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**Citation style:** Borzucka-Sitkiewicz Katarzyna, Kowalczevska-Grabowska Katarzyna, Gawlik Dorota, Lamczyk Dorota. (2017). Teachers' Opinions on Health Education Implementation in Polish Lower and Upper Secondary Schools. "The New Educational Review" (Vol. 47, iss. 1 (2017), s. 151-161), doi 10.15804/tner.2017.47.1.12



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## Teachers' Opinions on Health Education Implementation in Polish Lower and Upper Secondary Schools

DOI: 10.15804/tner.2017.47.1.12

### Abstract

The article presents the findings of the research conducted in order to learn physical education teachers' opinions on the implementation of the health education content. The study was carried out in lower and upper secondary schools located in the region of Upper Silesia (Poland). A quantitative method was used to gather and analyse data. The survey was conducted with a specially designed questionnaire including 17 items. The research was based on the analysis of core curriculum concerning the objectives and content of health education planned to be implemented during physical education classes in lower and upper secondary schools. The research allowed for identifying potential gaps and good practices in school-based health education and health promotion in the Polish socio-cultural conditions.

*Keywords: health education, physical education teachers, health literacy, school practice, core curriculum, teacher training*

### Introduction

Schools may play a special role in creating health behaviours. There are no doubts that the central role of the school is teaching and learning, but it is also a unique community resource to promote health among children, families and teachers, because health and education are inseparably linked (Tang, Nutbeam,

Aldinger, 2009). The significant role of the school in the improvement of health was indicated in a lot of international research (Mukoma, Fisher, 2004; Jourdan, Mannix McNamara, Simar et al., 2010). It was proven that healthy pupils who attend school tend to learn better and, furthermore, proper education influences the development of healthier population. Therefore, the development of national and regional school health policies is supported by the recommendations from the World Health Organization (1997).

For this reason, over the years there have been attempts to introduce health education into the core curriculum in Polish schools. Despite many years' attempts, health education was introduced as late as in 1997, but it was not included in the school timetable. Two years later, i.e., in 1999, 'health education' educational path was introduced in primary school and lower secondary school, and in 2002, 'health education' educational path was introduced in all types of schools. In 2008, a decision was taken to incorporate the 'health education' module in the core curriculum of physical education in lower and upper secondary schools. Policymakers assume that it should be followed by the school at specific education stages within the scope of many subjects (the Polish language, foreign languages, social studies, biology, preparation for family life), but mainly during physical education lessons.

Similar organizational solutions were implemented in, e.g., New Zealand and Australia – the school subject concerning health education was called there "Health and Physical Education" (HP&E). In New Zealand this subject was introduced into schools in 1999 and it is a part of school core curricula from the 1<sup>st</sup> to 10<sup>th</sup> year of education (5-14/15 year-olds) (Sinkinson and Hughes, 2008: 1074). The same regulations are applied in Australia (The Shape of the Australian Curriculum: Health and Physical Education, 2012: p.10; Lynch 2015). A congruent form has the school-based health education in Japan, Canada and Croatia.

Aims of health education in the framework of physical education are focused on the holistic concept of health (Antonovsky, 1987) and take into consideration mental, social and biological aspects of health, (i.e., explaining why health is a value for a human being and a resource for society and how health should be taken care of during youth and early adulthood, explaining the meaning of responsibility for one's own health and the health of other people, discussing constructive, optimistic ways of explaining difficult events and transformation of negative thoughts into positive ones, etc.) (Regulation of the Ministry of Education, 2009).

The teacher implementing health education should have the following competences (Erbas, 2013):

- The knowledge of: health and its determinants; prevention of common hazards, disorders and diseases; health education – its objectives, process, methods of implementation and evaluation; health promotion, with the emphasis on health-promoting school;
- The skills concerning: diagnosing students' knowledge, health behaviours and needs in the field of health education; planning of the health education programme; implementation of the health education basic issues; cooperation and seeking allies to carry out health education at schools; the use of activating learning methods and creating an atmosphere conducive to well-being, participation and activity of students; health education process and result evaluation;
- The attitude which is characterized by: the belief that health is a value and a resource for humans and society; willingness to improve one's own health, as well as personal and social skills; openness to the needs of others, empathy; the ability to create patterns of health behaviours for students, motivate them and support their efforts; the ability to create a healthy environment.

The above-mentioned issues prompt the reflection on how health education is implemented at schools by physical education teachers.

## **Methodology**

### **Research questions**

The presented study was focused on the opinions of physical education teachers concerning the implementation of the health education content at schools and their competences in the field of health education. The survey aimed to answer the following research questions:

1. What health education objectives and content, in line with the core curriculum of physical education, should be implemented in lower and upper secondary schools?
2. What health education content is currently implemented by physical education teachers at the stage of lower and upper secondary schools?
3. How much time during a school year do physical education teachers actually spend implementing the health education content?
4. What methods are used by physical education teachers while implementing the health education content?

5. What are the inhibitors of health education implementation in physical education teachers' opinions?
6. Do physical education teachers believe that they have the necessary expertise to carry out health education?

Due to the diagnostic type of the research, hypotheses were not formulated.

## **Instruments**

Document analysis and a questionnaire were two techniques employed in the research. Detailed analysis concerned the objectives and content of health education implemented during physical education lessons, specified in the *Regulation of the Ministry of National Education on core curricula for pre-school and general education in particular types of schools (27 August 2012), Attachment 4: Core curriculum of general education for lower and upper secondary schools, graduation from which results in obtaining a school leaving certificate upon passing a final exam*. Currently valid documents were the basis for drawing up a survey questionnaire.

A specially designed questionnaire including 17 items was used in the research. The questionnaire was reviewed after pilot research. The used tool posed a range of questions about respondents' teaching experience (i.e.: What objectives do you achieve during physical education lessons? How do you assess the core curriculum in the area of health education? What methods do you use during health education lessons? What inhibitors of health education do you recognize in your school?). The questionnaire also included questions about age, gender, teaching experience and completed courses/training. Participation in the questionnaire was anonymous and voluntary.

## **Participants**

Participants were randomly recruited. The sample consisted of 130 teachers of physical education, employed in lower and upper secondary schools in the region of Upper Silesia (Poland). 50.78% of the participants were female and 49.22% were male. Age distribution showed 17.97% to be 30 years and under, 32.81% aged 31-39 years, 35.16% aged 40-48 and 14.08% aged 49+. The majority of the respondents had 10-20 years of teaching experience. Only 16% of the teachers surveyed had completed additional training, out of whom 2 persons had had special training

in health education – other kinds of training and courses were connected with physical education.

## **Procedure**

The questionnaires were distributed by interviewers in randomly selected schools, and some of them were posted on-line. The participants filled in the questionnaire anonymously after giving verbal or written informed consent. The gathered data were analyzed using descriptive statistics.

## **Results**

Analysis of the Regulation of the Ministry of National Education of the 27<sup>th</sup> of August 2012 on core curricula for pre-school and general education in particular types of schools, Attachment No. 4, showed the guidelines of the Ministry in terms of learning objectives and content of health education. The table below presents a summary of learning objectives and teaching content for both types of schools:

**Table 1.** Learning objectives and content of health education in lower and upper secondary schools

Lower secondary school	Upper secondary school
<b>Learning objectives of health education</b>	
<ul style="list-style-type: none"> <li>• understanding the relationship between physical activity and health</li> <li>• personal and social skills conducive to health and safety</li> </ul>	<ul style="list-style-type: none"> <li>• implementation of the principles of a healthy lifestyle in daily life</li> <li>• skills conducive to disease prevention and improvement of physical, social and mental health</li> </ul>
<b>Content of health education</b>	
<ul style="list-style-type: none"> <li>• defining health</li> <li>• health determinants</li> <li>• pro- and anti-health behaviours</li> <li>• dealing with negative emotions</li> <li>• identification of one's strengths and weaknesses</li> <li>• coping with stress</li> <li>• social relations – with parents, peers and other people</li> </ul>	<ul style="list-style-type: none"> <li>• health as a value for a human being and resource for society</li> <li>• caring for one's health during youth and early adulthood</li> <li>• responsibility for one's own and others' health</li> <li>• positive thinking</li> <li>• self-esteem</li> <li>• decision making skills</li> </ul>

Lower secondary school	Upper secondary school
<b>Content of health education</b>	
<ul style="list-style-type: none"> <li>• seeking and receiving support</li> <li>• assertiveness</li> <li>• health and social damage resulting from risky behaviours</li> </ul>	<ul style="list-style-type: none"> <li>• self-improvement</li> <li>• social skills – coping with criticism, obtaining feedback</li> <li>• reasonable time management</li> <li>• self-examination, health self-control, significance of preventive examination</li> <li>• patients' rights (active patient)</li> <li>• knowledge about mental illnesses, fighting stereotypes and stigmatization</li> <li>• project on selected health issues - winning allies and co-participants in school, at home and in local community</li> <li>• co-participation and cooperation of people, organizations and institutions in activities for health</li> <li>• relationship between health and the environment, creating an environment conducive to health</li> </ul>

Source: Attachment No. 4 to the Regulation of the Ministry of National Education on core curricula for pre-school and general education in particular types of schools: Core curriculum of general education for lower and upper secondary schools, graduation from which results in obtaining a school leaving certificate upon passing a final exam. Obtained from: <https://men.gov.pl/zycie-szkoly/ksztalcenie-ogolne/podstawa-programowa/rozporzadzenie-o-podstawie-programowej-w-calosci.html> (04.11.2016)

In addition to the above teaching content, the legislator also plans to introduce other health-related contents to be implemented during physical education lessons, e.g.:

- lower secondary school: preventing accidents and injuries, personal hygiene during puberty;
- upper secondary school: search for reliable information on health and sport, critical analysis of media information, prevention of civilization diseases, negative health impacts of work, attention to health during youth and early adulthood.

The above table shows that health-related content is very broad, and by assumption it should help students to acquire the necessary knowledge and skills in the field of health education, prevention and health promotion. Guidelines of the Ministry contributed to the formulation of research questions and were used to develop a questionnaire for physical education teachers.

During the survey, the teachers were asked what they considered to be the main goal of health education. The largest part of the respondents, 75%, considered the awareness of the need for lifelong physical activity as the main purpose of health education activities in the classroom. In turn, over 69% said that in fact they had mainly implemented the principles of a healthy lifestyle in daily life. 51.6% of the teachers focused primarily on skills related to preventing diseases and improving all aspects of health. Almost 48% of the respondents had mainly achieved purposes related to being a critical consumer and sports viewer. More than 3% of the respondents had achieved goals related to social risks, skills of controlling emotions, cooperation in a group, or developing the skill of following certain rules.

As far as the teachers' attitude toward the implementation of health education content in the core curriculum was concerned, more than 69% of the respondents were convinced that the health education content was suitable and useful for students. Approximately 8% expressed the view that the content provided in the core curriculum was inadequate and should contain additional issues. Over 20% of the respondents had no opinion on the subject or they did not know the content provided in the core curriculum.

The respondents were also asked about the time during a school year that they actually spent implementing the health education content. More than half of the teachers stated that they spent 30 hours during the school year implementing the health education content (according to the commentary on the core curriculum). Almost 33% of the respondents did not follow instructions indicated in the core curriculum and spent less than 30 hours per year dealing with issues related to health. Almost 8% of the respondents spent more than 30 hours per year dealing with the health education content and another 8% stated that they devoted no time at all to that purpose.

Next, the methods that the teachers use while implementing the health education content were analyzed. Almost 85% of the teachers stated that they used such methods and techniques of activating students as discussion and conversation. In turn, nearly 40% of the respondents, pointed to the use of case studies and more than 33% used project work and presentations. Less than 19% of the respondents said they used techniques based on visualization (mind maps, posters, etc.). Over 15% of the teachers declared the application of simulation techniques (role playing) in the classroom. 8.6% of the respondents used methods not defined in the questionnaire like photo-expression. Only 6.25% of the respondents used a portfolio method during classes.

The teachers were also asked to indicate the inhibitors of health education implementation. A vast majority of the teachers believed that difficulties in imple-

menting health education stemmed from psychological determinants of students or no interest in health behaviours in their family home. Over 36% believed that difficulties in implementing health education resulted from a lack of adequate financial resources for this purpose. 25% of the respondents considered insufficient competences or weak commitment of teachers as the reasons for difficulties. The lowest percentage of the respondents thought that school managers and Boards of Education were responsible for failure in the implementation of health education.

The research also took into account the teachers' opinions on their expertise to carry out health education. Almost 48% of the teachers considered their skills and preparation as sufficient. A similar proportion of the respondents (46%) stated that their skills and preparation for implementing health education should be better. A little over 3% of the respondents considered themselves unprepared to carry out health education lessons and the same percentage had no opinion on this issue.

Finally, the teachers were asked whether they would like to improve their qualifications concerning health education. More than 41% of the respondents would be willing to take training in school. 34.4% of the teachers declared their willingness to take a 30-hour course. Almost 12% of the respondents expressed a desire to undertake postgraduate studies, and almost 8% – a 100-hour-course. 1.6% declared that they would like to enrol in an undergraduate course. More than 3% of the respondents were unwilling to take any activities to increase their qualifications.

## **Discussion**

The guidelines of the Ministry concerning health education reflect a holistic approach to health-related issues and fully meet educational needs of students. However, some concerns include the manner in which education objectives are to be achieved and content is to be conveyed by the teachers of physical education.

The conducted survey allowed for identifying gaps in school-based health education implementation in Polish educational conditions. As revealed, 1/5 of the respondents were not familiar with the issues of health education indicated in the core curriculum, or had no opinion on their usefulness or adequacy. Additionally, the physical education teachers marginalized issues related to psychosocial health; only 3% implemented such content during classes – the respondents mainly focused on physical activities. The gathered data are consistent with Muros Ruitz and Fernández-Balboa's (2005) research results, which showed that the knowledge and understanding of basic definitions and principles among the interviewed PE teachers in Spain were in many cases inadequate and inconsistent with the

literature. Likewise, while interviewing PE teachers in Norway, Dowling (2008; Dowling, Kårhus, 2011) found that their understanding of gender issues in PE was somewhat lacking, rooted in their biographies and common-sense understanding rather than being theoretically formed. The obtained data lead to the conclusion that among the teacher's competences mentioned in the first paragraph, knowledge is the primary one. As indicated by Santiago, Disch and Morales (2012), a prerequisite to be a competent and effective teacher is to have a strong knowledge of the subject matter taught. Teachers' content knowledge affects their pedagogical approach and influences their teaching processes as well as their confidence in teaching the subject matter.

The conducted research also showed that over 40% of the teachers did not spend the amount of time required in the core curriculum implementing the content of health education. Nevertheless, only 1/4 of the teachers surveyed considered their lack of competence and appropriate involvement as the reasons for failure in the implementation of health education, the majority of the respondents blamed students and their parents for such a situation. In this context, it is worth referring to Koeppel, Stylianou and Hodges Kulinna's (2014) research, which showed that when teachers have significant teacher preparation on a specific curricular model, perpetual professional development opportunities and administrative support, curricular models are taught with higher fidelity levels.

As far as the methods of implementation were concerned, discussion and conversation were the most frequently applied ones by the teachers interviewed. Typical activating methods were used only by 1/3 of the respondents. Only 48% of the respondents thought they had substantial qualifications for carrying out health education lessons. Fortunately, the vast majority of the teachers expressed willingness to improve their qualifications in the field of health education. However, most of them would be interested in training organized in school or a short-term course. About 3% of the teachers were not interested in the development of their qualifications in any form.

Thus, it can be concluded that the conducted research revealed the malfunction of a regulation existing in Poland since 2008 assuming the implementation of health education by physical education teachers. The study proved that contemporary solutions concerning school-based health education required changes, which should be started with more thorough training of future teachers. It has been scientifically proven that staff commitment plays a crucial role in health education implementation and the success of this initiative largely depends on their contribution and their capacity to do it properly (Jourdan, Samdal, Diagne et al., 2008). Therefore, it seems to be important to implement systemic changes in physical

education teachers' training in Poland, since solutions similar to the Polish ones are successfully realized in many different countries. In many European countries the training that PE teachers receive is compulsory and comprehensive to provide them with sufficient knowledge and skills. In most cases, countries have general strategies, which include continuing professional development (CPD) courses designed for all teachers. In turn, in several countries, different forms of CPD focusing on physical education are available to specialist teachers, but also to generalists who want to improve their skills in the subject. Some countries report that they have CPD courses targeted specifically at teachers of physical education. They are aimed at improving the quality of teaching and learning processes, updating the skills of teachers and introducing them to new techniques and trends in the methodology of teaching physical education at school. Special emphasis should be laid on Cyprus and Turkey, which provide compulsory CPD for physical education teachers on a regular basis. In Cyprus, nationwide seminars and CPD courses are held twice a year, along with annual two-day CPD training between school semesters. In Turkey, CPD programmes are usually organized at the beginning of each semester (European Commission, 2013).

As pointed out by Yager and O'Dea (2008), "in Australia and other Western countries, health and physical education teachers provide children and adolescents with information, teach skills and shape beliefs about and attitudes towards many health topics including nutrition, puberty, prevention of lifestyle diseases, movement skills, drug education, sex education, self-concept, road safety and mental health". It is essential for Polish physical education teachers to be trained in implementing the same content.

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