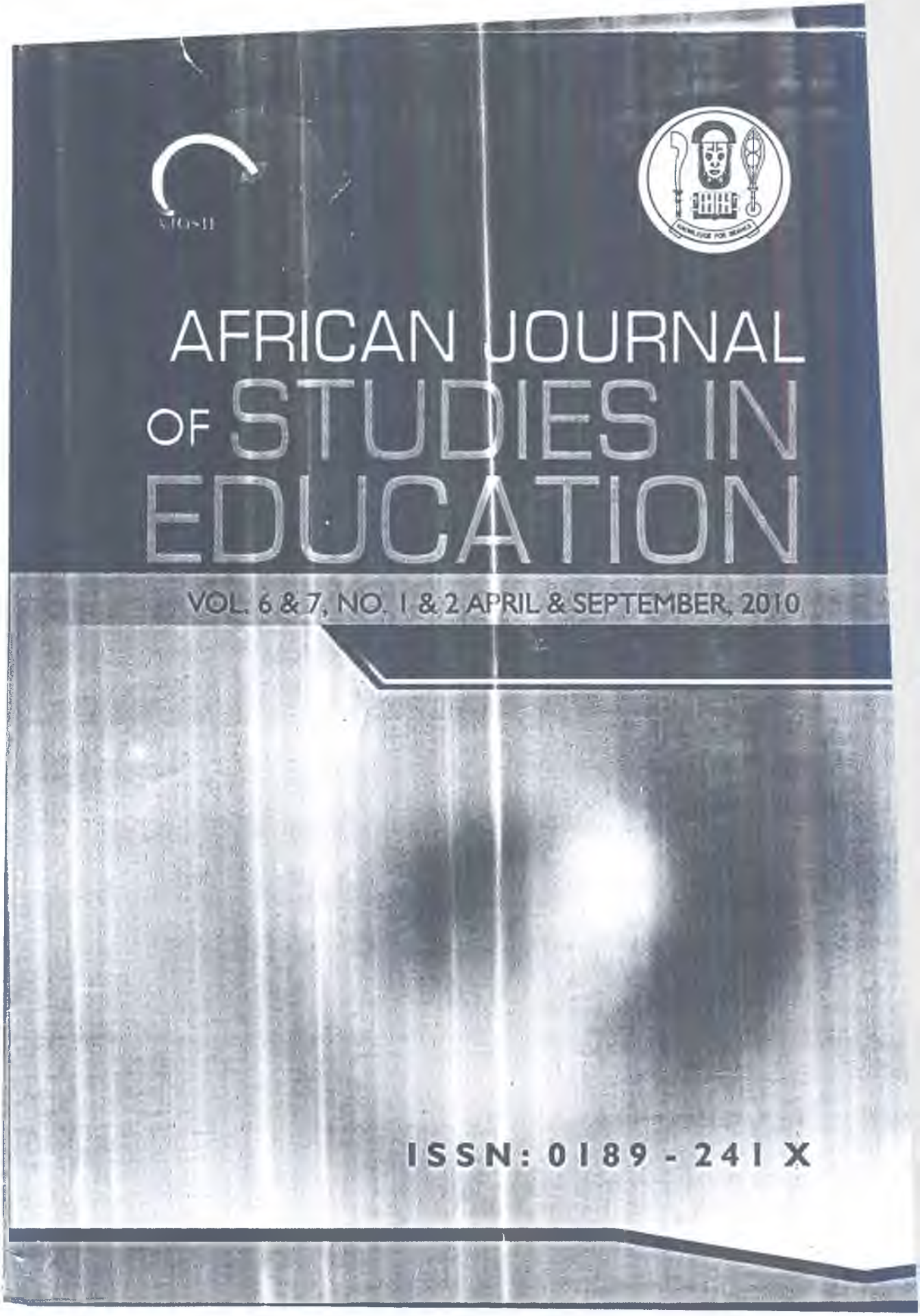
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THE BASES OF HEALTH EDUCATION

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Abstract

Teaching of health education in Nigerian schools is largely confined to the formal curriculum than focusing on the practical effects of the content of the curriculum. This is due to the fact that teaching is oriented toward passing terminal examination couple with un-enabling environment. Knowledge about health should consider the three learning domains in the following order (affective, psychomotor and cognitive) if application of what is learnt would be effective. The learner should first appreciate what is been taught before practicing and comprehending. Health is promoted through health education because it encourages people to value the health as a worthwhile asset and as well assist them to take actions that promote the health of both individuals and the community at large. Health education is all about achieving behavioral change due to increase in knowledge about health. It must not be seen as a form of medical outcome.

Introduction

The will-power bestowed in the mind of people would determine the level of commitment in the production and maintenance of desirable practices and attitudes towards health. This is possible with proper health education, coupled with enabling environment, because the child is taught how to use the water system toilet and it is provided within the school for use. This would help to develop desirable practice.

WHO (1996), Albert, Kwong-ka, Shin-hun, Cho-yee & Ting-tai (2001) and Usman (2006) reported that most schools across the world are involved in some form of health education, but teaching and learning efforts have to date, largely been confined to the formal curriculum rather than focusing on the practical effects of the content of the health education being imparted. Health education delivery in schools must take into cognizance the applicability of the concept taught. This would be accomplished by embracing knowledge, beliefs, and behaviours related to the restoration, maintenance and promotion of health in schools.

Knowledge

In a broad sense, knowledge connotes application of what is learnt which comes about as a result of learning via cognitive, effective and psycho-motor domains, which is much more than just acquisition of health facts. This means that the above three domains of learning must be utilized if the acquired health facts would be applied into practice. Knowledge about health can be justified as the most important outcome of learning; hence with increase in information, there is a development of one's acquaintance with reality. The reality here could be realized through what is known by convention or definition, or as finding due to result of inquiry, or as the more fruitful ways of attacking problems, or as means of organizing procedure for advancement (Umaru, 2008). It is generally assumed that as the information available to an individual increases, such individual becomes more knowledgeable about the health issues at stake. This is manifested from schools attended where learning processes take place that further enhance our thought and problem-solving ability.

David (2004) reveal that knowledge about health implies an understanding of specifics, facts, terminologies, conventions, ways and means of dealing with specific; trends and sequences, classification and categories, methodology, criteria, universals and abstracts, principles and generalizations as well as theories and structures. Hence knowledge about health does not stop at knowing or understanding phenomenon only, but equally extends to the application of what is learnt. It can be stressed that it equally implies comprehension, interpretation, application, analysis, synthesis, and evaluation of what is known (Umaru, 2008). This is because the three learning domains (cognitive, affective and psychomotor) are interwoven and related.

Health educators should strive hard to effectively utilize the three domains while imparting knowledge about health because the problem of learning does not stop at only formation of contents but equally of importance is methodology which aids in maximum learning and application of what is learnt. And since health education emphasizes the application of what is learnt, health knowledge will be acquired best as a result of the effective learning experience, followed by psychomotor then cognitive learning. These should serve as a guide for the future which is hoped to replace the present phenomenon in our secondary schools where the cognitive aspect of learning is given more priority.

It is necessary to adopt this future trend because of the fact that health knowledge can frequently be inferred from healthy behaviour, the possession of such knowledge (Cognitive) does not guarantee health –

promoting actions. For example, if a child is observed being able to brush his/her teeth correctly, it will be concluded that the child knows how to brush the teeth (cognitive and psycho-motor experiences); but a youngster who knows how to, may not always do it and sometimes may do it wrongly. This is because affective learning experience is not adequately utilized, as a result of which the child did not appreciate the knowledge acquired.

Promotion of Health through Health Education

Several authors for example Fejiwonyomi & Afolabi (1993), Moronkola (1999) are of the view that health education is a process of disseminating scientific knowledge of promoting positive health, attitude and motivating desirable health practices (Fejiwonyomi, 1993). Health education provides a model for effective positive change in the lifestyle of people. People with sedentary lifestyle are encouraged to change to active lifestyle and from unhygienic living to sanitized way of life. Moronkola (1999) reported that health education encourages people to value health as a worthwhile asset and to make people know how they can take actions to promote their health as individuals and that of their communities.

Based on ignorance, many people do not know about these attributes of good health that health education possesses, let alone know how to acquire them. This is where the school health education comes in. Nwachukwu (2004) posits that health education provides all the learning experience that positively influences knowledge, attitudes and subsequent practices of individuals on health matters. The school enrolls a reasonable number of the growing population, who would be the leaders of tomorrow. Whatever health knowledge and practices the child imbibes while in school, influence him/her all through life. The student, being ambassadors of the school, rebuild the health knowledge and habits of their parents and the wider society through their own behaviour when they go home. Olumba (2004) posits that it is apparent that by helping students to master basic health knowledge and skills while building upon it, we enhance the quality of learning as well as health of individuals and communities. But it may be that we have not fully understood how complicated and difficult this process of choice and delivery is.

Sylvester (2004) reported the implications of the observations/comment made during the education week for Nigeria as a nation is that, it can not have a competitive workforce, prosperous economy, vibrant communities or active and involved citizens unless the country has quality health education. Stressing the need for quality education generally, UNICEF in STAN (2002) emphasizes that every learner should be equipped

with the health problem co-existence in order to produce students with enhanced health knowledge, attitudes and practices. In Nigeria, health education is currently being taught as an integrated subject rather than distinctly on its own, using conventional methods, with emphasis placed on examination results (Umaru, 2008). This amount to inadequate care offered to health education outcomes. This in essence denies the students the opportunities abundantly remitted by health education. Such benefits include assisting the students to understand and value the proper utilization of health care system for care, health promotion for improving their health status, as well as the skillful use of health products and services. Adequate provision of health education through health instruction, health services and healthful school environment would cater for the aforementioned lapses. These would further enhance the coordination and incorporation of home, school and the community activities related to improve health.

Health Education Evaluation

What do we measure? Health or behaviour? This is a fundamental question that needs to be answered in order to remove some misconceptions about the effectiveness of health education. In the past, health education has been erroneously judged in terms of some medical outcome. However health education should be evaluated in accordance with whether or not it success in achieving some educational or behavioral goals such as an increase in knowledge or a change in lifestyle (Ian 1990). If such change does not lead to a change or an improvement in health, then the failure is epidemiological. For example, where a dental health education programme has succeeded in persuading mothers to establish in their children routines of rigorous oral hygiene and a reduction in the consumption of sweet stuffs, and those children have subsequently developed caries, then health education has been

successful in terms of its own objectives. The development of caries was due to an epidemiological failure to describe correctly the relationship between cause and effect.

Clearly, once it is evident that the epidemiological assumptions are false, it is folly to continue a health education programme based on them. Successful persuasion and propaganda usually depends in part on communicator creditability. Making empty promises destroys credibility. Therefore, evaluation in health education is concerned with evaluating behaviour that is useful in changing behaviour. Usman (2006) contend that attitude can be measured only on the basis of inferences drawn from the responses of the individual toward the object just like any other psychological determinants, which are accomplished through overt actions and verbal statements of beliefs, feelings, and predispositions to act with respect to the object. Attitude scale is the most widely accepted and used scale in its measurement, which consists of a set of statements or test items to which the person responds (Umaru, 2008). The pattern recorded from the response suggests the person's attitude.

Attitudes are measured by questionnaire methods. Various methods were used, for example Guttman Scale, Thurston Scale, and Likert Scale. Attitude questionnaires which are most widely used are an evaluating statement about the object which tapes the cognitive and feeling components. Thurstone Scale was used to study attitudes towards natives in South Africa, Murphy and Likert Internationalism Scale was used in 1938 for the same purpose of determining attitudes (Mukherjee, 2002). Summated – rating scales developed by Likert, consists of five steps scale in which subjects are asked to indicate the degree of their agreement or disagreement on each presented item validate subjects' attitudes in question.

However, many of the attitudes held by people lack validity, because they are not sufficiently well informed, even if the few facts that a person possesses are substantially correct, a lack of knowledge of related facts can distort the significance of his correct facts (Mukherjee, 2002). Evaluation of health knowledge, attitude and practice in order to assess the formative behaviour exhibited over a long time and which pertains to the mastery of factual health related information and development of skills, the application of which is associated with health enhancing behaviour and practice become necessary (Lawrence, Marshal, Sigrid & Kay, 1980). It is probable that no test of health attitude could be developed in which health knowledge would not be a factor influencing reactions. It is unjustified to believe that health

attitude plays no part in students' answers to health knowledge questions, especially "true or false" and "best-answers" types of questioning.

Conclusion

It must be noted that probably the soundest conclusion on this issue is that no test can be devised which tests either health knowledge or health attitude or health practice solely without an element of eliciting action of the other aspects. However, Patty (2001) contends that "complete recall" type of questioning seems to test health knowledge almost exclusively, while the "true and false" type, "best – answer" type and "matching" type evaluate influence of attitude and knowledge. Also the observation of health habits of students by the teacher or accredited health personnel gives promising results in habit evaluation. It will be good to know that parent's contribution in evaluating their children's health habit could equally present a good source of evaluating students' health behaviour.

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