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Doctoral (PhD) Dissertation Thesis

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Examination of health behaviour, health literacy and the pedagogical impact of health education in Eger secondary schools in the light of the School Health Index (iEGI)

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Table of contents

INTRODUCTION	2
SCHOOL HEALTH INDEX	3
THE AIM OF THE RESEARCH	4
RESEARCH QUESTIONS AND HYPOTHESES	4
METHODS	5
SAMPLE	5
SAMPLE CHARACTERISTICS	6
METHODS	6
ANSWERS OF THE DISSERTATION	7
CONCLUSIONS - THESISSES	8
REFERENCES	11
PUBLICATIONS	13

Introduction

The health behaviour and consequently the health status of the Hungarian school-age population is inadequate, as evidenced by a number of international (HBSC, ESPAD), national (iEKF) and regional small sample studies (*Horváth and Bognár, 2019; Horváth and Bognár, 2020*). From the domestic data of the International Health Behaviour among School-age Children (HBSC), we see a worsening trend over the past decade in terms of daily physical activity, fruit and vegetable consumption, peer abuse and, in the case of sexual behaviour, protection. A positive pattern also emerges from surveys of recent years, with a decrease in the number of smokers and alcohol drinkers and stagnation in drug use (*Németh and Költő, 2011; Németh and Költő, 2016; Németh and Várnai, 2019*).

Two main educational areas have a strong influence on the positive influence of these lifestyle factors: the family and institutional education. We consider school as a secondary socialisation area, where the child's culture, values and habits are no longer transmitted by the immediate family environment, but by other significant persons: educators, teachers, schoolmates, friends (*Tóth, 2003*). In addition to education, school has a crucial role in terms of social learning, in building relationships with peers and teachers (*Szabó, Zsadányi and Hangya, 2015*). Research has shown that attachment to teachers has a positive impact not only on academic achievement but also on the development of constructive, health-conscious life skills (*Kuperminc, Leadbeater and Blatt, 2001; Susánszky, Szántó and Hajnal, 2006*). Efforts and activities within the framework of institutional education to establish and reinforce constructive life skills, healthy behaviour and attitudes are fulfilled in the process of health education in schools. Health education in schools has a lot of potential if it is well planned and organised.

Although there are many promising school health education projects in our country, they are typically implemented in isolation (*Járomi and Vitrai, 2017*). By identifying and then developing the necessary intervention areas, a practice-oriented and complex health education programme based on the results of diagnostic studies can be achieved that is able to achieve positive habit and behaviour change in students, leading to improved health outcomes, as supported by international research (*Busch et al., 2015; Waters et al., 2017; Shinde et al., 2018*). In Hungary, there have been several initiatives to increase the effectiveness of health education in schools and to improve the health status of pupils, but these have typically focused on one area of the complex system of health education activities (*Matóné, 2010; Csányi, 2011; Deutsch, 2012*) or on the health education programme of one institution in order to improve its effectiveness.

Thus, in the course of my doctoral research, I am developing an instrument for measuring and evaluating the pedagogical impact system (School Health Index - iEGI), which is not yet applied in Hungary and which is able to identify the pedagogical impact system, the health behaviour and health literacy characteristics of students along objective indicators, to analyse the correlations and to contribute to the planning and implementation of evidence-based interventions.

School Health Index

The significance of the new school health assessment framework is that it is consistent with the definition of the national laws and regulations in force and takes into account national initiatives, projects and strategies. By using the iEGI, a health education programme can be designed for a school, for the students in the school, identifying precisely the factors and areas that have a positive or negative impact on the health education process and the areas that need to be strengthened to bring about positive health change.

The School Health Index indicator framework measures the pedagogical impact of school health education through a student-centred approach across 5 modules. The 5 modules are:

- Physical Environment Indicator (PhEI);
- Personal Environment Indicator (PEI);
- Health Literacy indicator (HLI);
- Health Behaviour indicator (HBI);
- Subjective Health Status indicator (SHS).

The 5 modules are measured using a complex questionnaire, with groups of questions based on the 5 modules' indicator system. The calculation process of the iEGI value is done using the formula below, which determines the percentage of the results of each module and the Health Index of the school by module.

$$iEGI = \frac{PhEI + PEI + HLI + HBI + SHS}{5}$$

5

The School Health Index (iEGI) is calculated by dividing the sum of the relative frequencies of the positive responses of the 5 modules by 5. Each module contains a different number of questions (5 to 44), for which a percentage of positive scores is calculated depending on the type of question.

Categories of the iEGI Institutional Evaluation Model:

- 100-80% Excellent
- 79-60% Adequate
- 59-40% Needs improvement
- 39-20% Needs enhanced improvement
- 19-0% Inadequate

The Aim of the Research

My main research objective is to develop a framework for institutional evaluation that can identify and monitor the pedagogical impact of the health education system and the health behaviour and health literacy of students, analyse the correlations, design and implement evidence-based interventions based on data, using objective indicators.

In addition to the main objective, I will investigate the health education objectives, activities and methods of the schools participating in the research from a theoretical perspective, using deductive logic, in the light of the Health Education Programmes of the Pedagogical Programmes, examining both formal and content-related elements.

I also aim to gain an insight into the practice of health education, the perceptions of health held by heads of institutions and teachers responsible for health education, and their role in health education.

A further aim of my research is to explore the health literacy and health behaviour of Eger's secondary school students in terms of physical activity, eating habits, alcohol and drug consumption habits, smoking, sexual behaviour and peer abuse at school and online.

Research Questions and Hypotheses

For the Health Education Programmes (H₁) study, I formulate the following hypotheses:

- **H_{1a}:** The Health Education Programs of the institutions under study typically do not have a holistic understanding of health.
- **H_{1b}:** The Health Education Program typically presents the class teacher, biology and physical education teacher as the arena for health education, and the emphasis on the role of the class teacher, biology and physical education teacher.
- **H_{1c}:** The activities related to the prevention of harmful addictions are the most prominent in the Health Education Programmes.

For the interview-based study of heads of institutions and teachers (H₂), I formulate the following hypotheses:

- **H_{2a}:** I hypothesize that both the heads of the institutions and the teachers under study have a holistic understanding of health.
- **H_{2b}:** I hypothesize that the majority of the interviewed teachers believe that health education is taught in biology, physical education subject lessons and classroom lessons.
- **H_{2c}:** I assume that the majority of the interviewed teachers consider that the actors involved in the process of health education are, in addition to teachers, health professionals, parents and external organisations' lecturers and staff.

For the areas covered by the Institutional Evaluation Framework (iEGI), I formulate the following research questions:

Q₁: What are the strengths and areas for improvement in each school:

- **Q_{1a}:** based on perceptions of personal environmental conditions influencing the impact of health education (PEI)?
- **Q_{1b}:** based on the perception of the physical environmental conditions that influence the effectiveness of health education (PhEI)?
- **Q_{1c}:** based on the indicator of pupils' health literacy (HLI)?
- **Q_{1d}:** based on an indicator of pupils' health behaviour (HBI)?
- **Q_{1e}:** based on the subjective health status of pupils (SHS)?
- **Q_{1f}:** in the light of the School Health Index (iEGI)?

Methods

Sample

The population of the study was defined in the full-time high schools of Eger, which consisted of five institutions. Each of the 5 institutions (G1, G2, G3, G4 and G5) responded positively to the survey, thus the entire defined population was included in the sample.

Teacher sample

For the heads of the institutions, the entire population, i.e. the heads of all five institutions, were included in the sample, while for the teachers, an expert sampling procedure was used, taking into account the teacher's key role and responsibilities in the process of health education in schools. Based on this, 2 to 2 teachers per school were included in the sample, resulting in a sample of N = 15 teachers.

Student sample

Due to the nature of the research and the limitations imposed by the coronavirus epidemic, the sample of students (N = 747) was selected using an expert sampling procedure. The expert criteria for inclusion in the sample were that the student was in at least his/her second year of schooling and that the student had completed the school year prior to the survey in a non-digital curriculum. These criteria were taken into account in the survey of pupils in grade 11 and 12 in the schools.

Sample Characteristics

53.4% of the teachers surveyed were male (8) and 46.6% (7) female, with an average age of 46.93 years \pm 8.47. 60% of the heads of the institutions were male and 40% female, with an average age of 51.4 years \pm 5.41. The average age of the teachers interviewed who teach in schools is 44.7 years \pm 9.01. 60% of the respondents are physical education teachers, and there are also teachers of mathematics, physics, computer science, history, biology and geography. 39% of the student sample are boys and 61% are girls. The average age of the pupils surveyed is 17.22 years (\pm 0.87). 34% of the pupils live in a county town, 16% in a city and half (50%) in a village or commune. By grade, 56% of the pupils surveyed were in grade 11 and 44% in grade 12.

Methods

The method of documentary analysis was used to analyse the Health Education Programmes. I used structured individual interviews with the heads of the institutions and teachers, using the method of oral interviews, which included questions relevant to the purpose of the research, such as the characteristics of the interviewees' school, the process, participants, settings, content, starting point, and objectives of health education in schools, as well as the model and less model health behaviour of the school's teaching staff.

To investigate the pedagogical impact of health education in schools, I designed a complex student questionnaire, taking into account that each module should contain at least 5 questions and validated sets of questions for comparability. On this basis, the iEGI questionnaire contained 128 typically closed questions. When completing the questionnaire, students were given the choice of a simple response, a 5-point Likert scale and short answer type response options.

Answers of the Dissertation

- Hypothesis **H_{1a}** was confirmed, as only two schools had a holistic understanding of health based on the Health Education Programme documents, which included physical, mental, social and emotional dimensions, but two other schools had a definition of health in the Programme in its physical and mental dimensions, and one school had no readable definition or understanding of health at all. Thus, overall, a non-holistic understanding of health predominates.
- Hypothesis **H_{1b}** is rejected, it is not confirmed, as Health Education Programmes typically mention all subject lessons and the emphasis on the role of all teachers. School G2 does not mention lessons and actors in the process of health education, however, schools G1, G3, G4 and G5 all mention the tasks and opportunities of other subjects in addition to the lessons of class teacher, biology and physical education, and the four schools' Programmes describe health education as the responsibility of all teachers in the school.
- Hypothesis **H_{1c}** was confirmed, as the topic of prevention of harmful addictions was the most prominent in the five schools studied, in G3, G4 and G5, but was also developed in detail in the document of school G2, only in school G1 the topic was not mentioned. In addition to the topic of harmful addictions, health education is also typically emphasised in the programmes of schools G3, G4 and G5, and is also mentioned in school G1.
- Hypothesis **H_{2a}** was partially confirmed, based on the interview responses of 15 teachers, it can be concluded that health is typically mentioned as physical and mental harmony, but that the heads of G1 and G5 schools described health in a holistic sense, as did the teachers interviewed in G1 and G2 schools. It can be said that in schools G3 and G4, physical and mental health was mentioned exclusively by all teachers interviewed.
- Hypothesis **H_{2b}** was confirmed, as 8 out of the 15 teachers interviewed answered that the focus of health education in schools was biology, physical education and classroom lessons. Looking at the school heads, we see that the opposite is typically the case, with G1, G3 and G4 headteachers identifying health education as the responsibility of all lessons, G2 school headteachers mentioning class teacher lessons, and G5 school headteachers identifying the biology-physical education-class teacher triad as the arena for health education. In the case of G3, it can be said that there is unanimity, both the

school management and the teachers, that it is necessary to address the process of health education in all lessons.

- The hypothesis **H_{2c}** was confirmed, that the majority of the teachers interviewed believe that the process of health education in schools is not only a process involving teachers, but also parents, school health workers and external organisations, invited speakers. In the responses of teachers in school G1, the family was represented, in schools G1, G3 and G4, external organisations, and in school G2, the participation of health professionals and non-teaching school staff in addition to teachers.

Conclusions - Theses

(1) Following the analysis of the Health Education Programmes, I conclude that for the schools studied:

- the understanding of health is typically not holistic,
- the documents do not include opportunities for extra-curricular health education programmes and activities,
- the programmes do not contain any specific information on health education in the curricula, nor do they include extra-curricular activities, nor do they include any specific information on health education in the curricula,
- the role of health professionals is emphasised in the document, as they are involved in health education in collaboration with teachers, as they are involved as presenters, facilitators, assistants in health assessments and in the planning of programmes,
- as described above, no data from screening and diagnostic assessments are made available to school staff and teachers, and are therefore not used in the design of the health education programme,
- the most prominent theme is the prevention of harmful addictions.

(2) Based on the results of the interviews with the head of the institution and teachers, I conclude that:

- according to teachers, health is a complex concept with several dimensions,
- health education in schools is focused on biology, physical education and classroom lessons,
- the actors in the process of health education in schools are not only teachers, but also parents, school health workers and external organisations, invited speakers,
- the health service is continuously involved in the planning and implementation of the health education programme, based on the specificities of the school and statistical data.

(3) Based on the theoretical basis of the Health Education Programmes and the responses of the heads of institutions and teachers on school practice, I conclude that there is not always a match:

- there is only partial correspondence between the understanding of health in the Health Education Programmes and the perception of health by the teachers interviewed;
- the results on duration and stage in the Health Education Programmes and in the interviews with teachers are typically the same;
- comparing the analysis of the results, I find that there is only a small degree of similarity between the actors in the Health Education Programmes and in the interviews with teachers, such as parents, health services, non-teaching staff;
- when comparing the diagnostic assessments and evaluations defined in the schools' Health Education Programmes with the content design baselines in the teachers' responses, there was a match between the results of the documentary analyses and the interviews in all schools.

(4) The main thrust of the research was the development of an institutional evaluation framework (iEGI). By using the School Health Index, the strengths and areas for improvement of schools can be identified, so that a health education programme tailored to the students of the school can be designed and progress can be monitored:

- the School Health Index measures the pedagogical impact of health education in schools through five modules and assesses it through five categories (excellent, adequate, needs improvement, needs enhanced improvement and inadequate);

- for four schools (G1, G2, G3 and G5), the School Health Index is in the adequate category, but for development purposes, the results of the indicators for each module, such as physical and personal environment, health behaviour, health literacy and subjective health, need to be examined and interpreted separately;
- in terms of institutional comparisons, the health education programme and pedagogical approach of school G3 is the most appropriate among the schools studied, taking into account both the analysis of its Health Education Programme, the interviews with teachers and the evaluation of its pupils.

The results of the research show that the School Health Index model is able to adequately measure and evaluate each of the components that make up the field of health education in schools, thus ensuring traceability and comparability.

Further work is expected following the development of the iEGI institutional assessment framework. The further significance of the research and the model is that it will be embedded in practice, with schools using the measurement-evaluation and planning tool to improve the effectiveness of health education.

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