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Challenges in Health Education of School Children in Maharashtra State

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Abstract – Health education is based on a multidisciplinary foundation of knowledge. The intent of the instruction is to promote the pupils' competence regarding health, well-being, and safety. The task of the instruction is to develop the pupils' cognitive, social, functional, and ethical capabilities, and their capabilities for regulating emotions.

Keywords: Education, Instruction, Health

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INTRODUCTION

The starting point for instruction is an understanding of health as physical, psychological, and social capability. The instruction develops knowledge and skills regarding health, ways of life, health habits, and diseases, as well as fostering a readiness to take responsibility and act so as to promote one's own health and the health of others [Nutbeam D, 2000].

As a subject, health education is pupil-oriented and supports functionality and involvement [Glanz K, Rimer B, Lewis F, 2002]. The starting points for the instruction must be the child or young person's daily living, growth, and development, and the course of human life span. The instruction also takes into account current health and safety questions, whether general or specific to the school and locale. The instruction develops important skills for the acquisition and application of information and promotes the critical consideration of the values associated with health and well-being.

Health education is taught in the first through fourth grades as part of the environmental-and-natural-studies subject group, in the fifth and sixth grades as part of biology/geography and physics/chemistry, and in the seventh through ninth grades as stand-alone subject. The instruction must be planned so that the pupil gets a comprehensive picture of health education throughout basic education. Instruction in health education, as well as in biology, geography, physics, chemistry, home economics, physical education, and social studies, must be planned cooperatively. In the planning of the instruction, collaboration also takes place with pupil welfare personnel [McLeroy, 1988].

The health and well-being of our nation's young people is not a matter of luck. It is not a chance or random event. It must be a planned outcome. The case for well-designed, well-resourced, and sustained health education in the nation's schools is compelling.

School health education programs can reduce health risk behaviors such as tobacco use, poor nutrition, lack of physical activity, drug and alcohol use, as well as actions that increase stress, and risk of injury, and violence. Because these behaviors are amenable to change, quality school health education taught by trained and certified health educators provides the best opportunity to promote positive health behavior among children and adolescents [World Health Organization, 2007].

A comprehensive, quality school health education program should use the National Health Education Standards to guide curriculum development. The Standards focus on increasing functional health knowledge and identifying key skills that are applicable to all aspects of healthy living. These skills include identifying the influence of family, peers, culture, media, and technology on health behavior; knowing how to access and use valid health information; and using communication, decision-making, goal-setting, and advocacy skills to engage in health enhancing behaviors. Further, the effectiveness and quality of health education programs have been linked to adequate instructional time devoted to health education in the classroom.

A strong relationship exists between school health education and health literacy. Health literacy is the capacity of individuals to obtain, interpret, and understand basic health information and services in ways which are health enhancing. The development of health literacy is essential for students to adopt and maintain healthy behaviors and have improved quality of life. A 2004 report by the Institute of

Medicine on health literacy states that "the most effective means to improve health literacy is to ensure that education about health is part of the curriculum at all levels of education" [Brener, 2001].

REVIEW OF LITERATURE:

According to the World Health Organization (WHO), research has provided evidence that effective school health programs are intense and begin prior to the onset of the risky behaviors; and both primary and secondary schools should have a planned, sequenced curriculum.

Adequate instructional time is necessary for students to learn essential health education knowledge and skills that are developmentally appropriate and build from year to year. The Joint Committee on National Health Education Standards recommends that students in Pre-K to grade 2 receive a minimum of 40 hours and students in grades 3 to 12 receive 80 hours of instruction in health education per academic year. In the WHO's Information Series on School Health, a decade of evaluation research indicates three important findings regarding quality school health education programs:

- Health education that concentrates on developing health-related skills and imparting health-related knowledge and attitudes is more likely to help youth practice health enhancing behaviors.
- Skill development is more likely to result in the desired healthy behavior when practicing the skill is tied to the content of a specific health behavior or health decision.
- The most effective method of skill development is learning by doing – involving students in active, participatory experiences, rather than passive ones.

The promise to ensure universal health and education is common to the Millennium Development Goals (MDGs) and the National Common Minimum Program (NCMP). Further, the government has committed itself to make elementary education a Fundamental Right of every single child in the 6–14 years age group through the introduction of the 83rd Constitutional Amendment (GOI, 2002).

The NCMP aims to increase public expenditure on Education to 6% of the GDP, and public expenditure on Health to 2-3% of the GDP as one of the strategies to meet this promise.

However to date, the total investment on Health and Education in India remains dismally low. Less than 1% of India's GDP is spent on public health, which is even lower than the public health expenditures of countries like Sri Lanka and Sierra Leone. Public Expenditure on Education in India is a little over 3% of the GDP.

HEALTH EDUCATION: VARIOUS CHALLENGES

Many research projects have been conducted in schools. The results show the importance of health promotion both as a way of improving health and as a way of helping pupils succeed in education. However, as the primary task of schools is not to improve pupils' health, the development of health promotion is not an easy matter. It will necessarily involve consideration of the specific nature of the school environment, and in particular the way in which teachers perceive their own role in health and social well-being. The publications show that many factors are involved in the way in which health promotion schemes are developed and implemented:

A) Political will, on which depends sustainable involvement by institutions and communities;

B) A favorable environment, in particular in terms of support by the school's management team, the existence of teaching pracattached to pupils' well-being;

C) teachers' own perceptions of their role in health promotion, their perception of the effectiveness and acceptability of projects, their feelings of competence in this area, any burnout and whether they have received training in health promotion;

D) and factors that are connected to implementation of the programme itself (training and support by teams). Training for teachers is often considered as a central factor that determines the quality of project implementation. Studies have shown that teachers who have received training in health promotion are more likely than those who have received no such training to be involved in projects, and have a more holistic approach to health education. Feelings of competence, and motivation to contribute to health promotion, are also directly linked to training.

The first is focused on showing the context in which training for teachers is developed, in the specific area of health education. The second defines the field of health education in schools, and the role of teachers. The third contains the theoretical frameworks that will help in explaining the basis for training modules and the conditions in which training for teachers in health education can be properly implemented. The theoretical frameworks that are proposed will act as ways of interpreting experience. They do not enable everything to be predicted and controlled, but they do at least help to explain the basis for actions, give meaning, and provide hypotheses that can be used in interpretation.

In this context, with its multiple layers of tension, the educational system, its partners and the professionals involved in it are all called upon to contribute to health education. The specific nature of work in schools arises from the fact that such work is organized according to our country's democratic project. As stated in the first article of the French law on education reform, "In addition to the transmission of knowledge, the Nation determines that the primary mission of schools is to have pupils share the values of the Republic". The foundation of democracy is confidence in citizens' ability to act in a free and responsible way. However, the capacity to decide for oneself and to take control over one's own existence is not innate. Education builds such abilities. In health, then, the role of schools and others involved in education (primarily the family) is to support pupils while they learn liberty and responsibility. In other words, this is about giving citizens the means to decide for themselves, and not allow the media, commercial companies, gurus or experts to do this form them.

The main consequence of considering health as part of this project that underlies all school activity is the fact that health should not be considered as an end in itself and the ultimate aim of existence. In a democratic society, health cannot be a substitute for universal emancipation. It is a precondition for being able fully to enjoy citizenship, and not an aim in itself.

CONCLUSION:

In this paper we found that the specifications for teacher training grant a significant place to health issues. They state that training for primary teachers must use a common national framework, based on "official texts that state the non-subject educational commitments of the school, in particular health education and education in environmental issues and sustainable development…" Health and prevention are issues that call upon the professional competencies of teachers, both as subjects to be taught along with all non-subject areas of education, and as components of the civil servants role (acting in an ethical and responsible way) "to identify students who have difficulties with health issues and high-risk behavior" and "to take responsibility for students who have disabilities".

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