

SECONDARY SCHOOL STUDENTS ATTITUDE TOWARDS HEALTH EDUCATION IN AKWA IBOM STATE

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Abstract

The study was carried out on Secondary School Students attitude towards health education in Akwa Ibom State. A total of 1049 (48%) males and 1051 (51%) female respectively JSSI to SS III from eight rural JSS and eight rural SSS Schools in Uyo Education zone. The survey instrument used in the study was the Edington (1968) instrument to measure the attitude of high school freshmen boys toward health education which was adopted. Data were analyzed using cross tab and analysis of variance (ANOVA) techniques. The level of significance was determined at 0.5 level. The findings showed that overall student felt that fitness, skill and domain are the most important aspects of the health education curriculum than the effective and cognitive aspects. Conclusion were draw.

Introduction

Early adolescence is a time of change. Between the ages 10-19 years, youths experience the profound physical, mental and social changes that occur during puberty. Their bodies mature, their mental abilities expand, and their relationships with their families and friends change all of which may have health implications. Many lifestyle behaviours that affect health are initiated or shaped in early adolescence. Health education can help guide youths through these critical years of experimentation and increasing independence, and help them to become health individuals who realize their full potentials.

Educators must recognize that for many, early adolescence may be the last opportunity for primary prevention. As age of initiation of risky health behaviour becomes younger and younger, it is critical to provide the young adolescents with health education that address current and critical health issues. Health education must include innovation and age appropriate strategies for helping young adolescents from health-promoting attitudes, locate and use credible health information and practice skills and behaviours to minimize risks and make healthy choices. Health education is offered in our schools with the rationale that instruction will alter health-related behaviour. Evidence that school health education alters behaviours is rare, although entirely absent (health 1998) Few schools evaluate their programmes on the basis of behaviour change. Most rely on traditional knowledge shape health attitudes, which then determine health behaviour, has been challenged in research. While health education increases knowledge (Rabinowitz & Zimmerli, 2001), it does not assure behaviour change (Stone, 2000, Alaga, Lail & Asato, 2002) knowledge does not necessarily change attitudes, nor are attitudes always consistent with behaviour (Prue, Wynder, Scharf, & Resnicow, 1887). Knowledge may change attitudes in a number of directions not all of which favour health behaviour change in the desired direction (Bruvold & Rundal, 2005). Knowledge increased therefore provide no assurance that desired change in attitude and behaviour have occurred. The body of research in this area is clear that increase knowledge, improved self-esteem and positive values and attitudes do not translate into prevention of risk behaviours.

A study carried out reporting the attitudes of Junior Secondary School Students from a rural public utilizing the Kenyon Attitudes scale towards health activity inventory (Atiatah, 2004), revealed differences in only one of the six domains in the inventory. The non-delinquent students scored significantly higher than the delinquent students on the social scale indicating that the non-delinquent students valued health activity as a social experience or in other words, an opportunity to interact with others. However, further analysis showed that the overall attitudes of the students were significantly different. It was found that the attitudes of the students from the rural schools, differed significantly from the students in the urban schools and the attitude from the student in the urban schools differed significantly from the students who were institutionalized as delinquent.

Most recently, (Asian 2006), studied the attitude of parents, teachers and secondary school students in Mbo Local Government Area, Nigeria. His findings indicated that the total sample suggested that the value of health education was for its contribution to personal health and physical fitness and the development of social skills. Group differences revealed that females and parents were not in favour of aggression, pain or danger as being included in the activities and male and female students were predisposed to health education providing opportunities to achieve high levels of skill acquisition.

Given the lack of enough research on the attitudes of secondary school students and given the importance of determining how secondary schools students perceive health education it was the purpose of this study to investigate

the attitudes (based on these five domains) of secondary school students in Uyo Education Zone of Akwa Ibom State, Nigeria.

Methods

Respondents

Subjects in this study were 1049 (49%) males and 1,081 (53%) females representing Junior Secondary School 1 (JSS1) to Senior Secondary School 3 (SSS III) from the eight rural JSS and eight rural SSS Schools in Uyo Education Zone. Classification according to class level indicated 50% of the respondents were in Senior Secondary Schools. All individuals who were enrolled in health education and in attendance the day the survey was administered in these sixteen schools were represented in the study.

Instrumentation and Analysis

The survey instrument used in the study was the Edgington (1968), instrument to measure the attitude of high school freshmen boys towards health education. The adopted 66-item instrument consists of 32 positive statements and 34 negative statements about health education and represents statement in the general domains of fitness development, skill development, cognitive development, affective development and social development. The Likert technique was used with modification. The neutral choice was eliminated to force subjects to make a positive or negative decision. The choices were Strongly Agree, Agree, Disagree, Strongly Disagree. The reliability of the final form was 0.82 to ascertain content validity: the questionnaire was reviewed by three health educators in the zone, all of whom reported that it was appropriate.

Additionally, a reading teacher in the schools zone reviewed the questionnaire to assess the reading level appropriateness. Construct validity was determined by administering the questionnaire to 46 (male n = 23, and female n = 23) JSSI students in the school zone under study who had been identified by their teachers as students who consistently exhibited positive behaviour towards health education and to 46 (male n = 23, female n = 23) JSSI students in the school zone under study who had been identified by their teachers as students who consistently exhibited positive behaviour towards health education and to 46 (male n = 23, female n = 23) students who did not consistently exhibit positive behaviour towards health education. Analysis of each domain revealed significant differences ($p < .05$), thus, suggesting the instrument was valid.

The investigators met with a representative from the education zone to discuss procedures for completing the questionnaire. The representatives, in turn, met with all the health educators who would be administering the questionnaire in their respective classes and instructed them on the procedures. On a designated day the questionnaire was administered to all students enrolled in health education. Those students not willing to participate in the study not complete a questionnaire.

Analysis

Answer sheets were scored and all useable answer sheets were retained for analysis. Statements were recorded, so that positive responses to the negative statement would be reflected. If a respondent was favourably disposed towards an item, the score would be closer to four and if a respondent was not favourably disposed the score would be closer to one. Data were analyzed using cross tab and analysis of variance (ANOVA) techniques. To examine the attitudes by class level and gender, 2x2 (class level x gender) ANOVA was employed. Separate analysis were utilized for each of the five domains (fitness, skill, cognitive, affective and social) A Newman-Keuls test was used for post-hoc mean comparison. The level of significance was determined at .05 alpha level.

Results

Table 1
Number of respondents by Gender and Class level n = 2.130

Gender	Class						Total
	JSSI	JSS2	SS3	SSI	SS2	SS3	
Male	264	247	158	162	134	73	1049
	46%	51%	43%	48%	58%	60%	49%
Female	306	241	207	177	97	49	1081
	54%	49%	57%	52%	42%	42%	51%

Grand Total 570 488 365 339 231 122 2130

Table 1, indicates the number and percentage of respondents represented at the various class levels in the study. It was observed that, there were a decreasing number of respondents over class levels from 570 representing JSSI to 122 representing SSS3. Representation by JSSI, and JSS2 and through SSS3 was nearly equal with 1058 and 1072 respectively. Male and Female representation by class ranged from 40% female and 60% male in SSS3 to 49% female and 51% male in JSSI. JSS males accounted for 48% of the respondents, JSS females 52%, SSS males 49% and SSS females 51%. Overall female represented 51% of the respondents and males represented 48%. Respondents were grouped into JSS (in- 1058) and SSS (n- 1,072).

Table2:
Means and Standard Deviations by Domains, Class level, and Gender

Domains		Class		Level		Overall
		JSS	Girls	Boys	SSS	
Fitness	2.95	2.92	2.87	2.92		
	(.39)*	(.40)*	(.39)*	(.41)*	(.40)*	
Skill	2.92	2.89	2.82	2.86	2.87	
	(.37)*	(.40)*	(.36)*	(.38)*	(.38)*	
Cognitive	2.71	2.64	2.60	2.59	2.63	
	(.36)*	(.36)*	(.35)*	(.37)*	(.36)*	
Affective	2.72	2.63	2.72	2.57	2.66	
	(.41)*	(.48)*	(.43)*	(.51)*	(.46)*	
Social	2.95	2.94	2.79	2.92	2.90	
	(.38)*	(.39)*	(.38)*	(.38)*	(.39)*	

• Deviations.

Table 2, shows an analysis of overall respondents and by domain (fitness, skill, cognitive, affective). It indicated that respondents perceived that the primary purpose of health education was the fitness domain (M= 2.92, SD = .40), followed by social (M= 2.90, SD = .39), Skill (M= 2.87, SD = .38), Affective (M = 2.66, SD = .46), and Cognitive (M = 2.63, SD = .36 domains). Further analysis by class and gender using rank ordering of the means revealed the SSS boys ranked fitness as the number one priority of health education. JSS boys and SSS girls also valued fitness domain as number one, but not more than the social domain as these domains had the same means (M=2.92 and M= 2.92, respectively for JSS boys and SSS girls). Girls however, felt that the social domain was the most important.

In order, from most important to least important, JSS boys reported the domains of fitness and social as equally important, followed by skill, affective and cognitive domains. Although not favourably disposed, SSS girls had rank ordering similar to the JSS skill, cognitive and affective domains.

JSS girls on the other hand, valued the social domain most, followed by fitness, skill cognitive and affective domains. SSS boys valued, in descending order, fitness, skill, social, affective and cognitive. Rank ordering as determined by group means, class and gender showed some similarities. Boys and girls at both the JSS and class levels ranked fitness, skill and social domains as the most important three domains in health education. Although the order was not identical for all four groups, it can be said that boys and girls in this study value fitness, skill and social domains more than the cognitive and affective domains. Concerning the affective domains boys at both class levels ranked the affective domain higher than the cognitive domain, whereas girls at both class levels ranked the cognitive domain higher than the affective domain.

Table 3 ANOVA-Class by Gender of Students Attitudes

Domains	Class		Gender		Interaction	
	F	P	F	P	F	P
Fitness	3.301	.069	1.084	.298	6.422	.01
Skill	17.261	.000	.115	.735	3.883	.049
Cognitive	24.226	.000	5.823	.016	4.888	.027
Affective	2.663	.103	38.091	.000	2.37	.124
Social	26.852	.000	10.499	.001	17.663	.000

df=2,2119

Table 3, shows a better understanding of the attitude of boys and girls in the two class levels and to determine if significant differences existed, a 2x2 ANOVA (class x gender) was performed on each of the five domains and a Newman -Keuls test was performed to determine mean differences and if a significant interaction existed. Results of the 2x2 ANOVA for the fitness domain indicated there was no main effect for class or gender, but a class x gender interaction was present. Since interactions precede over main effects, a Newman Keuls test was conducted.

**Table 4
Newman-Keuls Analysis of Class X Gender and Interaction**

Domain	Class and Gender			
Fitness	SSSB	JSSG	SSSG	JSSB.
	2.87	2.92**	2.93**	2.95**
Skill	SSSB	SSSG	JSSG	JSSB
	2.82**	2.86**	2.89**	2.92**
Cognitive	SSSG	SSSB	JSSG	JSSB
	2.59**	2.60**	2.64**	2.71
Affective	SSSG	JSSG	SSSB	JSSB
	2.57	2.63	2.72**	2.72**
Social	SSSB	SSSG	JSSG	JSSB
	2.79	2.92**	2.94**	2.95**
#*	Statistically Similar Junior			
JSSB	Secondary School Boys Junior			
JSSG	Secondary School Girls Senior			
SSSB	Secondary School Boys Senior			
SSSG	Secondary School Boys			
<i>P</i> < .05				

Table 4, revealed that SSS boys attitude was significantly poorer than other groups. JSS boys and girls and SSS girls attitudes towards fitness was statistically similar. In the skill domain, ANOVA analysis showed a significant main effect for class and a significant class x gender interaction. Newman-Keuls analysis revealed that SSS boys attitude toward the skill domain was significantly different from JSS boys and girls, but similar to SSS girls. However, the attitude of JSS girls and SSS girls towards the skill domains was statistically similar as was the attitude of JSS girls and boys. As in fitness domain, SS boys had the poorest attitude (M= 2.82 of the four groups).

As noted in Table 3, there were main effects for class and gender in the cognitive domain. However, post-hoc analysis revealed that only JSS boys (M~ 2.71) were significantly different from other groups. Apparently the high attitude of JSS boys was responsible for the significant class main effect. SSS girls reported the poorest attitude in this domain (MK2.59), but it was not statistically different from SSS boys (MK2.60) or JSS girls.

The affective domain, showed a main effect for gender only (see table 3) with a significant interaction. SSS and JSS girls attitude was significantly poorer than the JSS and SSS boys attitude as SSS girls attitude (M= 2.57) was significantly poorer than JSS girls (M= 2.63).

The last domain, the social domain, was similar to the cognitive domain by yielding main effects for class and gender as well as an interaction effect (see table 3), Newman-Keuls analysis revealed the same pattern as the fitness domain, with only the SSS boys significantly different from the other three groups. Once again, the SSS boys reported the poorest attitude (M= 2.79) among the four groups, whereas the JSS boys reported the most positive attitude (M = 2.95) among the four groups.

With regard to specific statements in the survey, there were several which yielded interesting responses. When asked the importance of health education to the respondents, 51% of the respondents either strongly agreed or agreed that it was as important as other subjects. An analysis by class level indicated a slightly more favourable position by JSS respondents than JSS respondents (58% and 44% respectively agreeing). When asked whether health education should be retained in the curriculum, across all respondents, 82% felt it should be part of the curriculum. JSS and SSS

respondents were evenly split concerning the statement, with (42% of the respondents responding that health education should be required at every class level. However, of those who agreed, the SSS respondents responded more favourably than did the JSS respondents. With regard to whether scores should be given in health education, 56%^h of subjects were in favour of assigning scores. The JSS students seemed to favour scores more than the SSS students (2% and 48% respectively). When asked whether written test should be given in health education, 84% of the respondents agreed, with JSS respondents and SSS respondents evenly split at 50%.

Discussion

The study showed that overall, students felt the fitness, skill and social domain's are the important aspects of health education curriculum. This finding is consistent with Stewart and Greens & Huelskamp (1997) and Britchards (1988), studies of parents of school aged children, who also shared this attitudes. Findings of those two studies as well as this one suggest that fitness, and skill aspects are held by the individuals studies to be more important than the affective and cognitive approaches in teaching health education. However, these results are not surprising given the traditional focus of fitness, skill and social objectives in our health education curricula.

With regard to the mean scores by domain it would appear that those JSS and SSS students were favourably disposed to health education. However, there were not as favourably disposed as some parent respondents who were studies in an earlier survey (Stewart & Green 1997), utilized the same questionnaire instrument. It could be that the additional exposure to health education activities that these subjects could become as favourably disposed as the adult respondents studies could develop overtime, particularly among boys. As noted in the results of this study, SSS boys attitude was significantly poorer than JSS boys attitude in all domains except the affective domain.

Additionally, JSS boys had the highest mean for all five domains among the four groups, whereas SSS boys had the lowest mean amongst the four groups for three of the five domains beyond the scope. It is interesting to note that girls in this study seem to realize the importance of the fitness, skill and social domains, but do not value health education, as determined by their attitude of the affective domain. In other word, cerebrally, girls know the value of health education, but do not like t, it could very be that, the activities that these schools choose to accomplish the objectives are appealing to girls. Boys in this study, on the other hand, seem to like their health education significantly more than girls but their attitude toward the value of health education significantly decreases with age. Boys in this study apparently find the activities in the health education programme fun, but do not necessarily feel that they contribute to the objective of fitness, skill, cognitive and social domain as other females counterparts.

With respect to the social domain JSS boys and girls as well SS girls had a significantly more positive attitude than the SSS boys. Slruab and Felock (1994), found Junior high school girls in their study to be predisposed to this domain also. Child development literature indicates that the Junior high school years are characterized by the social domain among peers and it could very well be that health education, by its interactive nature, is providing an avenue for that social interaction.

Conclusion

In some respects, the results of this study are encouraging in the light of the fact the generally speaking all groups are favourably disposed toward health education. Given that those JSS respondents will one day be making decision in their respective communities concerning the position of health education in the curriculum, the results are positive as indicated by 82% if them reporting health education should be part if the JSS and SSS curriculum. This finding is consistent with the finding of Pritchard (1988), who found over 80% of the population,, he investigated agreeing that health education should always be a part of the curriculum. It is clear the parents (Steqarits & Green 1997); Pritchard, 1998), College students (Mowatt, De Pauwn, and Hulac 2000), as well as students in this study were favuourably disposed towards health education and believe it should be a part of the curriculum. However, as resources and priorities change as a result of governmental and societal pressures, it is not clear if support for the inclusion of health education in the curriculum will remain high enough to withstand the pressures of other subject area interest groups. It is important that future studies focus not only on the importance of health education as a subject matter, but rather, its relative importance as it relates to other subject areas within the school curriculum.

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