' responses regarding the preventative hygienic regimen of school pupils. The most frequent statements (12,4%) refer to the physical activities during the school attendance, i.e. recreational breaks, physical education moments, relaxation moments and so on. However, we consider these as an integral part of the common regimen of the school as they belong to the basic hygienic and organisational conditions of education.

Very low frequency was shown in the statements regarding complex programmes and projects (2,4% statements), to which also the project *School Supporting Health* (0,9% statements) belonged. Concerning this project the result is rather surprising for the fact that the programme Health 21 was approved by the government of the Czech Republic, which counts on schools entering the said project en mass.

Relatively high representation (17,1%) was observed in the statements, which do not characterise any educational form targeted at pupils. These are especially further trainings of teachers in the field of health education, however, very frequently merely courses of first aid for teachers.

If we evaluate all the above commented results, a question arises as to what forms of education and arrangement of subject content the schools have implemented so far; or are planning to implement regarding the educational content of the educational field health education legislatively stated in the Standard for Basic Education in 1995 and specifically emphasised in FEP BE in 2005. We assume that health education cannot be in its stated educational extent implemented only via accompanying educational forms (projects and meetings), preventatively by the hygienic regimen of schools and by offering leisure time activities to pupils (hobby groups or school clubs). A majority of respondents did not state their opinion regarding the basic arrangement of the content of health education, e.g. integrating it with other school subjects.

The above stated commentaries regarding the results are generalised and do not cover the analysis of the individual questionnaires focused on understanding of the mutual connections between the individual statements of each respondent. On the basis of the qualitative analysis of the individual questionnaires, which we carried out, we can state that, with the exception of the headmasters who named the project *School Supporting Health* as the most effective part of the process of education at their school (only 10 respondents!), no other headmaster introduced a more elaborate and complex way of implementing the educational content of health education. This finding confirms our former finding that many headmasters do not know well the educational content of health education, or at the time of the research study were not prepared to deal with the complex situation regarding implementing health education into the school practice.

We can object that more accurate results would be obtained in a study of teachers who guarantee or teach health education at schools (such research in primary school was conducted by e.g. Wiegerová (2005)). We are aware of this fact, however, concurrently we suppose that as the headmaster is responsible for the running of the school and he/she is the person who decides in what way the educational context of the individual

field will be implemented. Many questionnaires also showed that they were completed in cooperation with the particular teacher or with the whole school staff. That is why we consider the results to be credible.

Due to the fact that the questionnaire survey was anonymous, the answers of the individual headmasters cannot be confronted with the real situation at the particular schools or with the particular school educational programmes. It is not possible to amend the answers either, e.g. with interviews with teachers or pupils (or any other way). On the other hand the anonymous way of questioning is assumed to provide significant openness and sincerity regarding the answers.

Even though the responses of the majority of headmasters did not provide a complex or concrete picture of the implementation of health education at the individual schools, more than 7500 respondent statements regarding health education presents a rich and suggestive material, which can be used as a source when drafting school educational programmes. These suggestions will be used in teacher training.

The results processing enabled us to get invaluable experience for further similar studies. We found out that the preparation of the questionnaires must be more thorough and precise. The main imperfection of the structure of the questionnaire was to assume that all the respondents would approach a questionnaire sent by the Czech School Inspection in a responsible way and fill in all the questions. Second erroneous assumption was that school headmasters would know the basic educational documents as well as the terminology and content of FEP BE on which the questionnaire was based. However, the analysis of the answers showed that at least one third of the respondents did not know the contents of the already approved curricular document. Third erroneous assumption was that the respondents being the top representatives of the basic education would show helpfulness towards the study, which refers to the necessary life value – human health. A number of the headmasters were not interested in the topic of health education at all. Some headmasters stated expressly that they considered health education within the basic education surplus and would not invest time to learn more about it. More than one quarter of the respondents did not return the questionnaire, which corresponded to the above stated assumption.

The analysis of the answers first brought a feeling of bewilderment. Many an answer showed that the headmasters' opinion of their work was sceptical and that they found the current state of the Czech basic education unsatisfactory. The answers also showed that some of the respondents found the questionnaire annoying and that they considered the study unnecessary. This finding confirms the generally known fact that a state of a phenomenon cannot be researched in one study; on the contrary, many other factors must be used, which are not covered in a questionnaire. We still consider the obtained data and opinions of a significant part of the headmasters of Czech basic schools rewarding and inspiring. Direct interviews would undoubtedly be more objective for fulfilling the aim of the research as well as direct observations carried out in schools; however, these methods would narrow down the sample of the researched schools and their headmasters.

The carried out discussion shows that we must not overestimate the content or statistical significance of the gathered results. Many other research studies in the field of health education are orientated mainly on teachers, pupils or students (e.g. Čech, 2005,

Kachlík, 2005, Marádová, 2006, 2007, Řehulka, Řehulková, 2004, Wiegerová, 2005 and so on). That is why we cannot compare the obtained results with other studies and thus make them more objective.

2.1.2 Opinions of Czech Citizens on the Implementation of Health Education

The incentive for researching the opinions of Czech citizens regarding the implementation of health education were the results presented in the previous chapter. These results document that health education until 2006 had not been, in many basic schools, implemented in compliance with the Standard for Basic Education (1995) and that the conditions suitable for implementing health education according to FEP BE had not been created either. The aim of this subsequent research was to document the opinions of Czech population regarding the level of health education at basic schools and identify the main reasons for satisfaction or dissatisfaction with health education at schools.

Research Method

The research was carried out in cooperation with the *Institute for Health and Healthy Lifestyle Studies* and the *INRES – SONES* agency towards the end of 2008. The opinions of the Czech population were gathered from a research sample, which included 1606 respondents (in November 2007) and 1796 respondents (in November 2008) who were selected randomly by means of quota.

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. 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 statistically significant correlations can be interpreted only as tendencies.

The research was designed as a sociological one and was based on questions proposed by the author of this paper. The survey was carried out by means of a standardised guided interview between an interviewer and a respondent. 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 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 to category form. The obtained results were interpreted and published by the author of the study (Mužíková, 2009, 2010a, 2010b).

Results and Discussion

The opinions of the representative sample of citizens regarding the level of health education at Czech basic schools were ascertained by means of open questions. The below stated questions were answered by 1606 respondents above 15 years of age.

We were not able to categorise or statistically process the answers to the question where the main positives of the current level of health education at basic schools are. The majority of respondents answered “I do not know”, “I do not have the slightest idea how health education is taught at schools”, “I do not have enough information” or did not answer the question at all. Only 29 respondents (i.e. 1,8%) stated that they were led at school to a healthy way of life, that their school focused on cleanliness, changing shoes, washing hands or that “everything is all right”.

When asked what are the main insufficiencies of the current level of health education at basic schools, 689 respondents answered (42,9%) and 917 respondents (57,1%) stated that they did not know, did not have enough information, were not able to answer the question, or did not answer the question at all.

689 concrete responses were analysed and on the basis of the aforesaid analysis we determined the categories into which the responses were divided. We succeeded in identifying the main reasons of dissatisfaction of the Czech population with the level of health education at basic schools:

The most frequent stated reason for dissatisfaction with health education at basic schools (34,0% responses) was the insufficient extent of the lessons (see Fig. 2). Relatively close were the responses regarding the content of the lessons (15,2%) and the level of the teachers (14,5%). Summing up those responses within the two categories, we found out that 29,7% respondents were not satisfied with the level of the lessons. The approach of pupils to the subject matter was criticized by 13,8% respondents, insufficient support in the family 5,1% respondents, financial demands of the lessons 1,4% respondents. Further reasons were not significant for the subject matter.

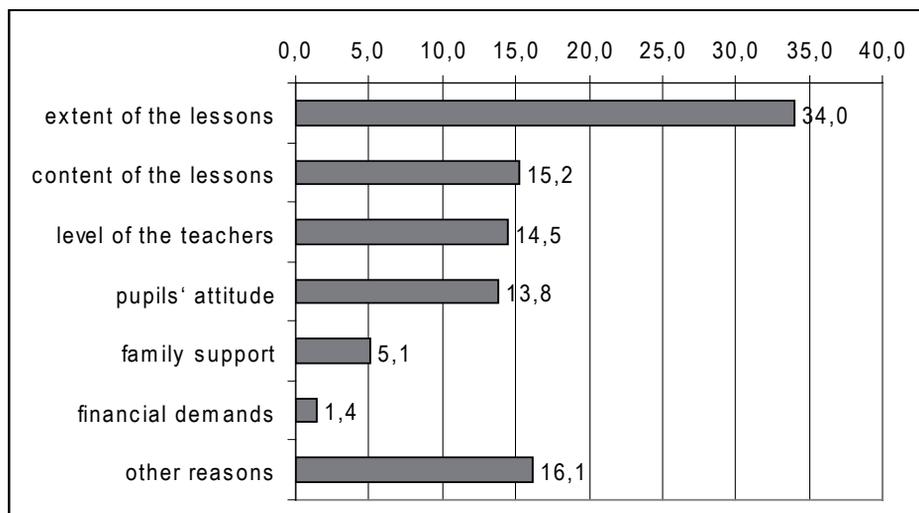


Fig. 2 Reasons for dissatisfaction of Czech citizens with health education (% statements)

The analysis of the relations in the frequency of the responses among the individual groups of the population ($p < 0,05$), carried out on the basis of second sorting, brought the following statistically significant results:

The small extent of health education is more frequently pointed to by women, students and single respondents, mainly young people not exceeding 24 years of age. Due to the fact that the frequency of responses in the young generation between 15 and 24 years of age statistically significantly differ from the responses of the older groups ($p < 0,05$), these responses were put aside and interpreted as a separate group. Another important moment is that the responses of the young population have a more up-to-date declarative value for evaluating the current state of the implementation of health education. Most of these respondents had already experienced health education that should have been implemented according to the Standard of basic Education (1995) during their school attendance.

Young respondents most frequently pointed out the insufficient extent and content of the lessons of health education and were also critically commenting on the level of the teachers, who allegedly did not have the qualification to teach health education. In comparison with the whole population, the young generation is more critical to the attitude of pupils to health education, however, the criticism of the attitude of families was almost the same with the older generation.

Another question: “Do you think that basic education should include also topics from the field of health support and healthy life style?” The question was asked in the way of closed dichotomic question with the possible “yes” and “no” answers.

Most of the citizens of the Czech Republic (88,6%) was of the opinion that topics from the field of health support and healthy lifestyle should be incorporated into the lessons of basic education. In doing so, women significantly more often agree, while the youngest age group (between 15 and 19 years of age) significantly more often disagree as well as the respondents with basic education who significantly more often disagree. On the other hand, respondents with A-levels significantly more often support it.

The question, which ascertained the opinion of citizens regarding the possible implementation of the topics of health education and healthy lifestyle into the lessons at basic schools, was of filtering character. The respondents, who supported the idea of implementing the topics into the lessons of basic schools (1590 respondents), were also asked to state, which topics from the field of health support and healthy lifestyle should be incorporated into the lessons at basic schools.

The question was formulated as semi-open and respondents could choose up to three topics they considered most important from the offered range. If they were not satisfied with the offered alternatives, they could state other topics in their own words. The range of answers offered to the respondents was as follows:

- topics concerning healthy diet (basic components of nutrition etc.),
- topics concerning physical activity (fitness programmes for the healthy etc.),
- topics concerning psychic and physical hygiene (daily regimen, prevention of diseases etc.),
- topics concerning personal safety (first aid, emergency situations etc.),
- topics concerning prevention of socially pathological phenomena (drug abuse etc.),

- topics concerning sexual and family education (contraception, venereal diseases, partner and family relations etc.),
- other topics (state which).

As shown in Fig. 3, the citizens of the Czech Republic mostly prefers the topics from the fiels of healthy nutrition (52,4%). Another group of topics, the implementation of which is supported by more than two thirds of the respondents are the topics from the field of sexual and family education (47,6%), topics from the field of pathological phenomena (45,0%) and topics from the field of physical activity (41,9%). The least supported topics were the topics from the field of psychic and physical hygiene, which were preferred by only a third of the respondents (31,2%). In the so-called „other topics“ the citizens frequently proposed senior citizen care and protection against bullying.

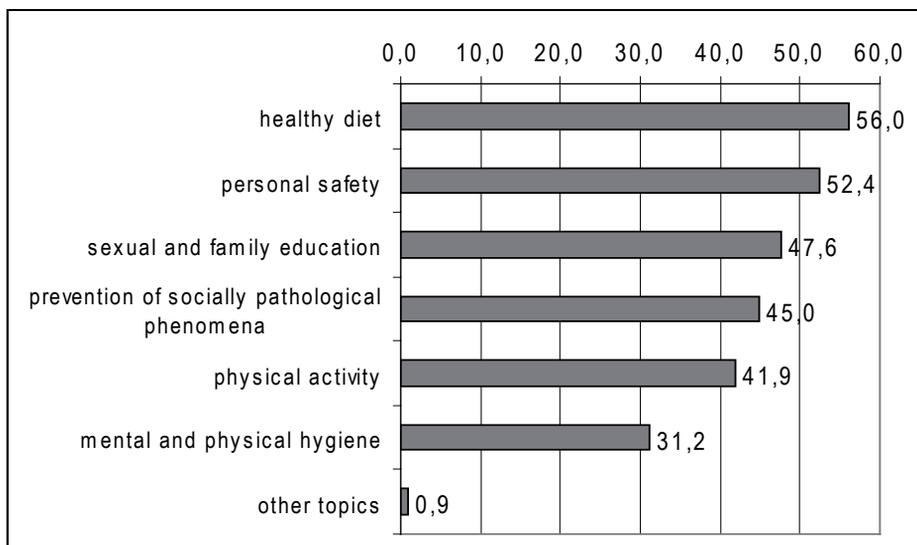


Fig. 3 Preference in topics of health education in Czech citizens' views (% statements)

Men significantly more often than women prefer physical activities, otherwise the opinions are balanced. It means that statistically there are no differences in the opinions of the individual age, education, or other groups of respondents, who were divided according to socio-demographic characteristics.

There was a minority of respondents (11,4%) who stated that basic school education should not incorporate topics from the field of health support and healthy lifestyle and that was why they were asked what the reasons for their view that the topics should not be incorporated into the teaching at basic schools were. The most important reasons mentioned were that it was not interesting or surplus for the children and that it was predominantly the issue to be dealt with within the family, that there is enough information on the topic in the media and other subjects, etc. or that it is a topic not comprehensible for basic school pupils. More than one fifth of the respondents who did not agree with implementing health education into basic school curriculum could not substantiate their reasons and chose the answer of "I do not know".

The applied testing criteria did not signal statistically significant relations between the stated opinion and the observed socio-demographic characteristics. It is necessary to mention that due to the small number of cases the possibility of their application was very limited.

2.2 The Findings Regarding the Implementation of Physical Education in School Practice

In 2007 a survey was carried out in the field of the curriculum research. It researched the opinions of secondary schools students on physical education they and to attend during their compulsory school attendance (Mužík, Janík, 2007, 2009). The results of the survey indicated that there was a discrepancy between the demands of the projected curriculum and the pedagogical practice. From the gathered findings we choose the following:

Secondary school students (basic school graduates) endorsed an opinion that the basic school physical education lessons focus most upon the skills from sport games, athletics or gymnastics. The answers of the graduates indicated that insufficient attention was paid to the complex fitness preparation skills, which are the pre-condition for the health orientated fitness (i.e. also the support of health).

The graduates stated that the physical education lessons were not focusing more significantly on acquiring knowledge. If there was some knowledge mediated to the students, it was predominantly focusing on presenting the rules of sports and games, less frequently on the influence of physical activities upon fitness and health (including hygiene and safety during physical activities).

The pupils were in the lessons of physical education mostly assessed for their sports performances. However, the fundamental aim of the contemporary physical education is creating a positive relation of the pupils to physical activity and health orientated fitness. The results indicated that physical education did not have any evidential influence upon pupils' physical regimen. The graduates showed, in the obtained results, a positive attitude towards physical activities, nonetheless, a less favourable attitude to physical education. Majority of the graduates did not consider their teachers to either observe or evaluate leisure time physical activities.

The opinions of boys and girls did not show from the point of the subject matter any significant differences. The exception was a statistically significant worse relation towards physical education in girls.

2.2.1 Basic School Pupils' Opinions Regarding the Implementation of Physical Education

In 2008 we carried out a subsequent study to the above described research. The aim of the research was to verify the above described results on a larger sample of respondents, separately for the primary school and junior secondary school within the basic school.

The research questions focused on evaluating the relation between the designed and the implemented curriculum. Simultaneously, these are subordinate to the target categories of the designed curriculum of physical education:

- What physical activities (skills) did the educational process of physical education focus on?

- What knowledge did the educational process of physical education focus on?
- How did the pupils perceive the aims or rather the concept of physical education?
- What is the pupil's relationship to school physical education and physical activity in their leisure time?

The research questions focused on selected aspects of the implemented form of the curriculum, however, there was an overlap of the results and outcomes of the learning. In our case, these were researched only implicitly on the basis of the reflection of basic school pupils. In doing so, we assumed that an average pupil is able to realise and evaluate the mission of a subject that he/she experienced at basic school.

Research Method

The method of the research was a non-standardised questionnaire, the items of which reflected the above stated research questions. The individual questionnaire items were created by partial closed questions with the alternatives of the answers on a four degree scale: Yes, definitely (1), Yes, quite (2), rather not (3), definitely not (4). Some of the items were accompanied by open questions with the possibility of free answers, however, those were used only rarely and that is why we do not comment on those in the results.

The questionnaire was drawn up and verified by the authors of the text. Cronbach's alfa was for all the items of the questionnaire 0,85 and for the individual items 0,55; 0,78; 0,58.

The questionnaire was handed out to pupils of the fifth grade at basic school and pupils of the ninth grade of basic school at the end of the school year of 2007/2008. The research sample consisted of 1170 basic school pupils, out of which 585 were pupils of fifth grade (260 boys, 325 girls) and 585 were pupils of ninth grade (276 boys, 309 girls).

The questionnaires were distributed with the help of the students of the Faculty of education. The students addressed the respondents in the places where they lived (each student one fifth grade pupil and one nine grade pupil), they explained the content of the questionnaire and supervised its completion. The condition for processing the questionnaire was that each respondent was from a different school or a different fifth or ninth grade. That is how we succeeded in gathering respondents from a large area of the Czech Republic, from more than 500 schools, even though the regions were not represented by the same numbers of respondents. The questionnaire was anonymous regarding the relation to the respondents as well as to the evaluated physical education lessons (or rather schools or teachers of physical education). However, the research sample of respondents is not representative according to the basic indicators (age, sex, and region).

The filled in questionnaires were processed during the school year of 2008/2009. The responses of the pupils were recorded on a four point scale (from "definitely yes" to "definitely not") and were transferred into the categorical values of 1 to 4. The frequency of the pupils' responses was then expressed by means of the basic statistical characteristics (arithmetical mean value, median, mode, minimal value, maximal value, variance and standard deviation). The observed dependences were verified by means of the statistical methods χ^2 -square and correlations. The statistical calculations were carried out using the software Statistica CZ 9.

Results and Discussion

The detailed results including the statistical characteristics had already been published (Mužík, Vlček et al., 2010), that is why we are below stating only the most important findings.

The ascertained results inform us in general terms about the implementation of the designed form of the curriculum in physical education at basic schools. The number of respondents was sufficient (1170 žáků), however the research sample was not representative in regards of the basic school pupils according to any indicator. The results cannot be generalised and only indicate the ascertained tendencies. Nevertheless, they are the evidence of the topical situation in physical education at basic schools and enable us to give general answers to the research questions.)

Some respondents thought that the lessons of physical education focused mainly on the activities and skills in the field of sport games, athletics and gymnastics, less on dance and rhythmical exercises or tasks. These findings equally corresponded to both the primary as well as junior secondary school.

The results further showed that physical education of both the above mentioned levels of basic school focused mainly on the rules of sports and games, which corresponds to the above stated result (i.e. the lessons focus on the skills from the field of traditional sports and games and, concurrently, on the knowledge of their rules). Furthermore, the lessons often incorporated safety rules in physical activities. According to the designed curriculum in the FEP BE (activities influencing health) pupils should also gain knowledge of the muscles of human body, compensatory exercises, fitness, hygienic habits and proper body posture.

The main objectives of physical education, as perceived by the respondents, are improving sports performances and developing personal fitness. Without the corresponding knowledge that would regard the influence on personal fitness, the intended concept of physical education “oriented towards health” cannot be properly fulfilled.

For almost 90% of fifth graders at basic schools (boys as well as girls) physical education lessons in primary school are enjoyable and pleasant lessons. Junior secondary school situation is rather different: about 80% of boys are contented, however more than 30% of girls have a negative attitude towards physical education lessons. These findings correspond to the results of a Slovak author Bartík (2009), who, nonetheless, researched the attitudes of Slovak pupils towards physical education significantly deeper.

The interest in movement and sport, however, is not related only to the physical activities in the lessons of physical education. The educational aim of physical education is, besides others, to support the need of the children to perform physical activities also outside school. That is why the questionnaire included a question asking if the pupils were physically active also in their free time. The results showed that most of the children took part in a physical activity outside school. However, there was a part of the children who stated a negative answer in the questionnaire. Surprisingly, 10 respondents from the fifth grade responded “definitely not” when answering the question if they liked performing a physical activity in their free time. We have not found such a response in the ninth grade respondents.

The opinions of the boys and girls differed in more cases. From the point of the subject matter the differences did not influence the results of the survey.

The carried out research confirmed, in many an indicator, the opinions of the secondary students presented in the introduction of the text (Mužik, Janik, 2007). The results show the discrepancy between the designed curriculum and the implementation of the physical education in school practice. We can also state that schools are generally keeping the traditional sport focus of physical education and do not reflect sufficiently the health orientated concept of physical education.

2.2.2 Czech Republic Citizens' Opinions Regarding the Level of Physical Education

The subject matter of physical education at Czech basic schools was researched from the similar point of view like health education. Besides the opinions of the Czech Republic citizens regarding the level of health education, we also ascertained the reasons for satisfaction or dissatisfaction of Czech public with the level of physical education. Furthermore, we tried to determine the preferences with regard to the preferred topics of physical education lessons according to the opinions of the Czech public.

Research Method

The research was conducted in two phases concurrently with the research of the opinions of CR citizens regarding health education. The research was designed as a sociological one using the questions proposed by the author (co-author of this chapter) according to the same methodology as in the previous survey.

The data collection was carried out by means of the method of the standardised directive interview between an interviewer with a respondent. The field testing was conducted all over the CR between November and December 2008. The opinions of the population of the CR were obtained from the sample of 1792 respondents selected randomly by means of quota. The sample was representative of the population of the CR aged 15 and above. Its representativeness was derived from the basic sample of the population of the CR aged 15 and above. We can state that the further described results of the research are representative for the population of the CR aged 15 and above with regards to sex, age, and region.

Results and Discussion

The authors are not aware of the fact that there had been a similar sociological survey regarding the educational field of physical education carried out in the Czech Republic prior to this research. The ascertained findings can, therefore, be considered pilot and descriptive. The evaluation of the data can contribute to a better understanding of physical education and can be a starting point to further improvement on the implementation level of the educational field Humans and Health.

To describe the public opinion as accurately as possible, the respondents were given an open question asking them what, in their opinion, were the main positives of the current level of physical education at basic schools. The respondents were not offered any choices and were asked to express the reasons for satisfaction with the level of physical education in schools in their own words. All the obtained answers were subsequently subjected to a content analysis and then were categorised into the following basic groups:

- Support of physical activities (responses of the following type: makes physical activity possible, forces children to be physically active, limits children's passivity, etc.).
- Health support (responses such as: it is a prevention of phenomena detrimental to health, obesity, enables healthy bodily development, etc.).
- Forming desirable personal habits and contributing to purposefully spent free time (responses such as: educates to discipline, perseverance, subordination, forms relations to a collective, leads to purposefully spent free time, etc.).
- A larger variety within the teaching (responses such as: it is more varied than before, it offers more types of physical movement activities, it offers various sports, etc.).
- Better equipment of gymnasiums and sports places (responses such as: there are more gymnasiums, sports places, they are of better quality, there are more sports apparatuses, aids, fitness centers, swimming pools, skating rinks, etc.).
- Better teachers (responses such as: teachers have better attitudes, they are more qualified, better prepared, they have more modern teaching methods, they are more able to motivate the pupils, etc.).
- Others (responses such as: the time is more modern, the demands are not so strictly focused on performance, etc.).
- No positives (responses of the following type: the level is worse, I cannot see any positives, it is good for nothing, etc.).
- Do not know (responses such as: I do not have enough information, I do not have the needed knowledge, etc.).

Almost half of the respondents (47,6%) were not able to define the reasons for their satisfaction with the current level of physical education and chose the response "I do not know". This group most frequently did not have children going to school and were not in contact with physical education even through a different channel (i.e. via the media, family relatives or acquaintances). More than one fifth of the respondents thinks that the main positive thing about the physical education at basic school is the fact that it supports physical activity in children and is a balance to their sitting at the desks or at the computer, it enables children to entertain themselves, relax, rest actively. Comparing this category with the opinions of the young between 15 and 19 years of age there is a significant statistical difference ($p < 0,05$). Physical activity is considered as the main positive asset by almost 28% respondents representing the young.

Another group of respondents (10% of the whole population, 13% of young citizens) considers the main positive asset to be the fact that the contemporary physical education at basic schools is more varied, offers more kinds of physical activities, more sports including the non-traditional. Almost the same group of population in number (10,5%) also of younger citizens between 15 and 24 years of age (12,4%; 13,0%) sees the main positive asset in the improved equipment of the gymnasiums. Other types of questions were not as highly represented, their proportion was within the range of 3 to 7%.

The analysis carried out on the basis of the second stage of sorting shows that the response "I do not know" was more frequently chosen by male respondents. It was demonstrably ascertained that older age groups had the least information on the level of physical education (citizens over 55 years of age more frequently than other chose the

response “I do not know”), while younger people up to 34 chose that response significantly less frequently (in the group of young people up to 19 years of age only 23,4%). From the point of view of education the least informed were the citizens who stated having a vocational training. The age worked also through marital status as the response “I do not know” was significantly more frequently chosen by married citizen and, especially, by widowed people, while single people opted for that response significantly less frequently and credited physical education with some of the above stated positives.

Besides the positives also the insufficiencies that the citizens of the CR attributed to physical education were ascertained in the research. The respondents were asked what the main reasons for dissatisfaction with the contemporary level of physical education at basic schools were.

Similarly to the process of identification of the reasons for satisfaction, we opted for the open question without predefined scale of possibilities. That is why the content analysis of all the statements of the citizens regarding the subject matter was carried out on the basis of which the categories were determined for the subsequent division of individual responses. Find the determined categories regarding the main insufficiencies of the level of the contemporary physical education at basic schools below:

- Insufficient number of lessons (responses such as: there are few lessons, it is not sufficient twice a week, it is needed to add lessons, etc.).
- Insufficiencies in the content of the lessons (responses such as: the lessons are monotonous, the content is bad, there is not enough gymnastics, athletics, swimming, it is not interesting, etc.).
- Insufficient preparation of teachers (responses such as: the teachers are not sufficiently qualified, they are not professionals, they are not able to motivate the children, get them interested, they are not consistent, etc.).
- Wrong attitude of children to the lessons (responses such as: children are lazy, reluctant, they are not interested in the lessons, they avoid physical activities, they are passive, etc.).
- Insufficient technical facilities for the lessons (responses such as: few gymnasiums, playgrounds, sports grounds, little sport equipment, old equipment, equipment of not satisfactory quality, etc.).
- Great financial demands of the lessons (responses such as: expensive leotards, sports clothing, equipment, courses, expensive skiing training, etc.).
- Other insufficiencies (responses such as: little support from the families, bad atmosphere in large cities, etc.).
- No insufficiencies (responses such as: everything is OK, the level is high, I cannot see any insufficiencies, etc.).
- Do not know (responses such as: I do not have information, I do not go to school, I do not have children who go to school, etc.).

More than half of the respondents (53,1%) were not able to find any insufficiencies in the current level of physical education at basic schools. These respondents chose the answers “I do not know”, or “I cannot judge”, “I do not have enough information”. Similarly to the positive responses, these were the respondents who did not have either direct or mediated information on the field. Their closer characteristics will be described in connection with the analysis carried out on the basis of the second level of sorting.

If the citizens stated any insufficiencies in physical education at basic schools, they saw them mainly in the wrong attitude of children to the lessons (12,8%), in the low number of lessons (12,0%), in the bad level of teachers (9,5%), or in the insufficiencies regarding the content of the lessons (7,2%). Other insufficiencies were less frequent and their occurrence was within 5%.

The responses of the younger population between 15 and 19 let statistically differed from the whole other sample of the population in the following categories: insufficiencies in the content of the lessons (12,0% of the young), insufficient level of the teachers (13,5% of the young) and do not know (36,1% of the young).

The responses of the population between 20 and 24 statistically differed from the whole sample of the population in the category of the insufficient level of the teachers (16,7%), in the category “other insufficiencies” (8,3%) and in the category “do not know” (31,9%).

The subsequent analyses carried out on the basis of the second level sorting signalled connections similar to those ascertained in case of the positive responses. The rule was that the higher the age of the respondent the more frequently the response “I do not know” was chosen while younger people opted for this response significantly less frequently. The age influenced the responses in mediation of other sociodemographic indicators. The response “I do not know“ was significantly more often chosen by widowed people as well as people with lower income. Similarly as in the case of the positive responses, the answer “I do not know” was more frequently chosen by men and the respondents who stated that their highest education was vocational school. Students more frequently than others saw the insufficiencies in the content of the lessons and the personality of the teacher. Bad teacher as the main source of insufficiencies was more frequently seen by female respondents.

The aim of the research was also to ascertain what the Czech citizens’ opinion was regarding the content of the lessons of physical education within basic education. This was carried out by means of semi-open question: „Do you think that physical education at basic school should include these topics? (Can you circle maximum 3 topics that you consider to be the most important?)“

The scale of possible answers:

- activities from the field of sport and sport games (athletics, gymnastics, basketball, volleyball etc.),
- physical recreational activities (amusement physical games, non-traditional activities such as juggling, activities of pupils’ free choice etc.),
- fitness exercises for the optimal development of physical fitness (especially muscle power and endurance),
- compensatory exercises within the prevention of the supportive physical system and body posture (stretching, strengthening and relaxing exercises),
- physical activities supporting self-cognition and self-control (yoga for children etc.),
- theory from the field of physical education and sport (the subject matter of physical load, lower muscle tone, measurement and assessment of fitness etc.),
- further topics (state which).

The evaluation of the responses brought the following results:

Czech Republic citizens regard the activities of sports and sports games as the most important within the content of physical education (see Fig. 4). This topic is preferred by more than two thirds of the CR citizens (68,9% respondents). Compensatory exercises within the prevention of the supportive physical system and body posture (58,6% respondents) are ranked second and the third most frequent answer stated were the fitness exercises for the optimal development of physical fitness (48,4% respondents). The respondents stated that the above mentioned three topics are the ones that should be definitely included in the physical education lessons. Recreational activities were not stated that often (36,4% respondents) and only less than fourth of the respondents (24,7%) considered the activities supporting self-cognition and self-control to be important to include in the lessons. Only 19,6% respondents thought the theory from the field of physical education and sport to be important. Other topics were, essentially, not proposed.

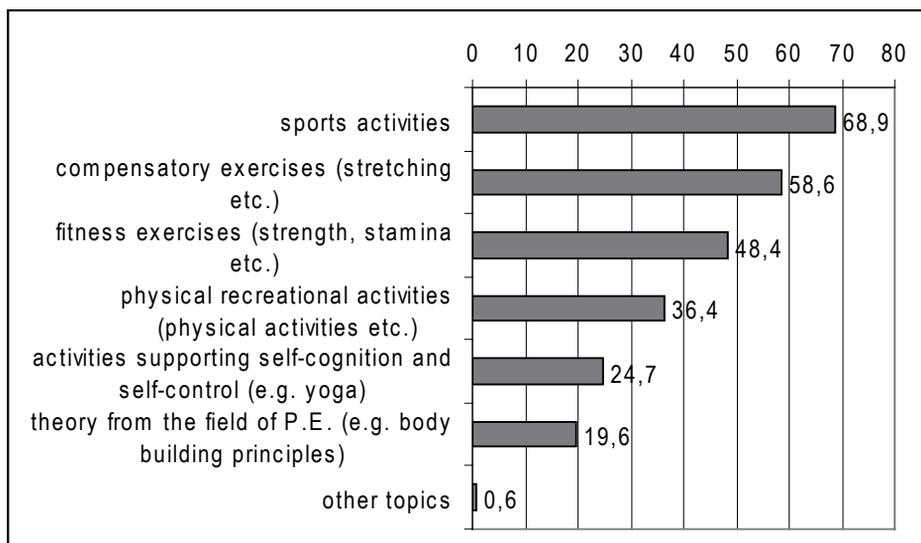


Fig. 4 Preferences in topics of physical education in CR citizens' views (% statements)

The opinion regarding the importance of the individual topics is dependent on the sex of the respondents. Males preferred the activities from the field of sport and sports games, while women considered compensatory exercises within the prevention of the supportive physical system and body posture, and physical activities supporting self-cognition and self-control. Other statistically significant differences were not found.

Approximately half of the Czech Republic citizens are not able to state the positives and negatives of the contemporary level of physical education at basic schools. If the citizens stated any positives, they saw them in the support of physical activities, greater variety and the improving equipment of gymnasiums and sports grounds. The insufficiencies were seen mainly in a wrong attitude of children to physical education or physical activity, small number of lessons of physical education, unsatisfactory level of the teachers and problematic content of the lessons.

The stimulus for a deeper research of physical education were the opinions of relatively fresh graduates of basic schools. About 28.1% of the young between 15 and 19 years of age showed dissatisfaction or complete dissatisfaction with the level of physical education. The most frequent causes according to the respondents are badly organised lessons (boring, uninteresting, monotonous, not varied, stereotypical etc.) and bad teachers whose approach disgusted the pupils and negatively influenced their relation to physical education.

Czech Republic citizens think that the most important topics that should be included in physical education lessons at basic schools are the activities from the field of sport and sports games and fitness exercises targeted at the optimal development of physical fitness. In connection with the research of Czech citizens' opinions regarding health education there is a discrepancy in the fact that they welcome the implementation of health education into the school curriculum but, concurrently, within physical education, prefer sports activities to fitness, compensatory and preventative activities supporting health.

The above stated findings provide recommendations for the pedagogical practice in basic education as well as for the pre-service teacher training. We recommend that pre-service teacher training in physical education emphasized more topics that are directly linked with health support, i.e. exercises within the prevention of the supportive physical system and body posture.

Supplementing Observations and Conclusions

The knowledge and findings regarding the field of education of health education in the Czech Republic are summarised below:

Health education as an independent educational field was defined in the projected curriculum (Standard for Basic Education) as late as in 1995. Nonetheless, the independent educational field of health education was not implemented after 1995. The topics of health education were incorporated mainly in the subject of family education that was implemented as "family education and health education".

Family education teaching could have been studied at faculties of education only since 1996. That is why the graduates of this educational field are very rare in basic education: in 2005 they were teaching only at about 13% of schools (Mužíková, 2006).

Health education was subsequently implemented into the newly emerging framework educational programmes for preschool, basic and secondary education. The educational aims of health education are very close to the educational aims of the programme *Health 21*.

Health education includes two specific educational topics: relationships among people and forms of cohabitation (e.g. relations in a couple), changes in human life and reflection upon the changes (e.g. sexual maturing and reproduction health), healthy way of life and healthcare (e.g. nutrition and health), risks endangering health and their prevention (e.g. civilisation diseases), values and support of health (e.g. holistic concept of a man in health and sickness), personal and social development (e.g. psychohygiene).

The FEP BE does not see the key point in the organisational structure of teaching but in the educational content. The FEP BE, therefore, leaves the traditional division

into subjects. The designed form of the educational content can be integrated at schools either into the traditional or new subjects or other forms of teaching in compliance with the demands of the individual educational fields.

Nevertheless, such a concept of health education is difficult to put into practice. Teachers without qualification in family education or health education do not have the suitable qualification for the whole designed extent of health education.

Since 2004 it has been possible to study teaching health education for the junior secondary school (i.e. upper level of basic school) at several Faculties of Education in the Czech Republic. Nonetheless, it is necessary to emphasize that there are very few graduates of the new field of Teaching Health Education in the Czech Republic. Also the assumed number of the future graduates of Teaching Health Education is relatively low and it is, within the territory of the Czech Republic, in tens in a year. Basic schools in the Czech Republic, therefore, will not have for a number of years enough qualified teachers of health education. Moreover, it is probable that headmasters of smaller schools will not be interested in employing graduates from the programme of Teaching Health Education (or Teaching Family Education) because it would be difficult to find a full workload for them. That is why schools usually manage the situation in compliance with the FEP BE by incorporating the content of health education into other educational fields or subjects.

The main organisational problem seems to be the time needed for health education in the upper cycle of basic school. The pilot version of the Framework of Educational Programme for Basic Education (2002) allotted health education 4 teaching lessons, i.e. 1 lesson a week in every year of the upper cycle of the basic school. In the basic version of the Framework Educational Programme for Basic Education (2005) the minimum time was lowered to 3 lessons and in the current valid version of the Framework Educational Programme for Basic Education (2007) health education is allotted only 2 lessons. The Framework Educational Programme for Basic Education does not state in which way or in which years the topics of health education should be implemented. Only in the pilot version of the Framework of Educational Programme for Basic Education (2002) there was a note to the curriculum that health education would be implemented usually as an independent subject or in a functional integration with another field of education. The subsequent versions of the Framework Educational Programmes for Basic Education did not include any organisational recommendation any longer⁴.

With regard to this information it is surprising and satisfying to know that according to the survey of the Pedagogical Research Institute in Prague (Tupý, 2008) health education was taught in the school year of 2007/2008 in 36% of basic schools as an independent subject health education and in 34% schools as an independent subject with an integrated part of the educational content into another subject. In 30% of schools the content of health education was integrated into other subjects, most frequently into biology.

In 2011 the Pedagogical Research Institute in Prague analysed 250 randomly selected school educational programmes (Tupý, 2011). It was ascertained that health

⁴ Contrary to the above stated, a directive for the educational field of Physical education requires: "The educational content of the educational field of Physical education is implemented in all grades of basic education; the time allotted for physical education must not be for health and hygienic reasons lower than 2 lessons a week." (FEP BE, 2007)

education is taught as an independent subject at the moment at 70% of Czech basic schools. Even more surprising was the finding that average time allotted to the subject at the upper cycle of basic school was 3 lessons. Many schools, therefore, complement the obligatory two lessons with their available lessons.

Integrating the content of health education within other educational subjects is, currently, used by about 30% of schools. Even though it is important to state that before any kind of integration of health education into other educational subjects there should be detailed analysis of the crosscurricular relations and the interconnectedness of the content of other fields, by means of the system method of modelling (see Maňák, 2007; Mužíková, 2010a, 2011; Dočekalová, 2010).

As stated above, in the Czech Republic health education is closely linked with the educational field of physical education. However, health orientated physical education puts increased demands not only on the ways of implementing the subject at schools but also on the teachers' qualification. Additional research orientated on physical education confirmed that schools as well as the Czech public prefer the content of the traditional sports activities (sports games, athletics and gymnastics). If the main aim of the educational field of physical education – a part of which is, currently, also health support as well as health literacy – is to be fulfilled, it is necessary for the lessons to concentrate not only upon the practical activities supporting health (fitness exercises as well as other physical activities supporting health but also upon acquiring the appropriate knowledge linked with the significance of physical activity for health. However, this should be carried out appropriately, in an attractive way and with regard to the age of the pupils. The question is to what extent the designed educational content of physical education at school is reflected and to what extent the implementation of physical education is perceived by the pupils as well as the Czech public.

ZKUŠENOSTI S VÝCHOVOU KE ZDRAVÍ V ČESKÉM ZÁKLADNÍM VZDĚLÁVÁNÍ

Abstrakt: Kapitola představuje výchovu ke zdraví jako nově se formující vzdělávací obor základního vzdělávání i jako předmět kurikulárního výzkumu. V českém rámcovém vzdělávacím programu je výchova ke zdraví spolu s tělesnou výchovou součástí vzdělávací oblasti Člověk a zdraví. Kurikulární výzkumy zaměřené na výchovu ke zdraví a na tělesnou výchovu odkrývají potíže, s nimiž se implementace výchovy ke zdraví do školní praxe potýká. Výzkumy výchovy ke zdraví i výzkumy tělesné výchovy rovněž naznačují, že v uvedených vzdělávacích oborech existuje nesoulad mezi projektovanou formou kurikula a její realizací ve školní praxi. Kapitola se proto zaměřuje na výzkumné poznatky a podněty, které mohou přispět ke zkvalitnění výchovy ke zdraví a tělesné výchovy v základním vzdělávání.

Klíčová slova: výchova ke zdraví, tělesná výchova, vzdělávací obor, vzdělávací oblast, rámcový vzdělávací program, školní vzdělávací program, projektované kurikulum, realizované kurikulum, výzkum výchovy ke zdraví, výzkum tělesné výchovy