Health Education is an attempt to combine traditional and scientific medicine, especially preventative medicine, with the techniques of communication, born out of the greater social understanding of the needs of the community. Despite the advancement of education as a science, many teachers believe that the teaching of public health principles to school children to be impractical administratively, although the staff of many colleges of education strongly endorse these ideas. Two aspects of health and physical education exist.

a. The direct contribution that physical education in schools can make to the fitness of the future population as a whole.

b. The opportunities that are available during the various activities undertaken, for the teacher to give an understanding of those hygienic habits and practices which are more traditionally associated with health education in schools. If the purpose of school is to teach children about life, the teaching must include guidance on the maintenance of both personal and community health. This is supported by the 1964 report of the Joint Health Services Committee.

In the United States of America, much practical work has been done with a view to discovering the most effective way of presenting health education, and in some states it is a compulsory school subject, but to be effective, must be relevant to the children's immediate environment. In Britain, theoretical consideration has been given to this problem but it appears that the link between theory and the somewhat sporadic health education teaching practised has not yet been forged. Perhaps it is only in physical education that attention is paid to the promotion of health through physical activity, that might be carried on into adult life. It is difficult to evaluate objectively the effects of physical education on the health of today's children, or in fact to measure fitness, apart from noting the incidence of disease and deformity. At routine medical examination, few children are classified as being in an unsatisfactory condition. In Worcestershire in 1965 only 15 out of 16,500 children examined, less than 0.1% were so classified. It is felt that a more useful category could be developed for giving a more realistic estimate of improvement or deterioration for the less serious defects.

With increased automation, recreational sport and exercise may be the only physical activity indulged in, and to halt the present trend of deaths from cardiac diseases the schools must develop the need and desire for exercise in every child, in a form that shall be carried into adult life. Some children have the natural build and aptitude for sport, respond well to teaching, and continue their chosen activity afterwards. For the remainder, without special sporting interests, teaching and motivation are needed, unless sport is to take a low priority in adult life, compared with non-active recreations. Although success in school sport gives the athlete self-confidence, the clumsy boy, and late developer may experience rejection and failure that make his emotional problems more severe. For the less gifted, it is essential
to design activities to suit their physical limitations, and allow them to achieve success. There are two problems to be overcome to achieve this: a. The administration needed to provide a wide variety of sports for younger children, and b. the traditional British attitude of encouraging a good loser, which holds good as long as one does not lose all the time. The use of sport is an important part of the therapy of the physically and mentally handicapped, and in a school can help to solve some emotional problems rather than cause them. In a school with a good sporting reputation there is sometimes a tendency to concentrate upon potential winners, which may be to the detriment of others. It is the responsibility of the physical education teacher to prevent this, whilst emphasising the advantages of physical fitness for its own sake, and the satisfaction obtained, even only in retrospect, by achieving some degree of success.

In both sexes there is a desire for a good physique, reinforced by the popular images from advertisers and by society's culture. Those of a physique below this image may experience inferiority and insecurity, and whilst not advocating activities designed to increase sex appeal, these desires and fears should be borne in mind.

Related to these aesthetic considerations is the high incidence of minor degrees of bad posture sometimes noted by examining school medical officers, although much might be done by physical education teachers to encourage and explain, to help these children. In the limited time available, priorities have to be settled, and a correct allocation of P.E. time made both for theoretical teaching and for practical work. Discussions preceeding practical work may be received badly, and they are probably best confined to the end of the lesson, even in the changing room, when a more relaxed and informal atmosphere prevails.

Several methods have been attempted to integrate health education into the rest of the school curriculum. As well as demonstrating poise and posture, the anatomical and physiological changes of adolescence might be discussed, together with the way they might effect athletic activities. Rapid growth of limbs might produce clumsiness; an understanding of various physiques might lead to sympathy with an endomorph's poor performance, or to an ectomorph becoming less withdrawn. Exercise, fatigue, diet and rest can be related to training methods, and precautions against preventable injury can be evolved. One particular topic lamentably absent from so many school programmes is elementary instruction in first aid, so essential in the home as well as the street or the games field. The physical education teacher should be able to fill an important need in the teaching of this subject. The development of leadership through sport may help many children to overcome antisocial behaviour.

A number of hygiene topics can also be considered during discussions—deficiencies of bodily or clothing cleanliness and the value of showers. It is essential that the relationship exists between child and teacher so that such problems can be discussed freely. Even today, several children every year are still needing disinestation, especially in junior schools. Fungus infections, associated with communal living, occur sporadically, and talks given on the spot, in the changing room or gymnasium, can be most useful.
Many more discussion topics might be introduced, but it is a guiding principle not to force health education considerations into all aspects of life, but to explain the reasons behind conventional routines and behaviour patterns. In the teaching of swimming, the coach will emphasise the necessity for correct strokes, style and speed, but the health educator the prime consideration should be survival and life saving.

Health education and physical education are closely allied. From a public health point of view, it is vital that the criteria for teaching physical education should include its continuance after children have left school, to contribute to the physical and emotional health of the population. Every child should be involved in some sport or activity, in which he can achieve some success, and the example set by his teacher can be a great help in achieving this. Explanation of the theories behind physical activity should help to show its significance to those who have no strong natural desire for exercise. The majority of personal aesthetic attributes are applicable to the gymnasium or games field, and deficiencies can be brought to light there. In fact the sports teams are almost microcosms of society, and the valuable lessons learnt there of selfconfidence, reliability and social relationships will well be utilised when the child enters the adult world.

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