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The role of health education in reducing disability in children and youth

In recent years, the issues related to health and disease, which so far remained within the focus area of medical sciences, have aroused interest among the representatives of social sciences, including educational sciences. Health promotion occupies a significant role, since it applies knowledge drawn from various branches of science, including both medical and humanistic sciences. Health promotion has its tradition. It originated as a pro-health social movement. The report produced by Marc Lalonde in [1974](#) in [Canada](#), entitled “A new perspective on the health of Canadians”, presented to the Canadian parliament, was of enormous significance. In 1978 The International Conference on Prime Health Care was held in Alma Ata. On the basis of the analyses conducted before, the conference reaffirmed that the health status of communities was constantly deteriorating, and pointed to the need for far-reaching action to protect and promote health. Another event of great importance for health promotion was the First International Conference for Health Promotion which took place in Ottawa, Canada, in 1986, at which “The Ottawa Charter for Health Promotion” was launched. It became a document of major significance for health promotion. The conference in Ottawa was followed by further international health promotion conferences in Adelaide (Australia 1988), Sundsvall (Sweden 1991), Jakarta (Indonesia 1997), Mexico (2000) and Bangkok (2005) ¹. Certain interdependent action areas for health promotion were identified in “The Ottawa Charter“. When taken simultaneously, the interdependent actions constitute a strategy for health promotion. They include: building healthy public policy, achieving health-supportive environments, strengthening community actions toward protecting health, developing personal skills facilitating health improvement, and reorienting health services ².

“Health promotion is the process of enabling people to increase control over, and to improve and maintain their health. To reach a state of complete physical mental and social wellbeing (good physical and mental state), an individual or group must be able to identify and realize aspirations, satisfy needs, and change or cope with the environment. Health is therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, it is not

only the health sector which bears the responsibility for promoting health, it should also remain within the scope of all social activities, which affect a healthy life style and widely interpreted wellbeing of all community members.”³ At the beginning of 1980s, approving the “Health for All” resolution, The World Health Organization proposed new health policy, which was presented in 1985. In 1998 the World Health Declaration – “Health 21-Health for All in the 21st century- has been adopted. It reaffirms all the goals set in the previous document, related to attainment of the level of health which would enable the whole population to lead a socially and economically productive life. The fundamental directives and regulations governing the area of public health within the European Union were laid down in the Treaties of Maastricht (Article 129) and Amsterdam (Article 152), concerning the activities of the European Union in the field of public health, aimed at health improvement, protection and monitoring the new health-related problems in member countries. The EU policy has, however, a complementary character and cannot replace the health policies of the member countries⁴. Following the declarations adopted by the World Health Organization, and regulations introduced by the European Union, many countries, including Poland, developed their National Health Programmes. In Poland several versions of National Health Programmes (NHP) have been developed so far. The recent (project) version of the 2006-2015 programme specifies three fundamental strategies which aim at⁵:

- improving health and reducing territorial and social differences, through the influence on life style as well as achieving equality of opportunities for the elderly and disabled;
- early diagnosis and treatment of most popular diseases at their reversible stage, with particular regard to primary health care services and short term care in life threatening situations;
- protecting population against popular health hazards.

The National Health Programme specifies 19 target action areas, whose superior strategic objective is improving health and the quality of life. The target area number 10 is related to limiting the number and consequences of accidents. The prevalence of accidents among children and young people poses an increasingly serious health, social and economic problem, due to the high treatment and rehabilitation costs it generates. Over 5 thousand people get killed in over 50 thousand road accidents which occur every year. It has been recorded that out of 145 thousand accidents that children meet with at school, 90 are fatal and 1.2 thousand are serious⁶. According to the data published in the report 2006⁷, and derived from a survey conducted in 2005 among a representative sample of school children, 35.5 % of the surveyed boys and 26.4 % of the surveyed girls sustained injuries requiring medical attention; and

within a group of students aged 16 and 18, boys and girls constituted 34.0 % and 27.9 % respectively. The report reveals that the most common injuries among the surveyed teenagers occurred as a result of participation in sports and recreational activities (55.9 %), a fight, or road traffic accidents (e.g. driving children without proper safety seats); they also happened while the teenagers were involved in work or some practical activities. Many children experience accidents at home (e.g. they are at risk from electric circuits that lack earthing, hot water or household detergents, the access to which has not been prevented by using proper safety means); at playgrounds (as a result of lack of control and improper maintenance of playground equipment, e.g. swing sets, merry-go-rounds and the like); and in some abandoned and uncontrolled places (streets, railway tracks, canals, rivers and the like), most often it is due to inadequate care provided by parents or caregivers. Low level of awareness among many parents and their lack of imagination, lead to some tragic results such as the child's disease, disability or death. The injuries which contribute to disabilities among children and youth are also related to domestic violence and child safety neglect perpetrated by parents, violence within peer groups, and organized crime. Young adults are often exposed to disability when they engage in risk-taking behaviours such as jumping into water head first, illegal night street racing, etc. One can distinguish between two types of accident causes among children and youth: endogenous (internal, originating from within the injured person) or exogenous (external, originating from the environment). Among the most important factors determining safety of children at school are: school physical environment (which meets the standards of hygiene and safety), organizing pupils' activities (such as design and technology classes, and breaks), teacher control over the relations between peer pupils (aggression and violence within peer groups)⁸.

There is an urgent need for safety promotion in Poland, including preventing accidents and injuries which result in disabilities among children and youth, since action taken within this area is definitely not strong enough. The World Health Organization has defined safety promotion as the process, applied at a local, regional, national and international level by individuals, communities, governments and other actors, to develop and sustain safety. This process includes all efforts agreed upon to modify the environment (physical, technological, political, economical and organizational), structures as well as attitudes and behaviour related to safety⁹.

It is also worth focusing attention on the injury and accident prevention strategies, outlined in the document "Health 21-Health for All in the 21st century", which include identifying and controlling the risk factors underlying injuries; educational activities aimed at protection of

places where young adults tend to gather (sports and recreation venues, work, school, places for entertainment); providing information concerning risk factors and prevention strategies; conducting research into determinants and consequences of injuries, and into treatment and rehabilitation methods.

1 J.B. Karski: Praktyka i teoria promocji zdrowia. Wybrane zagadnienia. Warszawa 2003 p.14

² Ed., J. B. Karski: Promocja zdrowia. Wydanie nowe. Warszawa 199, pp. 21-23

³ Ed. J. B. Karski, Z. Słońska, B. W. Wasilewski: Promocja zdrowia.wyd. II. Warszawa 1994, pp.424-425

⁴ Zdrowie 21. Zdrowie dla wszystkich w XXI wieku. Warszawa –Kraków 2001. Translated by J. B. Karski, p.9

⁵ Narodowy Program Zdrowia 2006-2015 (projekt) pp.10-11

⁶ Narodowy Program Zdrowia 2006-2015 (projekt) pp.29-30

⁷ Ed. A. Oblacińska, B. Woynarowska: Zdrowie subiektywne, zadowolenie z życia i zachowania zdrowotne uczniów szkół ponadgimnazjalnych w Polsce w kontekście czynników psychospołecznych i ekonomicznych. Raport z badań. Warszawa 2006.pp.45-49

One of the most important areas of activity, though not the only one, especially in school environment, is health education. It is aimed at achieving safety in the living environment of school children, avoiding risk-taking behaviours, and learning about their health and social consequences. Health education is a tool for promoting health. It is the process, grounded on scientific principles, which creates possibilities for methodical education aimed at enabling individuals to make deliberate choices concerning health, and to follow them. Responsibility for the process is placed on a family, educational system and on the whole society¹¹. Literature devoted to the subject of health education distinguishes its three models¹² : disease-oriented, aimed at preventing particular diseases; risk factor-oriented, directed toward preventing several diseases simultaneously; and health-oriented, based on the holistic and biopsychosocial approach to health, which focuses not on disease, but on people and places which should remain within the scope of educational activities. The efforts are channeled into developing and implementing extensive health education programmes, aimed at social environments, which are of key importance for the health of the particular community. Educational activity should be directed toward developing physical, mental and social health potential, offering children and youth opportunities for a good start in life and for achieving

their life aspirations and optimal quality of life. One of the possibilities of reducing prevalence of accidents and injuries among children and youth, which result in disability, is undertaking educational activities which would aim at increasing the health awareness among children, youth and their parents. Family is the fundamental environment which bears the responsibility for the child's safety, but in many cases it is low level of parental awareness regarding health hazards, and neglect of caregiving, which leads to the situations in which parents themselves put their children at risk for disability, loss of health, or even death. An urgent need exists to take multi-institutional action directed toward increasing parents' or caregivers' awareness regarding protecting child's health, by creating a safe family environment, reducing exposure to all potential safety hazards, and providing children with care appropriate for their age. It should be expected that health education, aimed at safety, and introduced among kindergarten children and at successive stages of school education, will bring, among other results, reduction in disability rates. The health-oriented activities within the system of school education should concentrate on approaching the problems and issues which to some extent correspond with child's age, in regard to the highest risk of exposure to safety hazards. Hence, there are certain particularly significant areas of education which cover: fundamental traffic rules (e.g. crossing the streets the safe way, safe places to cycle, roller blade, skateboard, using protective gear and accessories, etc.); home safety (e.g. hazards related to playing with electrical appliances or sharp tools, eating household chemicals, starting fire, etc.); safety at sport and entertainment venues (e.g. hazards related to swimming pools or bathing in other water bodies, playing in unsuitable places, playing with unknown objects of unknown origin, using sports equipment in an unsafe way, etc.); school safety (e.g. hazards resulting from disobeying fundamental rules of safety during sport activities, breaks, design and technology classes, in laboratories, etc.); effective lifesaving premedical aid.

Different kinds of health education can be distinguished, depending on the type of the knowledge provider-recipient communication mode, which affects the course of educational process. They include: authoritative education, based on one-way transmission/imposing of knowledge; participative education, which involves two-party information exchange, and is based on mutual trust and empathy among the participants of educational process. The objective of this approach is to develop skills and abilities, and create conditions and relations which would facilitate the process of developing individual and group potential, and adopting to the constraints and necessities in everyday life. There is also promotional education, based on intentional exchange of experiences and educational knowledge between the participants of the process, and aimed at introducing changes. The model postulates autonomy of the

education receiver, hence it involves the process of self-educating/ self-modification which should be based on self-reflection. In this model great significance is attached to positive relations between the subjects of educational process. It is worth mentioning that providing knowledge concerning the positive and negative models of health behaviour is equally important as developing skills and abilities which would help to put the knowledge into the practice of everyday life. Depending on the priority objective of educational activities, and the age of the subject, different educational models can be used in health education among children and youth, with preference given to the educational methods which stimulate active involvement.

⁸ Ed. B. Woynarowska: Zdrowie i szkoła. Warszawa 2000, pp.375-376

⁹ Narodowy Program Zdrowia. 2006-2015 (projekt), p.30

¹⁰Cf..Zdrowie 21-Zdrowie dla wszystkich w XXI wieku. Warszawa-Kraków 2001, p.104.Translated by J. B. Karski

¹¹ Ed. B. Woynarowska: Zdrowie i szkoła. Warszawa 2000, p.418

¹² Quoting : Z. Słońska:Wychowanie dla zdrowia W: ed. J. B. Karski, Z. Słońska, B. Wasilewski:Promocja zdrowia. Warszawa 1994, pp.325-327, cf: ed. J. B. Karski: Promocja zdrowia. Wydanie nowe. Warszawa 1999, pp.304-317

Translated by: Iwona

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References:

1. Karski J. B. , Praktyka i teoria promocji zdrowia. Warszawa 2003 i 2006.
2. Karski J. B.(Red.) Promocja zdrowia. Wydanie nowe. Warszawa 1999.
3. Karski J. B. ,Słońska Z., Wasilewski B.W.,(Red.): Promocja zdrowia .Wyd.II. Warszawa 1994.
4. Narodowy Program Zdrowia 2006-2015 (projekt).

5. Oblacińska A., Woynarowska B., Zdrowie subiektywne, zadowolenie z życia i zachowania zdrowotne uczniów szkół ponadgimnazjalnych w Polsce w kontekście czynników psychospołecznych i ekonomicznych. Raport z badań. Warszawa 2006.
6. Woynarowska B. (Red.): Zdrowie i szkoła. Warszawa 2000.
7. Zdrowie 21-Zdrowie dla wszystkich w XXI wieku. Warszawa-Kraków 2001.
Translated by J.B. Karski.