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Putting School Health Education into Practice: Some Insights by School Pupils in Kenya

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Abstract:
This paper argues that while health education may enhance the knowledge and awareness of learners, there is usually a gap in the application of the same. It suggests that some of the factors that may promote application of health education be enhanced while the constraints are addressed. The conclusion is that humanity cannot benefit from health education if it is not applied in everyday life.

Key words*: health education, Pupils, primary health care, health action*

1. Introduction

Healthy living is a crucial concern of all individuals, communities and nations. A healthy community is a national treasure as individuals are able to pursue their individual and collective goals and as such contribute to personal and national development. One of the concomitant requirements for healthy living is the awareness and knowledge of how to live in a health-promoting manner. Health education seeks to meet this need in individuals and communities. This more so if health education is seen as the process of instruction and acquisition of health knowledge aimed at increased awareness of self, change of attitudes and acquisition of skills to ensure individual and communal well-being (Muia 2001:16). Consequently, health education may be deemed as an imperative need for healthy living.

Health education has a long history. It is important to note that health education has always been part and parcel of health care. Before the scientific revolution of the 16th and 17th centuries, health education was embodied in the instructions about healthy living habits that were typical of Greek, Arabic and medieval times.

For instance, the advice of Hippocratic medicine on diet, physical exercise and rest was not based primarily on a medical benefit, but also on the prevailing worldview of the Greek society that emphasized harmony, balance and moderation. The scientific revolution, however, infused health education with medicine, with physicians seeing it as their duty to also cultivate living habits conducive to ill health.

Today's health education may, however, be seen as both the infusion of medical as well as lay people's efforts to improve their health. This dimension becomes much more so when it is noted that in the search for lower cost and more value for resources, governments through both the health and education sectors have been searching for new approaches to better health. In the process, the health sector broadened its agenda to incorporate disease prevention. The education sector, on its part, focused on learning, both inside and outside the school. The net effect has been that, not only has education facilitated but has also supported health care efforts through what has since come to be known as health education.

Health education is taught in schools as a way of promoting healthy behaviour. This is besides its meeting the traditional aim of the development of the cognitive capacities of learners in the discipline. As a health promotion subject, it is expected that the learners will develop capacities for control of their health actions. This is when health promotion is defined within the conception of the World Health Organisation's Ottawa Charter, as "the process of enabling people to increase control over and to improve their health" (WHO, 1986).

For health education to benefit individuals and communities, the knowledge and skills so gained should be translated into health promoting action and behaviour. This then calls for health education to focus on developing the necessary health action competence whereby individuals and communities can take responsibility for their own and others' health behaviour. The bottom line should be to get learners to understand what they need to do and have the necessary skills to enable them translated that knowledge responsibly into appropriate health action. That is what has otherwise been conceptualised as action competence by Jensen (1997) when he contends that action competence involves getting involved in an issue, then one goes on to investigate, reflect, critically make up his/her mind and act accordingly individually, and together with others in a responsible way. The end result being the development of abilities based on critical thinking and action for a more healthy and humane community.

As such, it may be said that individual's ability to act on what they learn in health education will be determined by the environment they may find themselves in. It may also be argued that while many factors affect how health education is utilised. There are facilitating as well as constraining factors in the process of translating health education into appropriate health care seeking behaviour (Muia, 2001). What all this means is that one may have all the health education, but is unable to apply it or translate it into healthy behaviour. Consequently, there would be a gap between what an individual may know and the extent to which they may take action to appropriately utilise that knowledge.

Despite the noble expectations that health education leads to healthy living, there has also been arguments to the effect that health education by itself may not accomplish this goal. Many studies have arrived at that conclusion. Taylor (1979:240), basing his argument on the lifestyle approach to health education, argued that health education by itself is insufficient. His argument was that it could only be sufficient if conducive circumstances were created to support it.

The school based health education approach is also criticized by Ascroft and Muturi (l994: 9) as,

Limited and unsustainable...the rote-learning, chalk talk method often dealing with subject matter of little relevance to the socio-cultural context of society, let alone its daily life and aspirations.

Hewlett (1992) says that health education,

Falls short of requiring pupils to apply what they learn in everyday activities and situations.

Moreover, health education needs to be given in a concrete and a demonstrable way such that they see its relevance to their daily health behaviour. This will amount to health education being applied by pupils in their health care-seeking behaviour. Otherwise, the whole process of health education might end up being reduced to mere belief and hope. The contention by English and Videto is a good caution;

In health education, there tends to be the belief that knowledge leads to practice (English and Videto l997: 4).

This belief is subject to debate. This is because there is a potential for health knowledge and skills being put into practice. However, in most cases environmental or community circumstances as well as school-based factors do not readily complement positive health behaviour thus constraining application of health education. Hence, if these constraining community circumstances are addressed, it will be a lot easier for healthy behaviour to be practised, and thereby health education translated into health action.

In a nutshell, what is eluded here is that, all the health awareness may not count for much if there are no concrete moves to offer the education in a concrete manner and to facilitate its translation into health action. For example, it is important to note that among other factors, schools largely give health information to learners primarily for purposes of passing examinations. As such all the health awareness may not translate into healthy action and consequently a gap exists between what individuals may know and the health actions they take. It is therefore imperative that measures are put in place to bridge this gap.

2. Objective of this Paper

This paper, therefore, seeks to highlight some of the issues that may need to be taken into account if this health awareness-action gap for healthy living is to be bridged, and learners apply health education knowledge and skills in their lives. The discussion is limited to insights based on school health education in Kenya.

3. Justification for School Health Education

Schools have for quite some time been promoted as a major setting for the provision of health education. The 1978 WHO/UNESCO Alma Ata conference on Primary Health Care gave education sector a major role in the promotion of primary health care. In the Alma Ata Declaration, it is stated that,

Schools could provide the efficient means to attain primary health care and could ensure that young people can be educated to have a good understanding of what health means, of how to achieve it and of how it contributes to social and economic development

The call is largely for schools to serve as centres from where the future generation learns how to take care of their health needs and the needs of others while gaining from the wider benefits of school life. A global review of the status of school health education prepared by the WHO in 1990 stressed the importance of health education for all children whether or not they were able to attend school. Some of the recommendations of the review included that; a) there be a linkage of health education with the education for all initiative; b) a high priority be given to the pivotal role of teachers in the promotion of health in schools and communities; and c) that school health education must be planned and implemented in the context of the pupils' families and the wider community.

The World Conference on Education for All, which was held in Jomtien, Thailand in 1990 could also be seen to have called for a comprehensive policy where schools should provide opportunities for learners to meet their basic learning needs. These needs could be seen as both the essential learning tools and the basic learning content required by human beings to be able to survive, to develop their full capacities, to improve the quality of their lives, to make informed decisions and to continue learning. There is no question

that of all areas of human life this kind of learning would be more useful in the area of human health. It is no wonder then "much hope has been invested in the capacity of schools to make a significant contribution to health (Tones and Tilford 1994:141).
School health education is seen as vital because it is also presently widely accepted that globally health is improved, first and foremost, through the provision of a number of years of basic education. It has also been observed that, "health cannot be guaranteed by health services alone, as the experience of many developing countries has demonstrated. Freedom from disease will depend on broad economic development, improved food production and distribution, safe drinking water, better housing, education and anti-poverty measures" Timberlake 1985:41). Education thus emerges as one key pillar in enhancing health.
A few other justifications (see Muia 2001) can be cited with regard to the promotion of school health education, and the school as a major setting for the provision of health education. This is especially given that in most developing countries, the youth represent close to half the total population of most developing nations.

- Firstly, schools have an important role in socialization. This ranges from benign to active social control. In the process health care seeking behaviour and practices are learned by pupils.
- Secondly, primary schools have more or less replaced traditional institutions as socializing agents. Accordingly, parents look upon schools to impart habits and discipline, including those related to health.
- Thirdly, there is the widespread view that education for health should occur during childhood. This is in recognition of the significance of early learning whereby health related knowledge; attitudes and behaviour will be easily internalised for future appropriate health care seeking behaviour. For this purpose, schools offer a convenient way of reaching a significant proportion of children and young people over extended periods of time.
- Fourthly, under the United Nations Universal Declaration of Children's Right, as contained in the Convention on The Rights of the Child, adopted by the General Assembly of the United Nations on 20th November, 1989, children have a right to knowledge about health. Article 24 states that,

"The child has a right to the highest standard of health and medical care attainable. States shall place special emphasis on the provision of primary and preventive health care, public health education and the reduction of infant mortality..."
Schools therefore have an important role to play in pursuance of this right.

- Fifthly, school children are a captive audience that can be systematically trained to influence their communities in desired directions. It is this potential which primary school health education is expected to exploit when shaping pupils' health care seeking behaviour.
- Sixthly, according to an AMREF (1987) study, pupils are highly motivated to participate in activities outside the classroom, including passing information to parents, friends and close relatives. Thus, given that the health education they receive is essentially useful to them if their environment is equally supportive, then pupils can be potentially useful in health education campaigns aimed at enhancing a healthy environment. This is by and large beause, this is one area where there is structured health education given to a large pool of learners. The learners are at their formative stage of their lives and are also in a position to influence the behaviour of their peers, families and community.

4. School Health Education in Kenya
In Kenya, effort to involve communities in their health development through education started in 1952 with the creation of a unit for Health education within the Department of Health (Mwalenga 1987:26). Presently, both the Ministry of Health and the Ministry of Education primarily provide health education in Kenya. There are a number of Non Governmental Organizations (NGO) also involved in the provision of health education, although these largely focus on topical issues in their mandate areas, for example, water and sanitation, child survival and development, control of communicable diseases and reproductive health, just to mention a few.
In Kenya, health education is integrated into the curriculum, whereby the Ministry of Education provides health education through the national education system. As per the syllabus released by the Ministry of Education (MOE) in 1992, health education is integrated into the science and home science syllabus. The content of the health education syllabus includes information that is expected to lead to improved health status and practice of users that is the pupils. The syllabus is designed such that in the lower classes (1-3), issues related to hygiene are taught. In the upper classes (4-8), pupils learn about personal and domestic hygiene and sanitation. Put into broad categories:
Standard Four covers lessons ranging from body care the dangers of sharing personal items, body parasites, to the use of latrines.
Standard Five are taught health hazards at home.
Standard Six learn the use of available facilities.
Standards seven and Eight learn about common diseases and waste matter
(MOE, 1992)
It is however important to point out that with the reorganisation of the school curriculum in 2002, health education remains an integrated subject and taught through carrier subjects.

5. The Way Forward in the Application of Health Education by Pupils

From the foregoing discussion, it appears that there is untapped potential for health education to benefit pupils. There is no doubt that pupils are ready to translate some of the health education learned into appropriate health care seeking behaviour. However, the constraints to the effective translation of health education into appropriate health care seeking behaviour need to be addressed. The creation of an enabling environment is one main way of facilitating the utilization of health education knowledge and skills by pupils. Other suggestions have to do with how health education is presented in school.

- Foremost, school health education was perceived by pupils as just another lesson to be learnt. A schooling routine. Indeed, during interviews, pupils were unable to immediately isolate or pinpoint cases of health behaviour related or resulting from health education instruction given in class. One explanation by the teachers was that "because health education is so much tied up with everyday behaviour, pupils tended to see the health education given in class as just a formal class lesson". The implication of this observation was that health education tended to be reduced to a routine class lesson, often without any bearing on its attitudinal and affective behaviour dimensions and application. Consequently it was suggested that there is a need for the lifelong benefits of education to be brought to the attention of learners, by possibly de-routinising health education.
- Secondly, from the perspective of the pupils, creation of an enabling environment means ensuring the community is aware of health education so that ultimately they are supportive of what the pupils do. This to a large extent calls for community wide health education. In any case in the overall, the primary responsibility for pupils' health rests with virtually all members of the community, starting with the parents, then the teachers, the pupils, then the wider community. In any case, parents, teachers and the pupils' peers are key sources of health education (Muia 2001). This argument concurs with Haglund's (l996:35) position that basically "education is more than what happens inside schools and other formal places of learning". Education should be given to all people and in all places. A community that is aware will be able to support what the pupils learn and do. Indeed, the pupils' perspective is also that they themselves needed to be involved in enhancing health education amongst their peers and parents. This was largely an indication of their appreciation of health education. This appreciation also fits into what the Child-to-Child approach in health education expects of health education among children: children taking responsibility for their health and that of others (Child-to-Child Trust, l992).
- Thirdly, the instruction, school regulations, content of what is taught, parental support and peer support were said to be factors that facilitate learning and possibly the eventual application of health education into health care seeking behaviour by pupils. This is especially so when we appreciate that the value of health education offered in primary school extends beyond its academic value. Parents and the immediate community stand to benefit by way of improved health practices by pupils. A male teacher, concurring with pupils, observed a situation where parents are socialized into better health practices by their children.

With continuous practice of healthy habits, pupils can influence their parents to adopt new habits, e.g. drying dishes after washing.

This line of argument is consistent with the Child-to-Child approach. The Child-to-Child approach sees the child as a significant actor. It seeks to educate the child fully, including in matters of health. The expectation is that the child will share such education with others. It is because of this that the Child-to-Child approach seeks to involve children actively in re-educating the family and the community (Bennaars l993). Basically this is also what is called for by the UNESCO/UNICEF/WHO developed *Facts for Life*, which observes that the health of children could be dramatically improved if all families were to be empowered with today's essential health information. Health education as given to pupils is an effort in this direction. The critical point is its link with or how it fits in with daily realities and development needs of individuals and communities.

- Fourthly, pupil's perspective, just like that of adults was that the creation of an enabling environment is a broad concern. In addition, to enhancing the awareness of the people immediately close to the pupils, both at school and at home, they called for guidance and counselling by resource people. The idea was that pupils be supported in their utilization of health education. They also called for material improvement of the economic status of the parents. While everything cannot be explained away by economics, it is important to mention the widespread poverty in Kenya's rural areas. Ministry of Planning and National Development, l998 data show that 47 percent of the population is absolutely poor. This means that almost half of Kenyans live below the poverty line where they can barely afford basic necessities of life. Poverty limits peoples' choices and hence in this case, the ability of parents to offer a conducive atmosphere as well as facilities consistent with what pupils learn in health education.

Indeed, a study done in Nigeria by Ekeh and Adeneyi (1988) affirms this argument by noting that:

On the enabling factors, students who translated their knowledge into practice had access to resources necessary to effectuate the action. For example, some of the practices called for implements to clear bushes, remove surrounding debris or cover potential breeding grounds for mosquitoes (See Ascroft and Muturi l994: Annex 6).

The conclusion, therefore, is that a measure of economic empowerment is imperative for the creation of an enabling environment for translating health education into healthful behaviour and practices.

- Fifthly, the pedagogical approach as a way of enabling pupils to eventually apply health education in life needs further comment. In essence the teachers should ensure that they cover the content, use demonstrations, use teaching and learning aids and motivate pupils. Thus, teachers can actually do more than what they are already doing. However, since most teachers went through the old system of education, which did not include health education as a distinct area of concern, it

may mean that the teachers can benefit from in-servicing in health education. In any case, the child can only benefit from a well-prepared teacher. Ascroft and Muturi (l994:3) presents the same argument by asserting that:

What the child will learn from these sources of health information will depend on what the source knows.

If the teachers are not fully conversant with health education topics, then helping pupils becomes difficult. An Amref Health Education Pilot Project in Nakuru District shows a situation where, "children often failed to understand health concepts well enough to be able to translate them into practical activities" (Kinunda 1989). Health education teachers, therefore need to be knowledgeable in the subject, as well as motivated to use all the necessary teaching methodologies and tools for effective teaching.

- Sixthly, closely related to this was the issue of teachers being overloaded. This observation concurs with Mwanzo (l996: 55) who observed that:

Teachers concern was that the workload meant they could not give each subject the required attention.

In such a situation, then one may conclude that teachers were likely to concentrate on what they thought needed to be covered, and especially for examination purposes. It is important to mention that presently in many Kenyan schools, there are different examinations the teachers have to prepare pupils for. These include the national examinations, district, divisional, locational, and zonal examinations. All this has implications for what is covered and how well it is covered. Topics not regarded as examinable may receive less attention from the teachers and also by the pupils. Consequently, those aspects not fully covered may not benefit the pupils in their health care seeking behaviour.

- Seventhly, the teachers indicated some areas where there was inadequate content (Muia, 2001). It may be useful that besides the teachers searching for relevant materials, for their teaching, they should be given some in-servicing in this area. Medical personnel from nearby health units, should be encouraged to offer outreach and extension services. In this way, the capacities of teachers and ultimately pupils will be enhanced to better handle health education issues. Indeed, Ascroft and Muturi (l994:9) observe that, in the Third World, normally the health workers presence in schools is often crisis driven. In some cases, however, visits by health workers to schools have resulted in teachers learning from health workers and incorporating their new knowledge and skills into their regular teaching approaches. Hence, the need to find a way of making schools focal points for health education.
- Lastly, it is also important to point out that the fundamental objective of teaching health education is ought to be the development of the learners' ability to take concrete health action. Consequently, all efforts in health education ought to be directed at creating the capacity of learners to become competent actors, what Jensen 1994 calls action competence. This calls for health education in the first place to be designed such that it builds the capacity of learners to understand their material conditions and to develop a vision and desire to employ the knowledge and skills gained to constructively take appropriate health action. Simply put, the health knowledge-action gap can be bridged through a health education that besides the availing knowledge to learners also builds their abilities to utilise that knowledge in addressing their own and their community's day-to-day health needs.

The thrust of the foregoing arguments is that health education can lead to appropriate health care seeking behaviour and health action, but only in so far as the content and process of giving this health knowledge and skills takes into account the practical realities in the given social contexts. The call could be seen as one of creating a critical mass of people who will offer a more conducive atmosphere and support for pupils to translate their health education into appropriate health care seeking behaviour, the value of which the rest of the community will be aware of and appreciate. In any case, health care seeking behaviour of pupils is basically a social action. Bilton (l987:604) avers that:

"Action is creative and innovative. But it never takes place outside social contexts. These social contexts involve inequalities of power, knowledge and material resources as well as socially constructed meanings, definitions and rules".

All these are vital elements in the pupils' environment. These contexts will largely determine whether appropriate health care seeking behaviour and health action occurs. Indeed whether health education is translated into health action.

6. Conclusion

There is no debate about the value of health education. It is however important that this value may benefit humanity only by health education being applied in life. Hence efforts need to be put by all actors in health education to remove all barriers to the translation of health education into health action by learners. Efforts also need to be directed towards developing a health education process that is empowering by way of capacity building.

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