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## **Health Education in Upper Secondary Schools – Assumptions and Opportunities of Implementation in the Light of the Curriculum**

<http://dx.doi.org/10.12775/PBE.2020.001>

### **Abstract**

The effectiveness of health education, an important area of school education, depends on many factors. One of them is the conceptual layer expressed in the core curriculum. The aim of the research presented in this article was to check whether the learning objectives and content in Polish upper secondary school curricula are consistent with theoretical assumptions based on the achievements of health pedagogy. Qualitative and quantitative content analysis was used. First, the main assumptions of school health education were reconstructed to define analytical categories for further research (dimensions of health in a holistic model, concepts of health, pillars of health education, and methodological approaches). Then, the learning objectives and content of the 2018 core curriculum for Polish upper secondary schools were analysed. The obtained results indicate insufficient compliance of objectives and content with the assumptions of health education, which suggests the existence of a hidden program in this area already at the conceptual level.

**Keywords:** health education, health pedagogy, core curriculum analysis.

### **Introduction**

Health is one of the most precious values, but largely at a declarative level, as evidenced by the results of research on the lifestyles and health condition of

Polish women and men (Boguszewski, 2016; Gaweł, 2016a, pp. 139–152; Nackiewicz & Baran, 2019, pp. 75–87). This also applies to young people, who often choose values more competitive to health even at the axiological level (Grad & Kiliś-Pstrusińska, 2015, pp. 19–23; Łosiak-Pilch, 2017, pp. 17–31). Interestingly, this group presents quite ambivalent attitudes towards health. On the one hand, the research results indicate lack of knowledge and quite unfavourable behaviours related to nutrition, the use of stimulants, insufficient physical activity, sleep deficits, and inability to cope with stress (Nitecka-Walerych, 2014, pp. 171–189; Patrzalek, 2017, pp. 63–71; Leksy, 2019, pp. 87–99). On the other hand, it is the youngest generation that shows a growing awareness of the importance of a healthy lifestyle and taking pro-health and pro-ecological actions — in many environments becoming a fashion or even excessive concentration on health called *healthism* (Kostencka et al., 2014, pp. 128–146; Dzwonkowska-Godula, 2016, pp. 25–46; Michalska & Kukula, 2017; pp. 7–16; Garncarek, 2017, pp. 201–216). These ambivalent attitudes often result from opposing media reports: some of them encourage health-promoting activities, others promote ‘cult of the body’ or harmful products and behaviours (Latoch-Zielińska, 2014, pp. 295–306; Dziukiewicz, 2018, pp. 127–142). Therefore, universal, systematic, consistent and effective education seems to be necessary to shape healthy attitudes.

Health as a concept and value is strengthening its position in the education system. This is visible in the increasingly socio-ecological approach to health (Puchalski, 2008, pp. 205–222<sup>1</sup>; Gaweł, 2016a, pp. 137–152). However, it is difficult to consider them as consistent health policy in the context of problems that have not been solved for years, and are recently exacerbating, such as students’ overload, both physical (heavy backpacks, sanitary, hygienic and housing conditions) and mental (excess of duties, breaking the rules of mental hygiene in planning school activities, lack of psychological support), as indicated in scientific reports (Lewicka-Zelent et al., 2018) and *NIK*<sup>2</sup> reports (Safety and Hygiene of Teaching in Public Schools, 2016).

Objectives and content of health education described in the core curriculum still determine the main area of acquiring knowledge and skills, and shaping students’ attitudes. This is supplemented only by preventive programs or other

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<sup>1</sup> An example of this approach is the *Schools Promoting Health* movement in Poland (see e.g. Rasmus et al., 2013, p. 366).

<sup>2</sup> Supreme Audit Office in Poland is the top independent state audit body whose mission is to safeguard public spending.

school activities, which are usually implemented in an erratic, event-like way, and are not always effective. The effectiveness of actions in this area depends on the quality of the concept of school health education and on the harmonization of all elements in this process: the selection of content, organization, methods and forms of work, teachers' competences, and cooperation of various entities at the level of the school and the local environment. In the present text, I will focus on the conceptual layer of the health education program because the direction of further actions depends on it.

## **Problems and research method**

The aim of the present research was to analyse how the theoretical assumption of health education are reflected in learning objectives, content and implementation recommendations at the upper secondary level<sup>3</sup> contained in the core curriculum. Focus on this educational stage is driven by the special importance of health education in the late stage of adolescence. 15 to 19-year-old youth usually have already gone through the most important changes related to biological maturation, while they intensively shape their individual and social identity, using developmental achievements in the cognitive, emotional, moral, and social sphere. Increasing self-reliance and self-awareness also mean that, to a much greater extent than before, students can autonomously choose their own lifestyle, attitudes, and values, and make decisions about pro- or anti-health behaviours (Wojciechowska, 2014, p. 131).

The main research problem was the question:

Is the 2018 core curriculum for upper secondary schools, including objectives, content scope and distribution, and organization of health education compatible with the approach to health and educational activities in this area created based on health pedagogy – as it is presented by Polish researchers?

Specific problems were also formulated:

1. What are the assumptions and what is the model of modern health education in the light of the dominant trends in health pedagogy?
2. To what extent are health education objectives and content at the level of upper secondary schools compatible with theoretical assumptions?

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<sup>3</sup> Secondary education in Poland in 2018 is optional and starts at the student's age of 15. Students can choose between 4-year general secondary schools, 5-year technical secondary schools, and 3-year stage I sectoral vocational schools (followed by 2-year stage II sectoral vocational schools). Secondary education finishes with Matura exams.

3. Do the current organizational solutions for health education in upper secondary schools enable successful goal realization?

The research method included a qualitative and quantitative analysis of the content in the following materials:

1. In the first stage:
  - a. selected texts by Polish researchers in the field of health pedagogy presenting theoretical assumptions of health education (e.g. Demel, 2002; Woynarowska (2017; Gawel, 2016b; Syrek, 2019);
  - b. supplementary materials for school principals and teachers interpreting the conceptual assumptions of school health education in relation to the new core curriculum of 2018 (MEN, 2018) by Barbara Wolny (2019) and, due to the continuation of the approach to health education, analogous materials to the previous core curriculum edited by Barbara Woynarowska (2014);
  - c. the assumptions and organization of health education in upper secondary schools outlined in the 2018 core curriculum.

Theoretical assumptions related to health education were reconstructed to enable developing categories of content analysis for further research.

2. In the second stage, learning objectives and content referring to health and health education in the 2018 core curriculum for upper secondary schools (for a 4-year general secondary school and a 5-year technical secondary school, omitting the stage II sectoral vocational schools) were analysed. The analysis included the general part of the document and the programs of individual subjects implemented at the basic level<sup>4</sup> or basic and extended level if these are presented together. The subjects which have their extended level discussed separately were omitted as well as whole subjects (Regional language – Kashubian and language of the national or ethnic minority) due to the limited number of students who learn these subjects.

The data were obtained from text fragments (phrases, sentences, and paragraphs) referring to a specific area of knowledge, skills, or attitudes related to broadly understood health and health education.

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<sup>4</sup> The core curriculum makes a distinction between subjects taught at the basic and extended levels and additional subjects, with the number of hours to be allocated to them in the 3-year cycle.

Analytical categories will be presented after the discussion of the results of the first stage.

### **Theoretical assumptions of school health education in the perspective of health pedagogy**

An optimal approach to didactic and educational practice has been developed within health pedagogy (as a theoretical reference plane for health education) based on WHO documents and knowledge accumulated in this pedagogical subdiscipline by Polish scientists (Demel, 2002; Gawel, 2016b; Woynarowska, 2017; Syrek, 2019). Within this framework, health is treated as:

1. a positive category: “complete physical, psychological, and social well-being of a human being, not just the absence of illness or disability” (Wolny, 2019, p. 9) seen primarily in the perspective of subjective well-being;
2. a value and a resource for both the individual and society – an important element of human and social capital (Syrek, 2019, p. 12);
3. a multidimensional phenomenon, including interrelated physical, mental, emotional, social, spiritual, and sexual health (a holistic, biopsychosocial health model – Gawel, 2016b, pp. 29–30; Woynarowska, 2017a, p. 23);
4. the result of complex connections of the man (“smaller whole”) and the environment (social and natural “larger whole”), which are expressed in the socio-ecological model (Syrek, 2019, pp. 12–13), while, following Lalonde’s concept of “health fields”, human behaviour/lifestyle is of the greatest importance for strengthening health potential (Woynarowska, 2017b, pp. 14–15). Health is, thus, a potential that may change depending on everyday activities in a positive or negative direction (Wolny, 2019, pp. 12–13).

The concept of health understood this way implies the objectives and goals of school health education. The health education model set out in the 2018 core curriculum is a continuation (apart from a slight shift of emphasis) of health education initiated in 2009 (MEN, 2009) and then only modified along with subsequent changes in the core curriculum (Woynarowska, 2014a, p. 5).

The most important determinants of this model include the adoption of a positive holistic approach to health, which entails:

1. focus on health as an individual’s potential (its maintenance and development) and not on diseases: emphasis on promotion rather than prevention (Woynarowska, 2017c, p. 99);

2. taking into account all interrelated dimensions of health: physical (healthy body, including the functioning of individual systems and organs, and physical activity), mental (the cognitive component – mental health, and the affective component – emotional health), social (proper relations with other people and cooperation as well as independence and autonomy of the individual), and spiritual (in a secular perspective: internal harmony, treating health as a value, sense of the meaning of life, etc.)<sup>5</sup>;
3. treating health not as a goal, but as a means to achieve a better quality of life and better social functioning, not only for the individual but also for the society;
4. including health in axiological categories as a value (Gaweł, 2016b, pp. 33–36; Wolny, 2019, pp. 10–13).

Health education understood as a didactic and educational process, should be considered in the broader context of health education and the general strategy of health promotion whose main goal is to help people gain control over their own health and multiply its potential (Demel, 2002, p. 18–24; Gaweł, 2016b, pp. 35–38). To achieve this goal, all participants of the school community must be involved in working on themselves and creating a favourable environment for health (Wolny, 2019, pp. 13–14). This means taking advantage of all situations conducive to health education (not only the content of the subjects, but also preventive-educational programs and role models), harmonizing health knowledge obtained from various also out-of-school sources, including students in planning and implementing health education by referring to their needs and interests, and encouraging students to a healthy lifestyle (Wolny, 2019, p. 15).

This approach to health education should result in its proper implementation:

1. holism: focus on all areas of health;
2. integrity (cross-subject correlations and links with overall educational impact);
3. prospective orientation (preparation for lifelong care for one's own and others' health), instead of an actualistic one (shaping the pro-health attitude of the student in the present);

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<sup>5</sup> It is worth noting that, compared to the interpretation of the holistic health model in the assumptions of the previous core curriculum (Wojnarowska, 2014b, p. 14), the emotional dimension has been included in the mental dimension (which seems logical), while the sexual dimension has been omitted (Wolny, 2019, p. 11–12). Nevertheless, the sexual dimension will be included in the content analysis.

4. axiological rather than instrumental orientation (Wolny, 2019, pp. 15–16), which emphasizes the spiritual dimension;
5. focus on shaping a comprehensive positive attitude towards health, including not only the cognitive dimension but also the emotional-motivational and behavioural dimensions (Gaweł, 2016b, pp. 36–37).

As a result, out of the five approaches to health education: medical, behavioural, educational, focused on the individual and on the environment distinguished by L. Ewles and I. I. Simnet (Woynarowska, 2017c, p. 99), particular attention should be paid to the last two since they result from the personalist approach to the student and the place of this education in the health promotion strategy (Wolny, 2019, pp. 12–14). However, the implementation of health education ought to be based – quite traditionally – on three pillars: knowledge (about health, illness, and safety), skills (related to physical and psychosocial health: personal and social competences)<sup>6</sup> and a pro-health attitude (awareness of one's own responsibility for health, respecting the principles of a healthy lifestyle, coping with health threats). Insofar as knowledge ought to be an essential element of health education, attitude ought to be the foundation for the right choices and health behaviours in a lifelong perspective (Wolny, 2019, pp. 16–17).

The organization of health education at school, as in the previous core curricula, gives the leading role to physical education, and additionally incorporates selected content into other school subjects (a dispersed model). In this solution, each teacher is obliged to care for students' health and to engage in health education. Additionally, content related to health (focused on axiology and protection) is included in the educational and preventive program of the school (Wolny, 2019, pp. 18–19).

Health education, both in terms of objectives, content, and methods of implementation is adapted to the specifics of individual educational stages. Regarding upper secondary school, it focuses on revision and developing students' independence and their need for self-improvement (Wolny, 2019, p. 24). This should be reflected in a democratic and individual-oriented rather than a moralizing approach to health education (Woynarowska-Soldan & Woynarowska, 2014, pp. 24–25).

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<sup>6</sup> In the assumptions of health education in the previous core curriculum, they were more specifically defined as *life skills*, in accordance with the WHO classification (Woynarowska, 2014b, p. 16; Kostencka, 2015, pp. 155–163).

Based on the analysis of theoretical assumptions of health education at school, I selected four analytical categories for further research. These are:

1. Dimensions of health (holistic model): physical, mental (mental and emotional), social, spiritual, and sexual.
2. Concepts of health: positive (promotional approach), negative (risk-focused preventive approach), and neutral (still related to the scope of health education).
3. Pillars of health education: knowledge, skills, attitude.
4. Approaches to health education: medical, behavioural, educational, individual-oriented, environmental.

The analysed content is divided into the one with or without direct references to the context of health / health education.

### **Theoretical assumptions and goals of health education in the core curricula**

The analysis of the objectives in the core curriculum shows that theoretical assumptions are reflected in the introductory part of the document in a very general and brief manner. There are no references to health education either in the learning goals or among the most important skills to be acquired in the educational process (except for the ability to cooperate, which can be considered important for psychosocial health, but it is not placed in this context). It is only later that (as an important task of the school) health education is mentioned: *aimed to develop students' attitudes of taking care of their own and other people's health and the ability to create a health-friendly environment* (p. 4<sup>7</sup>), and there is a reference to health as a social resource (p. 5). These two references point on the one hand, to a declarative 'importance' and 'significance' of health education, and on the other, to the focus on the social rather than the individual dimension of health. This approach significantly narrows down – compared to the assumptions – the understanding of health education and indicates its marginality among other educational goals.

In the initial presentation of individual subjects (pp. 7–24), despite the adoption of a dispersed model of health education, only two: Physical education and Safety education contain visions and specific goals of health-oriented

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<sup>7</sup> Page numbering refers to the pages in the analysed core curriculum document - MEN, 2018.



actions. The leading role of physical education in health education is emphasized, with health presented as the goal of physical activity. Emphasis is placed on the prospectivity of health education (in terms of lifelong physical activity and health care) and on preparation to making favourable choices for individual physical and health needs (p. 21), which suggests a behavioural, individual-oriented approach to health and its positive concept. These trends are confirmed by specific learning objectives, where, apart from a positive attitude towards lifelong physical activity in service of health, the ability to apply principles conducive to physical, mental, and social health (holism) is also included (p. 307).

In the case of safety education, first aid and health education are recognized as the most important thematic areas, with emphasis primarily on threats to life and health and ways of dealing with such situations (preventive approach). In the general learning objectives, one can notice a prospective concept of health education, because they emphasize the need to develop skills so that they become a habit allowing a proper response in a situation of a real threat in the future (pp. 21–22). In the learning goals (pp. 312–319), general requirements are formulated as key phrases – module names. Two of the four relate to the analysed issues: first aid and health education, with reference to individual and collective health and health-related behaviour, breaking the impression of focusing only on threats. However, a more detailed analysis of the goals of this subject indicates a medical-behavioural approach to health education.

References to objectives related to health can also be found in the general discussion of biology, but only in the area of deepening knowledge about the structure and functioning of the human body (p. 17). It is only in the learning goals (pp. 201–202) that the requirements directly related to health education are formulated. They include deepening knowledge of health determinants (positive: planning pro-health activities and related to threats) and human relationships with the environment, which can be considered a reference to the socio-ecological model of health. Learning objectives seem focused on knowledge (educational approach) related almost exclusively to the physical dimension of health.

Only the three subjects mentioned above refer to health in their general presentation. Apart from them, only family life education contains very indirect references to the goals of health education regarding a better understanding of oneself and others and making the right decisions now and in the future (p. 22). References to obtaining knowledge about sexuality and procreation, and rules of conduct in this sphere of life, creating your own personality, reflecting on life tasks and choices about the future, shaping positive attitudes towards health

attitudes and society can be found quite late in the core curriculum (p. 321). Thus, objectives refer to the mental, sexual, spiritual, and social dimensions of health. They suggest an educational and individual-oriented approach, and point to the prospective perspective: focusing on choices and attitudes related to taking family roles at later stages of life.

In the case of other subjects there are no references to the analysed issues in the general part of the core curriculum. There were, however, references to various areas of the holistic model of health in the learning goals:

1. social: shaping selected soft skills, such as communication, conflict resolution, cooperation, and defence against peer pressure (civic education p. 138; geography – p. 163; introduction to entrepreneurship – pp. 192–193; IT – p. 298; ethics – p. 325);
2. mental: shaping intellectual and emotional maturity, self-understanding, personal competencies (Polish language – pp. 25–32; civic education – p. 138; introduction to entrepreneurship – pp. 192–193);
3. spiritual: mainly related to reflection and moral maturity (Polish language – p. 25; ethics – p. 325);
4. physical: compliance with safety rules (chemistry – p. 236; physics – p. 267).

In the core curriculum section devoted to “Conditions and methods of implementation” in some subjects the recommended methodological solutions facilitate the acquisition of selected social and personal competences by students such as cooperation, communication, and strengthening of self-esteem.

The goals of most subjects are not directed at health education, although some of them are related to social and personal competences constituting the determinants of social, mental, or spiritual (moral) health. In this sense, they refer to health understood holistically and positively, although – without this context – they may well be treated as a part of generally understood upbringing, and not contribute to raising the rank of health education in upper secondary education.

#### **4. Analysis of content related to health education in the core curriculum**

Considering the length of the analysed material (344 pages of the text of the Decree 2018 – MEN, 2018), content presentation is quantitative. The tables present the total number of references to individual analytical categories, with the first number in the table representing all references, and the ones given in brackets only those clearly related to the category of health / health education.

Table 1 contains the results of content analysis related to health dimensions in the holistic model. In the case of a modern foreign language, contents of two versions of the subject were analysed: as a continuation of the foreign language taught in primary school (III.1.P) and taught as a second foreign language (III.2.0). The table does not include six subjects in which no content related to the analysed issues was found. The fact that some subjects lack any content related to health education undermines the declaration that all teachers are involved in this sphere of activity.

Table 1. References to dimensions of health in the content of individual subjects

Dimensions of health / school subjects	physical	mental	emotional	social	spiritual	sexual and procreational	Total
Foreign language 1	8 (4)	-	4 (1)	3 (1)	-	-	15 (6)
Foreign language 2	2 (1)	-	4 (1)	1	-	-	7 (2)
Philosophy	-	-	-	-	2	-	2
Music	-	-	-	4	-	-	4
Civic education	4 (4)	1	-	11	2	-	18 (4)
Geography	2	-	-	4	-	1	7
Introduction to entrepreneurship	2	-	-	2	-	-	4
Biology*	46 (46)	1 (1)	-	-	-	3 (3)	50 (50)
Chemistry	8 (6)	-	-	-	-	-	8 (6)
Physics	1 (1)	-	-	-	-	-	1 (1)
IT	-	-	-	5	-	-	5
PE	33 (24)	2 (2)	3 (3)	3 (1)	2	-	43 (30)
Safety education**	26 (18)	-	7 (6)	5 (3)	-	-	38 (27)
Family life education	4 (3)	-	-	16	2	24 (6)	46 (9)
Ethics	3 (3)	-	1	7	2	2	15 (3)
Total	139 (110)	4 (3)	19 (11)	61 (5)	10	30 (9)	263 (138)

\*For biology, all content in the basic scope concerned the structure and functioning of the body, so the table includes only those that directly referred to health issues.

\*\* For safety education, the chapter "Basics of first aid" is not included because of the very detailed scope of content entirely related to this issue. However, the content omitted here will be included in further analysis as holistic content modules.

Source: Author's research.

The quantitative analysis does not fully reflect the actual proportions of the references to individual dimensions, because in some subjects the references are

made to detailed descriptions (e.g. biology, security education), in others – to fairly general ones (e.g. physical education), which often means that one data point covers various student activities over a number of lessons. Still, some trends can be noticed.

The data in Table 1 show that educational content does not reflect a holistic approach to health, which advocates maintaining a relative balance between the distinguished dimensions. Physical health is dominant, especially if it also includes entire modules (omitted in the table) regarding human anatomy and physiology (biology) and first aid (safety education). The second most prevalent dimension, social health, often has a problematic relationship with health education. The content mostly relates to social competences without any reference to health, so they can be viewed in a completely different context (e.g. pro-social, civic education, etc.). In addition, this content is dispersed, uncorrelated between subjects and related to many skills (e.g. assertiveness, empathy, communication) – poorly defined. Even teamwork skills, most frequently represented in the analysed material, are treated more as a natural result of tasks shared by students than as a competence that should be shaped in a thoughtful way. In turn, the dimension of sexuality and procreation is implemented almost entirely within one subject, while slightly less than 1/3 of this content has direct references to health issues. Interestingly, family life education is not a compulsory subject, so some students may never acquire the knowledge so important for adolescents.

Mental health in the emotional component is perfunctorily represented in content related to the naming and expression of emotions (mainly in foreign languages), knowledge about mental disorders, stress or references to family relationships, while it is almost non-existent in the mental component (no content related e.g. to mental hygiene or learning techniques). Given the students' developmental stage such poor concentration on mental health can raise serious doubts, even more so because the experience to date with the implementation of this content is negative (Chotkowska, 2018, pp. 177–186). There were 10 references to the spiritual dimension of health, although their context is quite general (philosophical and moral, not health-related). However, it can be assumed that this aspect of holistically understood health is implemented in religious education, which, although optional, is chosen by most students (How many students attend religion classes?, 2020). However, the content of this subject is not part of the core curriculum, so it is difficult to talk about its integrity with other areas of education.

Table 2 shows the results regarding the concepts of health: positive (promotional) negative (preventive), and neutral. The neutral category groups content that is difficult to qualify to either group unambiguously or is not evaluative.

Table 2. Positive vs negative concepts of health

Concepts of health/ Subjects	Positive (promotional)	Neutral (hard to define)	Negative (threats, prevention)	Total number of references
Foreign language 1	1	7 (2)	7 (4)	15 (6)
Foreign language 2	-	6 (1)	1 (1)	7 (2)
Philosophy	1	1	-	2
Music	4	-	-	4
Civic education	7	3	8 (4)	18 (4)
Geography	2	3	2	7
Introduction to Entrepreneurship	2	2	-	4
Biology*	12 (12)	14 (14)	24 (24)	50 (50)
Chemistry	2 (2)	4 (2)	2 (2)	8 (6)
Physics	1 (1)	-	-	1 (1)
IT	4	1	-	5
PE	23 (15)	13 (9)	7 (6)	43 (30)
Safety education**	14 (12)	7 (5)	17 (10)	38 (27)
Family Life Education	22 (3)	16 (2)	8 (4)	46 (9)
Ethics	8 (1)	5 (1)	2 (1)	15 (3)
Total	103 (46)	82 (36)	78 (56)	263 (138)

Source: Author's research.

Data in Table 2 indicate that most references to health focus on its positive aspects compared to references to threats and diseases. This image is not so unambiguous, though, if we add the extensive issues not included in the table: neutral in biology (knowledge about the structure and functions of the body) and content on first aid (Safety education), which focuses primarily on the negative aspects to health (injuries, accidents, danger of loss of life). Considering this neutral and negative content, the advantage of the content characteristic of the promotional model becomes only apparent and one can speak of a relative balance of the positive and the negative concept as represented in the curriculum.

Table 3 contains the results of the division of content into three pillars of health education: knowledge, skills, and attitudes.

Table 3. Pillars of health education

Pillars of health + education/ Subjects	Knowledge	Skills	Attitudes (including values)	Total number of references
Foreign language 1	13 (6)	2	-	15 (6)
Foreign language 2	5 (2)	2	-	7 (2)
Philosophy	1	-	1	2
Music	-	-	4	4
Civic education	14 (4)	1	3	18 (4)
Geography	6	1	-	7
Introduction to entrepreneurship	3	1	-	4
Biology*	50 (50)	-	-	50 (50)
Chemistry	8 (6)	-	-	8 (6)
Physics	-	-	1 (1)	1 (1)
IT	2	-	3	5
PE	25 (16)	15 (12)	3 (2)	43 (30)
Safety education**	31 (22)	5 (3)	2 (2)	38 (27)
Family life education	37 (8)	2	7 (1)	46 (9)
Ethics	6 (1)	2	7 (2)	15 (3)
Total	201 (115)	31 (15)	31 (8)	263 (138)

Source: Authors' research.

In the assumptions of school health education, the basic element ought to be knowledge, while attitudes ought to be the foundations since they allow the acquired information to become permanent and used in practice currently and in the future. The first assumption was confirmed: knowledge prevails (content presented in the table and supplemented with content from biology and safety education). Skills are mainly developed during first aid training, which is particularly emphasized in Safety education. However, the 'foundation' in this perspective appears very fragile, since attitudes have the least numerous representation in the educational content (only 8 references are made directly to health-related attitudes) where in fact changes in personality should be the most important (Czarnecka & Cierpialkowska, 2007, p. 164; Ogińska-Bulik, 2017, pp. 46-57). Results in Table 4, referring to methodological approaches in health education, confirm this trend.

Table 4. Approaches to health education

Approach Subjects	Medical	Behavioural	Educationa	Individual-oriented	Environmental	Total
Foreign language 1	2 (2)	-	10 (3)	3 (1)	-	15 (6)
Foreign language 2	1 (1)	-	3	3 (1)	-	7 (2)
Philosophy	-	-	2	-	-	2
Music	-	-	-	4	-	4
Civic education	2 (2)	-	13 (2)	1	2	18 (4)
Geography	-	-	4	-	3	7
Introduction to entrepreneurship	-	-	4	-	-	4
Biology	34 (34)	-	16 (16)	-	-	50 (50)
Chemistry	1 (1)	-	7 (5)	-	-	8 (6)
Physics	-	-	-	1 (1)	-	1 (1)
IT	-	-	2	3	-	5
PE	1 (1)	4 (2)	26 (16)	10 (10)	2 (1)	43 (30)
Safety education	8 (7)	1 (1)	24 (16)	3 (2)	2 (1)	38 (27)
Family life education	2 (2)	2	36 (6)	3 (1)	3	46 (9)
Ethics	-	1	11 (3)	-	3	15 (3)
Total	51 (50)	8 (3)	158 (67)	31 (16)	15 (2)	263 (138)

Source: Authors' research.

Proportions of content referring to knowledge, skills, and attitudes are parallel with the distribution of results in individual approaches to the implementation of health education. The dominance of the educational approach is clear, then the medical, which is also based primarily on knowledge. Biology content and part of the Safety education content refer to these two models. The least represented behavioural approach is reinforced with first aid skills, which makes it quantitatively equivalent to the individual-oriented model. The environmental approach is the least visible, which means that school health education does not encompass the socio-ecological model of health. And although these data can be interpreted as a departure from the outdated medical model (that presents health in negative terms – threats, diseases), the dominance of knowledge and the educational approach suggests that health education remains only theoretical and declarative. The weakness of the individual-oriented approach (only 16 direct references to health education) may lead to a situation when knowledge is

fragile and not practical, and thus will not be strong enough to influence health-promoting behaviour, especially in a lifelong perspective.

Given the differences between the subjects, it can be concluded that physical education is the most consistent subject with the theoretical assumptions of health education. Its contents, although in different proportions, refers to five out of six health dimensions, the promotional model prevails over the preventive one, and skills (over knowledge) and individual orientation have a relatively large share.

A separate issue is the implementation of health education even in the shape of the program (content) that emerges from the above analysis. The biggest doubts arise from placing the main responsibility for realizing the objectives and content of their subject, but also for coordinating the activities of other teachers and persons (e.g. supporting medical staff, or parents) on physical education teachers. This applies not only to their competences, especially in areas other than physical health, but also to the possibility of exerting a real influence on this aspect of school education. A diagnosis made by B. Wojnarowska et al, in 2014, after several years of operation of the model analogous to the current one, showed that there were many irregularities in the implementation of this model. They concerned both methodical aspects of conducting lessons, as well as insufficient preparation of PE teachers. This meant that a large part of the content was not included, and it was difficult to talk about effects due to the lack of evaluation of health education – both in relation to lessons and additional preventive programs (Wojnarowska et al., 2014, pp. 172–178). In turn, the NIK audit carried out at the same time regarding the implementation of physical education in schools of various types showed that in most schools “practical and pro-quality changes in the approach to the subject were not made / ... / health-related concepts were not taught” (Zaleski-Ejgierd, 2014, p. 53). Perhaps in the next few years the situation improved thanks to training, methodical materials available online, the experience gathered by teachers, but I could not find more up-to-date reports on this topic.

## **Conclusions**

The school program of health education in many aspects has the features of a program hidden behind the facade of noble assumptions. The analysis of the conceptual layer outlined here indicates deficiencies and inconsistencies if one considers the ideas and recommendations formulated on the basis of health pedagogy and assumptions for school education. Referring to the described above



desirable features of upper secondary school health education, based on the analysis of the core curricula, it can be stated that:

1. it does not consider the holistic approach to health, neglecting important areas of psychosocial and spiritual health;
2. it is not integral, because apart from three leading subjects (physical education, safety education, biology and, partly, family life education) there is no health orientation or cross-curricular correlation of the content;
3. the curriculum does not present health in positive terms, since the promotional approach does not dominate – it is equivalent to neutral and preventive content;
4. it is more actuarial than prospective, as evidenced on the one hand by a small representation of the latter content, on the other by a clear prevalence of knowledge (educational and medical approach) over skills (behavioural approach) and especially attitudes (individual-oriented approach).

Therefore, it seems that the adopted dispersed health education model is not optimal. Perhaps a separate subject *health education* implemented in accordance with the assumptions of the holistic model of health would be an opportunity to offer multifaceted but at the same time coherent and consistent education. Another solution could be to supplement the current model, in which education for physical health is quite well represented, with a subject devoted to psychological literacy, focused on psychosocial and spiritual health (in a secular sense)<sup>8</sup>. One may wonder about other, better solutions from the current one (Wojnarowska et al., 2014, pp. 184–186) but it is the educational authorities who are responsible for the changes, and they – not only in the field of health education – too rarely consider the educators' voice.

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<sup>8</sup> I postulated the introduction of this type of subject under the name *practical psychology* already a quarter of a century ago (Pankowska, 1995), but so far the development of students' personal and social competences has not found its rightful place in the Polish education system.

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