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Adolescents Perceptions of Health Education in Secondary Schools: The Need for a Dialectical, Practical and Transcultural Proposal

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Abstract: *Health education in Spanish schools is still considered as a controversial subject, which Educational laws and programs have always faced ambiguously. This report presents adolescents' opinion about health education in their schools. In particular, which curricular and extracurricular aspects are being developed, and which strengths and problems related to health education they identify in their educational centers. Based on the situational analysis, we make a quick diagnosis of the state in which health education stands, in order to find a starting point for the improvement. We conducted 15 depth interviews with Romanian and Spanish students in 3 teaching centers of the South of Spain. The qualitative analysis of data was carried out using Atlas Ti, version 7. The results show that participants do not consider schools as the main source of health learning, while family, peers and technologies are seen as more significant agents. In secondary schools, most of the information related to health is received through outside educational programs, and it is seen as ineffective because they are partial, merely informative and not continuous over time. The main health problems in secondary schools identified were stress and bullying, and we may consider as relevant the existence of discrimination based on origin or precedence. Furthermore, participants provide an essentialized, stereotyped and inferior vision of health in other foreign continents (Africa) and religions (Islam). Adolescents portrays a School far from health, with a traditional health education model and a biomedical conception of health. This scenario suggest a need to bring back the Perugia School approach based on developing dialectical, praxiological and transcultural methodologies and where students could get involved and participate in their own health learning.*

Keywords: health education, transcultural health, adolescents, school health education

Introduction

Throughout history, schools have incorporated health-related elements either due to curricular requirements as part of natural science subjects or either as a result of teachers' own personal interest but without developing a specific conceptual or curricular framework, thus being incomplete and focused mainly on the physical dimension (Gavidia Catalán, 2001). It is from the WHO definition of health in 1946 and later, in the 80s after the Declaration of Alma-Ata when the definitions of Health Education were defined in more detail. Early definitions included some relevant aspects such as the relevance of "linking the gap between health knowledge and practice" (Griffiths, 1972), enhance learning about health in order to improve health behaviours (Green, Kreuter, Deeds & Partridge, 1980,) and the importance of improving health literacy and developing life skills in order to reach individual and community health (WHO, 1998, pág. 13).

During this period of conceptual development different health education views emerged for schools. The importance of school health education is based on its role in contemporary societies being responsible for transmitting sociocultural and cognitive values and its ability to create healthy behaviours and habits. It is considered, together with the family, the main agent of early and adolescent socialisation. In fact, it is considered, along with the family, the primary agent of socialisation in childhood. Health education in childhood is more likely to generate healthy behaviours during adulthood (Jourdan, Samdal, Fatou, & et al., 2008).

The two main pedagogical positions regarding health education were represented by the Anglo-Saxon School and the Italian School (from Perugia). The Anglo-Saxon model falls within the positivist paradigm. It calls for an objective, universal, quantitative education with an educational project focused on the transfer of knowledge. It uses top-bottom strategies where the teacher/student relationship is understood as a way of patronage. At a theoretical level it is influenced by cognitive-behavioural theories. The traditional and planned models are included in this group such as PROCEED. Furthermore, the Italian model or Perugia School model incorporates the socio-critical and interpretative paradigm with qualitative, comprehensive methodologies that are primarily directed towards emancipation. It has a democratising vision and, therefore, uses bottom-up strategies. It is theoretically influenced by the social interactionism (at a pedagogical level) and the liberation theories (Sánchez, Ramos & Marset, 1997). The modern educational models and those based on empowerment belong to this group (Hagquist & Starrin, 1997).

At present both models are used but the Anglo-Saxon is predominant. Some programmes have even identified the co-existence of both paradigms leading to educational consistency deficits according to Altaze Yepes (2006).

In addition to educational models, health education puts into question what should be the health model on which to work. The biomedical model understands the health and disease processes from an individualistic and biologist perspective and has a mechanistic and dualistic view of the human body, directing interventions to repair partial damages or erratic behaviours. Biomedical health conceptions have been in conflict with broader concepts such as the bio-psychosocial perspective. However, the biomedical paradigm just as the Anglo-Saxon model is still very present (Menéndez, 2005).

The health education in schools in Spain

The development of health education models has not always resulted in their incorporation into the educational system. In Spain, despite the recognition contained in the Constitution on the right to health, none of the most recent Spanish education laws: LOGSE (1990), LOCE (2002), LOE (2006), LOMCE (2013) have included a specific subject focused on health nor specific curriculum have been designed. It was addressed in a lax and flexible manner employing formulas such as the transversal formulas first, or skills, most recently.

There has been an attempt to supplement the lack of a specific approach in the classroom with the participation in different networks and health programmes at the local, regional, national or even European level such as the Schools for Health in Europe network, SHE. However, these programmes have significant territorial inequalities (Salvador, Hernández, & Rodríguez, 2008).

Heterogeneity and the lack of conformity in school work plans show the need for setting guidelines and structure pedagogies so that the Health Education can be an effective tool for change. Thus, it is necessary to conduct a thorough analysis of the situation faced by various stakeholders in the educational process.

Objectives

To find out which is the students' perception and view of health education in schools.

Methodology

The research methodology was qualitative, using in-depth interviews as a data collection technique. The interview script focused on the status of health education in schools. The development of the research was conducted in three state secondary schools in Almeria.

The interviews were analysed with the ATLAS.ti7 qualitative analysis of data program, following the steps proposed by *Corbin and Strauss* (2008).

Characteristics of the participants. The participants were 15 adolescents aged between 14 and 17; Eight of them from Romania and 7

from Spain. They were all were students in their third year of Secondary school.

Ethical considerations. In order to ensure information and the voluntary and conscious participation of all participants training sessions with students were held, they were given a written informed consent, which had to be signed by the parents or guardians and, moreover, a verbal consent was recorded before the interviews.

Results

Family the main socialising agent in health and school the least relevant

In order to ascertain the subjective importance of school health for young people they were asked which were the main agents responsible for the acquisition of health knowledge and habits. They highlighted the family as the most important institution, followed by peer influence and technology. The school was ranked the last. Specifically, they insisted on the influence of the mother figure in their eating and emotional patterns. "*No... they tell us (the mother) that if we don't learn to cook we will not eat. And I like to cook but... I can not cook, I can prepare two dishes at most, but... to learn I have to be with my mum*" (Participant 9, man)

Students perceive school as a learning space that reflects an approach focused on the physical dimension of health "*Not much I don't think (the psycho-emotional health) ... it focuses more on physical health: in sports... but never focuses on mental health*" (Participant 12).

Health content taught in schools. Curricular aspects

Regarding the health formal contents the participants identified two sources of information: the content integrated into the subjects and external lectures on specific topics pertaining to local, regional or state health programmes. According to young people health is addressed mainly via the second source.

The balance of health content taught through the school curriculum was not positive. Students reported that they receive little information about the content covered in the interviews. They stated that some aspects were covered such as the reproductive cycle (sexuality) or anatomy and some information on the physiology of the human body in subjects such as biology and natural sciences. And aspects regarding sports in physical education.

"Lectures" given by professionals from outside the school are the most widespread form of receiving training in health promotion. They mentioned that they had received lectures on drugs (cigarettes, alcohol and other drugs), sexual education, road safety and bullying. But they highlight the lack of information on aspects such as hygiene and self-esteem.

Teenagers are sceptical regarding the effectiveness of the lectures. Even though they consider that they can be useful for acquiring some valuable

information, most students find that this information does not change behaviours or lifestyles. Sometimes they also refer to the lack of continuity in the talks and the lack of coordination.

> *No, they are totally useless. It's like when I keep telling my mum to quit smoking again and again and she says, "I'll try".* (Participant 2, women, Romania)
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> *Yes, of course, I know what I have to do. In each course they repeat the same things four or five times. It is a bore (*Participant 3, woman, Romania).
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> *I think that many do not give talks enough importance; they see it as a way to get out of the classroom. A way of skipping a class. And many who attend do not pay attention. INT: why? - P04: (sighs) I don't know, some (students) ... aren't interested, others think they are meaningless, others will think, I am not going to be told what I have to do* (participant. 4, man, Spain).
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> *There have been talks... and have they been useful? People insist they are but then do as they please... There are talks organised but in depends on the people you hang out with. If you hang out with people who... smoke you just end up smoking yourself.* (Participant 15, man, Spain)

Extracurricular aspects and hidden curriculum in health

There are some aspects in relation to the organisation and functioning of the educational system that adolescents associate with their health conditions such as: evaluation methods, educational counselling service or the food services to which they have access (canteen).

Evaluation systems focused on examination temporarily alter lifestyles and increase stress. "*During the exam period, yes. And when we have them altogether one gets stressed*"(Participant 13, woman, Spain.)

The work of the educational guidance service is a resource well perceived by students who considered it to be very helpful when facing difficult situations (good for health) ENT. *Do you think that your environment offers you possibilities to feel better? P10: Yes, for example here in secondary school when one is not feeling well he can go to the counselling department* (Participant 10, woman, Spain.).

When it comes to addressing the food they eat at school, most of them admit that they buy mid-morning breakfast in the canteen. The opinion regarding the availability of healthy products varies within the school service. Some consider that healthy foods are available (fruit), whilst others claim the opposite. They do, however, fully agree that the food they eat is not too healthy: fried food, bakery products, sweets... and a set of high-calorie foods. We observed a greater concern regarding healthy eating in state primary schools than in secondary schools. "Yes, there is (fruit). We can buy them in the canteen. And also... at the school I attended before we had to bring a piece of fruit every Tuesday and Thursday or otherwise we would get a negative point. (Participant 8, man, Romania)

The main health issues perceived at school

Educational centres are also a place where school life and the functioning itself generate friction or situations perceived as problematic that have an impact on the health of the participants.

The problem mentioned the most was bullying and discrimination, especially focused on being fat. They claimed to have received lectures about bullying that had raised awareness but acknowledged that it has not made the problem disappear.

> *In high school it happens between students […] They pick on the most quiet people, those who least often mess with others, or… those who mind their own business. There is always the funny guy… They pick on those who wear glasses… those who do not have many friends, are lonelier… and also those who are overweight… and glasses, sometimes, braces (dental) […] I was overweight when I was a kid. I weighed 93 kilos when I was 12 and I joined the Football School and then because I grew quite a bit I joined the Basketball team… and little by little, from 93 kg I went on to weigh 75kg. They used to pick on me during physical education at school… it was quite noticeable* (Participant 5, man, Spain).

Stress is the second aspect mentioned the most. It appears as a result of various situations such as peer pressure, bullying, exams or to keep pace with the many activities they do.

Perceived sociocultural differences at school and regarding health

Despite the time that Romanian participants have been living in Spain they identify differences between schools in Romania and Spain. Some of the differences mentioned by the students refer to the timetables as they have afternoon classes from a certain year onwards, having to memorise too much at Romanian schools and its strict nature regarding content and not so much so in terms of behaviour rules. Participant six criticises the Spanish school for excess of notifications to parents for inappropriate behaviour (talking, eating, chewing gum…).

> *School is different there, for example, from 5th grade, you only go to school in the afternoon… […] it would be better because then students could get more rest… They would not have to get up at that time… Everyone can rest more or study late. I feel more more tired* (Participant 7, man, Romania)

Among the Spanish group of students, fundamentally, a stereotypical view of health was portrayed in other countries or religions. The conception of a Muslim or an African continent as a homogeneous whole that is inferior to the Western world.

In my class almost everyone has a religion... some are Catholic Christians, other evangelicals, Muslims. I'm Catholic... there are many evangelicals... Romanian...of Eastern Europe. There are many people [...] There are extremist Muslim countries that stone women for no reason, they kill them... cut off the hand of men convicted of robbery. I think that it is linked to health... the more tolerant a religion is, the less it influences the health of a person. (...) I think that Catholicism is one of the most developed (religions), more tolerant now. And now even the new Popes accept the use of condoms for contraception... well, they do not accept them, but I think Benedict said they could be used to avoid contracting diseases. (Participant 4, man, Spain).

In some African countries that are less technologically developed in the health field. I do not think it's right, people die from drinking contaminated water or eating sand or from malnutrition. ENT: So do you think that the health standards are better here? P05: Than in those places?, yes. (Participant 5, man, Spain).

Discussion and conclusions

According to the study conducted some of the aspects that seem to characterise health education in schools analysed in South-eastern Spain are as follows:

- Schools and the teaching sector still perceive health in biomedical terms, which is an obstacle when articulating proposals that reconcile the health and education sector in a close, coordinated and continuous manner (Barnekow et al., 2006). Furthermore, it was observed that both sectors are disconnected, to some extent, from the health conceptualisations of the adolescents themselves.
- The school health models shown continue to respond to a traditional conception of prevention. This is observed in the work for health education mainly based on specific lectures given by people who are not part of the school.
- Lectures and educational work carried out in schools are discontinuous and inconsistent (in one same course not all the different classes receive them). They address different subject matters disjointed from one another and cover the most relevant or problematic issues at the point in time or political interests.
- The model that characterises health education described by young people fits within the more traditional Anglo-Saxon model and responds to top-up strategies developed from the top without the participation of young people.
- All the adolescents who took part highlighted a crucial aspect regarding health education: to receive health information does not, in itself, generate behavioural changes, and even less so lifestyle changes. This implies a tough counter-response to the established education model based on providing information on health.
- The level of health literacy in its cognitive and conceptual dimension, a condition that is necessary for health (Nutbeam,

2008) exceeded the level that had been assumed for these groups. However, the apprehension and application of this knowledge continues to remain a challenge.
- The health approach or approaches in other countries or cultural frameworks highlight the ignorance and stereotypical vision of other realities.

The study results reinforce the need for health education models that address the sociocultural differences among students and are models in which teachers and students adopt an active role in their own learning. It is a cross-cultural perspective as an educational need.

Reflecting on a health education proposal: dialectic and transcultural

Schools meet conditions that make them the preferred space to implement health promotion and education. Given the increase in immigration in globalised societies, schools are the socialising place where most contact and cultural diversity occurs between children and adolescents (Soriano, 2005). Therefore, health education must be transcultural, that is, it has to analyse and understand health cultural differences in order to develop frameworks that respect and share diversity whilst integrating key elements for all.

However, this task entails risks. This study shows, as suggested by Barnekow and others (2006) that agents or places such as family, community and school can provide both protective and potentially harmful environments for the health of young people. This means that it is not sufficient to address health from schools, which is the community (understanding schools as schools within a community) we must work based on a critical analysis that reflects the nature of schools and health in a specific context.

As Di Leo states it is necessary to articulate new work scenarios for health promotion aimed at understanding health as a common good and as an answer to the fundamental demand: the right to be. Develop proposals (based on sociology and critical pedagogy) in health education that have a critical and dialectical nature, aiming at the empowerment of people. To achieve this objective, it is argued that these scenarios should include the following core dimensions (Di Leo, 2009):

1. To present health as a problematic field in constant change open to an ethical political process of criticism, dispute and dialogue between the different discourses.
2. Generate frameworks that overcome essentialist and dualist definitions of the individual.
3. Enhance the dialectic movement of the social experience in the subjects themselves, that is, generating dialectic contradictions with them and with others so that individuals are transformed and constantly updated (offering new possibilities to individuals that were previously inconceivable).

In our view, it is essential to recover some elements of the model representing the School of Perugia that is based on more democratic and participatory formulas. A health education that can understand, problematise and address the social, cultural, economic and political contexts in a constantly changing world. An education where the practice is the epistemological and methodological framework for reflection and transformation. Therefore, we support the need to further develop a dialectic, praxiological and transcultural education.

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