

EFFECTS ON HIGHER EDUCATION AND HEALTH

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ABSTRACT:

Health education builds student's knowledge, skills, and positive attitudes about health. Health education teaches about physical, mental, emotional and social health. It motivates students to improve and maintain their health, prevent disease, and reduce risky behaviours. Health education curricula and instruction help students to learn skills so that they will use to make healthy choices throughout their lifetime. Health education is vital for students as it builds their knowledge and attitudes about health. Health education does not only concentrate on being healthy. It also focuses on emotional, mental and social health too. Educating students on the importance of health builds their motivation. As a result, they strive to maintain good health, prevent diseases and avoid risky behaviour. Instilling the importance of good health in schools, helps students to make healthy life choices when they grow older and continue doing so throughout their lives. It helps them understand the dangers of using illicit drugs, smoking and drinking alcohol. It helps prevent various injuries, diseases, such as, obesity and diabetes, and sexually transmitted diseases.

KEY WORDS: Health Literacy, Beliefs about Health and Health Care

INTRODUCTION:

Present day higher education is largely academic. Realistically, this orientation needs to be changed for a balanced development through inculcating health conscious amongst students. This includes the development at physical, mental and social levels. With the increasing emphasis on academics in the World of employment and elsewhere and the rapid advances in science and technology all over the World, parental pressure has been driving academic training at the cost of health and physical fitness of the youth .It is in this context that there is now an urgency to lay a strong foundation and strengthen physical in higher education and sports programmes in the higher education institutions. This calls for the integration of physical education, sports, yoga and recreation activities in the higher education system for the overall good of the younger generation.

Health in higher education is important to teach to higher education students awareness about living a healthy lifestyle. Health education encompasses social, mental, physical and social health. Health education teaches people of all ages about how diet and exercise contribute to a healthy lifestyle. It also encourages positive changes in behaviour and lowers the risk of addiction to drugs, alcohol and unsafe sexual practices. The majority of schools around the country have courses aimed at teaching health education to students. These courses often revolve around the body, healthy eating, sex and exercising. Some students are taught basic health and physical fitness early on. More in-depth courses are designed for middle and high school students. Many are the blessings of imparting health education. Health education enables a person to remain physically fit and in proper health. A healthy person can enjoy life fully. He can carry out his duties in a responsible manner. He is an asset to the family, the society and to the entire nation. He is always full of energy. He lives a long and happy life. A healthy peasant is happier than a monarch without health. Health education encourages a person to make healthy choices. They are instructed to avoid unhealthy habits. 'A sound mind lives in a sound body'. Rabindranath Tagore and C.V. Raman, if they were confined to sick bed, could not have won the Nobel Prize. In fact, a sickly student with all his talents and abilities lags behind in the race of life. Health education also teaches about the emotional and mental health of the student. A healthy person is the happiest person in the world.

OBJECTIVES OF THE PAPER

1. To study the Health literacy in higher Education
2. To know the beliefs about health and health care in higher Education.

METHODOLOGY:

The methodology in Social science research collected the secondary data; the secondary data were also collected from the Govt. publications. Monthly journals on effects on higher education and health wherever, necessary reference have also made in different issues of bulletins of effects on higher education and health part from this Different edition of daily news papers, such as Hindu. Vijay Karnataka, Indian express, Kannada Prabha, Praja Vani etc. used for the purpose of secondary Data collection for Effects on higher education and health

HEALTH LITERACY IN HIGHER EDUCATION:

The significance of the global health risk factors has led to a major emphasis in public health policy on education interventions. This role for education has traditionally focused on providing information and skills to help people make choices and/or changes that will promote individual and societal health and well-being. Contemporary health education had three main aims: to reduce morbidity and mortality through changing the behaviour and beliefs of individuals; to foster the appropriate use of health services; and to create general awareness of health issues. Policy makers have historically designed specific health promotion programmes that, through health education, put the onus on individuals to change behaviours that lead to ill health. However, this approach implies equality of choice among populations, and a direct relationship between the acquisition of information and rational decision making. It also fails to take into account the socio-political context in which individual health resides and the unequal distribution of constraints on behaviour Health promotion has shifted toward addressing the contextual and social as well as the behavioural determinants of health. Health policy, thus became concerned with creating supportive contexts that make “the healthy choice the easy choice”. As such, pervading all policy is the ultimate goal of reducing inequities, furthering human rights and building social capital – an approach which addresses the social determinants of health. Health education has also moved toward the adoption of a “life-skills” approach

through raising consciousness about factors that influence health and increasing the ability for individuals to make informed choices through fostering empowerment. These models of health education aim to encourage personal growth through enhancing awareness, self-esteem and self-assertion.. The movement toward life skills encourages health literacy; a shift away from the simple transfer of information, toward the development of self-esteem and confidence that allow individuals to make educated choices about their health and seek out more information if necessary. used on the effects of measures either of the number of years of schooling or on the educational level reached. There are fundamental distinctions between these constructs that it is important to highlight and it is also important to emphasise that each is distinct from an important, broad third category, namely the quality of learning. A particular concern in relation to the use of the number of years of schooling as a measure of educational participation is that it takes no account of the quality of that schooling or of the extent to which learning or other important features of development occurred. It is a useful proxy measure of progression within the school system and all else being equal one may assume that if educational experience is a good thing then more of such experience is better than less. However, the quantity proxy conflates individual progression with learning and gives no guide as to the features of the learning experience in educational settings that are important for outcomes such as health. Thus while qualifications attained can be thought of as an output measure of learning, the quantity measure that is commonly used to proxy for educational outputs is really just a measure of the duration of experience of inputs. As a measure, qualifications attained tends to be highly correlated with the length of participation in that it is generally necessary to attain entry level qualifications to proceed to the next stage of learning and those with greater quantity of education (years of schooling) will therefore also tend to have higher levels of qualification. Thus it is difficult to tease out the separate effects of participation and qualification, although consideration of effects for those who fail to qualify at the end of a learning experience can give some guide to the difference in effect of duration and qualification.

BELIEFS ABOUT HEALTH AND HEALTH CARE IN HIGHER EDUCATION:

Preceding any action are notions about the significance of that action. These notions or beliefs determine whether or in which form action is taken. In terms of health and health care, beliefs are important because they drive behaviours that have implications for health outcomes.

This relationship is illustrated in the Health Belief Model. This model suggests that individuals will take action to protect themselves from disease and injury if a particular set of beliefs is in place about their position with respect to a condition. Components of the model include perceived personal susceptibility to an illness or ill-health condition, an understanding of the severity of a given illness, a position on the benefits of a course of action and a calculation of the barriers versus advantages of any health-related behaviour. Perceived susceptibility is the subjective measure of risk to contracting a health condition. It is an individual's understanding of a diagnosis or the probability of him/her becoming ill. For example, before attending a screening for breast cancer, a woman must believe that she is vulnerable to the disease. In addition to perception of vulnerability or risk, an individual's opinion of the consequences of becoming ill or leaving an illness untreated also partly determines his/her decision to take action. Using the example of breast cancer screening, a woman's perception of the extent to which developing breast cancer will be physically or socially debilitating will influence whether she will attend screening. Additionally a sense of the benefits of a suggested action is important for health behaviours. A woman's belief in the efficacy of breast cancer screening in reducing susceptibility and severity or perceived threat of breast cancer is implicated in her attendance. An understanding of the negative aspects of any potential action also weighs upon the likelihood of engaging in health behaviour. According to this approach, largely unconscious calculation of the relative cost in time, energy, money, or psychosocial costs, such as embarrassment or distress, precedes any action. A consideration of the benefits of learning about breast health may or may not be seen as advantageous depending upon the potential financial or social implications of attending screening. It is additionally theorised that cues to action and self-efficacy impact upon decisions to engage in health behaviours. The Health Belief Model suggests that an instigator, such as awareness provoked by learning new information through, for example, a media campaign for breast cancer screening or a bodily event, such as the detection of a lump in the breast, serves as a cue to action. Self-efficacy is more important for a change in lifestyle or behavioural factors than for one-time actions, such as attending screenings, as adjustments in behaviour changes require further confidence in one's ability to change, for example in the cases of smoking behaviour and exercise. The Health Belief Model is useful for identifying the beliefs or ideas that come before a change in health behaviours. However, an understanding of the source of beliefs is also necessary to determine locations for intervention. An individual's beliefs

or perceptions are shaped and influenced by an assortment of demographic (age, ethnicity, gender), socio-psychological and structural (socioeconomic status, education) variables, some of which can be modified through intervention. Evidence for the potential for prior beliefs about health to influence decisions about behaviour is found in a qualitative study using focus groups on parent's beliefs about child immunisations. Evans et al. (2001) found that parents' lack of confidence in health professionals is in some part due to their knowledge that health professionals have to reach targets for vaccination in order to be paid. Therefore, the advice of health professionals is not seen as beneficial for the child, but rather as self-interested. Further, lay beliefs about health often compete against attempts to educate populations about the benefits of particular health behaviours. Smith and colleagues found that, in Australia, despite health promotion activities about preventative health, there was still variable public awareness and confidence in ability to avoid a number of health outcomes, including cancer and heart disease. Beliefs around health and individual level of control over their health were linked to socio-demographic factors, such as higher educational attainment, gender and ethnicity that were not sufficiently taken into account in the design and delivery of health promotion activities. Other research with vulnerable populations in the United States discovered an association between stereotypes about physicians and health care satisfaction and behaviour. Individuals with negative stereotypes about health care providers were less likely to seek care when sick, to be satisfied with the care received when they did attend and to adhere to doctor's recommendations for treatment. This research is limited by its ability to determine the direction of these relationships, but the association is important for the understanding of the link between beliefs and health behaviours. Education can act as an initial source of information about health and health care, but is also important in triggering cues to action through the provision of new information in health promotion activities. Targeted and tailored health education that addresses both the beliefs that precede actions and the varied socio-demographic and cultural sources of beliefs can instigate actions around health.

CONCLUSION:

It is very important to recognise the positional aspect to the benefits of higher education. We highlight this for two reasons in particular. First, in policy terms, to the extent that education effects on health are causal and absolute, caused for example by benefits of good learning for neurological development or cognitive functioning, one may assume that expanding participation would result in improvements to population health. However, to the extent that benefits are due to relative gains one cannot generalise from an estimated causal effect of education to what would happen under a system of wider participation in higher education. If benefits are positional and relative, changes in the distribution of participation are likely to have unintended consequences that may or may not lead to improvements in overall public health but rather may change the distribution of health amongst the population. Secondly, in terms of effect sizes, it is important to recognise the positional impacts of education because to the extent that access to education is slanted toward those in search of positional advantage, education is allocated with a selection bias such that it would always be false to assume that an association of higher education and health implies an effect of higher education.

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