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POSITION OF PRIMARY SCHOOLS IN PROVIDING HEALTH EDUCATION AND PROMOTION OF HEALTH LITERACY

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Abstract

This research aims to find out the condition of public primary schools in Manavgat, Antalya in terms of social health care and the learning needs of parents about this issue. The universe of this research that is in screen model comprisespublic primary schools in Manavgat. In data analysis, frequency, percentage and chi square techniqueswere used. The majority of parents who did not take any education about the health education which affect student success are willing to take an education like that. Nearly half of these parents prefer to takethis education at the weekends in the daytime and one third of them prefer this education on weekdays in the daytime.

Keywords: Health Education, Health Literacy, Student Success, Parent Education

1.Introduction

Schools in Turkey are hosting 20 millions of school children (pre-school, primary and middle schools) which constitutes significant portion of Turkey's population (Ministry of National Education, 2012). Schools are the most important elements of education system since they satisfy educational needs of a social and economic environment. Basic function of school in an education system is to ensure that students gain desired behaviors and to arrange appropriate environment to accomplish this objective (Taymaz, 2003, 4).

The first article of the 222nd of the Primary Education Law describes the Primary Education as an institution which provides service to students for their physical, intellectual and moral developments.

One of the factors which have been observed that it has an impact on students' academic success and their moral and physical development considered as other expected tasks of schools is health literacy. The significance of health literacy concept has been increased in both education and in health disciplines. The concept is defined differently in medical and educational sciences:

Health literacy is a personal capacity regarding acquisition, evaluation and comprehension of basic health knowledge and services; and personal competency to use these sorts of information in terms of betterment of health (Marx *at al.*, 2007, 158).

Health literacy is the degree of personal comprehension concerning health related information and services to make right decisions about their health. Health literacy is supportive tool in regard to social skills and personal development areas such as self-confidence (US. Department of Health and Human Services, 2010).

In health literacy, a three-stage hierarchy is suggested (Nutbeam, 2000, 263-264):

- (Level 1): Communication of basic/ functional health literacy - information,
- (Level 2): Development of communication/interactive health literacy-personal skills,
- (Level 3): Critical health literacy- personal strengthening /authorization and group strengthening / authorization.

Functional health literacy (level 1) includes transmitting of basic information hygiene, nutrition, safety, drugs, relationships, sexuality, and parenthood. For example, classes, books and brochures. Interactive health literacy (level 2) includes development of personal skills in personal problem solving, cooking, hygiene, and communication. For example, small study groups at school, analysis of the current health problems and discussion homework. Critical health literacy (level 3) includes learning opportunities in classroom and society to consider social injustices, health determinants, policy development efforts, and ways to influence the change (e.g. participation into the school society discussions which handle current policy and applications selected by students (Leger, 2001, 201).

Application of these skills are not only enable students to increase their academic success, but also to help them to have mental, social, emotional, and physical health which are important in appreciating all opportunities and in overcoming all challenges which they may encounter along with their lives. Healthy students learn better and these students establish healthy societies (Marx *et al.,* 2007, 157).

Some researches reveal that there is a positive strong correlation between poor health and success in education (Lavin, Shapiro & Well, 1992; Devaney,, Thornton, Fasciano & Gavin., 1993; Igoe, 1993; World Bank, 1993; WHO, 1996a; Leger, 2001, 198). Low level of health literacy skill makes strong contribution individuals' health. According to the Institute of Medicine, low level of health literacy has more significant impact on personal health compared to factors of age, income level, occupation, education level, and race (Ickes and Cottrell, 2010, 492).

The general literacy rate in Turkey is above 88%; while the rate among women is 80.4% and among men is 96% (Turkey Statistics Agency, 2012). However, the average education year per person is 5.97 (among men 7.01 years, and women 4.96 years) is quite low than the western countries (Turkish Census and Health Research, 2008). There are few researches in Turkey in the area of health literacy. However, when the fact that the average education period is 5.97, years/person is considered, it can be deducted that health literacy level must be rather low.

Although provision of health education at school has essential importance regarding physical, mental and moral development of students, some researches reveal that the health education provided at schools in Turkey is not sufficient. It was understood that parents who make significant amount of sacrifice and spending for academic success, do not pay required attention to health literacy which has impact on children's physical, moral and social development in addition to their academic success. This situation suggests that school administrations and parents do not comprehend significance of health education services in students' physical, mental and moral development.

In order to gain more word and to take over more responsibility on students' education is only possible for parents to acquire sufficient and accurate information about education. If the importance and functionality of health literacy are appreciated and known at schools, perhaps they would not have disregarded. Negligence of health education suggests that school administrations and parents are not aware of this issue.

The starting point of adult education is need. Being aware of their needs and knowing whether adults are aware of their needs are essential in terms of adult education. Therefore, there is requirement to determine educational needs in the initial stage of adult education.

Based on this information, the research subject is consisted of determination of position of public primary schools in Manavgat County of Antalya Province regarding provision of health education and examination of learning requirements of parents concerning this subject

2.Method

2.1. Research Model

The research is a descriptive study using screening model and aims to reveal current position of public primary schools operating under the Ministry of National Education and located in Manavgat Country of Antalya Province in terms of provision of health education based on the views of parents and school principals and to determine learning needs of parents concerning this subject.

2.1.1.Research Population

The universe of the research was consisted of parents of the students who were attending to the public primary schools in Manavgat County of Antalya Province. Within the universe of the research, there were 10 public primary schools. These public primary schools include 13,928 student parents and 44 school administrators (manager, assistant manager) (Ministry of National Education, 2012).

2.1.2. Research Sampling

Following the research universe description, all of the schools were included in the research sampling based on the school districts. While constructing parent sampling, the "Stratified Sampling" method was used. Accordingly, each school's share within the total based on the number of students was found first; and a sampling group was taken from each school according to this rate (Büyüköztürk, Çakmak, Akgün, Karadeniz & Demirel, 2010, 85-86). It is paid attention that the sampling was covering several student parents from various classes so that sampling was conducted through disproportionate element sampling approach.

In determination of sampling size, hypothetical sampling size scheme was utilized for universes in different sizes. Based on this scheme, sampling size was determined for student parents. It can be seen that 13,928 student parents can be represented by 384 samples according to the scheme for 95% reliability level and for 5% deviation rate (Balcı, 2001, 107). As this scale was taken into account, number of parent which would be included into the sampling was determined as 384. In each school, number of students' parent was determined as its proportion to the total number of parent from all schools.

Number of student parents who were included in the research sampling was selected through impartial stratified sampling method by taking student lists from each school to determine each school's proportion to the total number of students. While number of student parent which was planned to be included in the research sampling was 384, number of respondent was 349 (90.88%). When we look at the distribution of the respondents according to the schools, it was observed that there were 35 parents who did not fill out the inquiry form and these forms were not taken into the consideration.

2.1.3. Development of the data collection tool

A survey was developed by the researcher to determine views of parents who have children studying at the public primary schools operating under the Ministry of National

Education and located in Manavgat County Municipality of Antalya Province and school principals concerning health literacy.

Survey questions regarding "health literacy" were prepared by the researcher based on the health literacy and scales in the literature (Leger, 1999; .Leger, 2001; Nutbeam, 2000; Brown, Teufel & Birch, 2007; World Health Organization, 2009; World Health Organization, 2011; Marks *et al.,* 2007). The scale draft was submitted for critics of specialists. According to their views, some questions were rewritten by taking some factors such as comprehensibility, clarity and grammar rules into consideration. Thus, the scale draft was prepared for preliminary application. The designated scale is consisted of choices of "Yes", "No" and "preliminary". In the present section, there are open-ended questions as well.

The draft inquiry form was submitted to the specialists for coverage and facial validity evaluation. The draft was rearranged in terms of life-long learning and adult education, education management policy according to the opinions of specialist in the field of research and measurement evolution. Moreover, opinion of a group of parents was taken into consideration. Along with the specialists' opinions, some expressions were rewritten due to some principles such as comprehensibility, distinctiveness, and grammar rules. Therefore, draft scale was prepared for preliminary application.

A preliminary inquiry application was conducted to measure validity and reliability of the Health Literacy. The preliminary application was applied to the schools which would not affect the schools in which the essential study would be carried on. An inquiry form was distributed to 33 parents whose children were attending to the public primary schools; and then these 33 responding were taken into consideration.

The inquiry form was re-evaluated for conceptual validity by the specialist persons (face validity) (Balcı, 2005). According to this evaluation result, few of the expressions were dismissed while some other was being added into the inquiry; some expressions were amended due to the suggestions of specialists so as to give the final form to the inquiry form.

The draft inquiry form was re-arranged based on the opinions of the specialist in the areas of life-long learning and adult education, education management and policy, research and statistics; and opinions of a group of parents were taken into consideration as well.

It was planned to collect data through interviews. For this application, an inquiry form copy and a copy of permission taken from the city directorship of national education was left to the school directorships. The appointments for the interview process with the parents were determined over telephone calls for dates of 21st June and 6th September 2011; and the interview was conducted with the parents who came to the school on designated dates. For parents who were not able to come to the school, a field visit was arranged to interview them in their house or in the place found appropriate by them. The inquiry was applied as an interview. After relevant explanation, school managers and student parents were asked to fill out the inquiry form.

3. Data Analysis

Acquired views of parents and school principals were evaluated based on their frequencies and percentages.

4. Findings

This section is consisted of findings and assessments of answers given by school principals, parents and other student relatives to the questions regarding health literacy.

Table 1: *Demographic information regarding guardians or parents of students covered in the research*

Characteristic	**f**	**%**
Age ($\bar{x}$ = 40.02)		
-25	4	1.1
26-30	23	6.6
31-35	54	15.5
36-40	122	35.0
41-45	84	24.0
46+	62	17.8
Unanswered	54	15.5
Total	**349**	**100.0**
Are you the Children		
Mother	180	51.6
Farher	158	45.3
Grandmother	4	1.1
Grandfather	2	0.6
Another relative of children	4	1.1
Unanswered	1	0.3
Total	**349**	**100.0**
Educational Status		
Illiterate	9	2.6
Literate	13	3.7
P rimary School	154	44.1
Secondary School	35	10.0
High School	68	19.5
College	25	7.2
University	38	10.9
Graduate School	7	2.0
Total	**349**	**100.0**
Marital Status		
Married	327	93.7
Widow	6	1.7
Single	6	1.7
Divorced	10	2.9
Total	**349**	**100.0**
Number Of Children		
1	36	10.3
2	174	49.9
3	98	28.1
4	22	6.3
5	7	2.0
6 +	4	1.1
Unanswered	8	2.3
Total	**349**	**100.0**
Economic Status		
Very Good	15	4.3
Good	80	22.9

Average	174	49.9
Bad	46	13.2
Very Bad	33	9.4
Unanswered	1	0.3
Total	**349**	**100.0**

As it can be seen from the Table 1, in terms of their ages, while 1.1% of the parents or relatives of the students within the research coverage were 25 and younger, 6.6% of them were in the range of 26-30, 15.5% of them were in the range of 31-35, and 35% of them in 36-40, 24% of them in 41-45, and 17.8% of them were 46 and older.

From the Table 1, it was stated that 51.6% of the respondents were mother of the students, 45.3% of them were father of the students, 1.1% of them were grandmother of the students, 0.6% of them were grandfather of the students, and 1.1% of the respondents were another relative of the students. While 2.6% of the respondents were illiterate, 3.7% of them were only literate with no any graduation, 44.1% of them were graduated from a primary school, 10% of them secondary school graduate, 19.5% of them were graduated from a high school, 7.2% of them were graduated from a college, 10.9% of them were graduated from a university, and 2% of them were holding a master degree.

As 93.7% of the respondents were married, 1.7% of them were widowed, 1.7% of them were single, and 2.9% of them were divorced. When the respondents were asked about their economic conditions, 4.3% of them answered as "very good", 22.9% were answered as "good", 49.9% of them were answered as "average", 13.2% of them were answered as "bad", and 9.5% of them were answered as "very bad".

4.1.Positions of Schools in Provision of Health Education

Table 2**.** *Distribution of answers given by school principals to the question of "Have teachers at your school taken first-aid training?"*

Yes		**No**		**Total**	
f	**%**	**f**	**%**	**f**	**%**
9	90.0	10	10.0	10	100

When the Table 2 is considered, it is seen that 90% of the answers were "Yes", and 10% of them were "No".

Table 3. *Distribution of answers given by school principals to the question of "In the last 12 months, has your school provided any health training to parents of students?"*

Yes		**No**		**Total**	
f	**%**	**f**	**%**	**f**	**%**
3	30.0	7	70.0	10	100

As it can be seen in Table 3, parents have been given health training in three out of ten schools; no training has been given in seven of ten schools.

Table 4**.** *Distribution of answers to the question of "Have you given any training at your child's school regarding environmental impacts (e.g. nutrition, hygiene, and safe environment) on your child's success?"*

Yes		No		Unanswered		Total	
f	**%**	**f**	**%**	**f**	**%**	**f**	**%**
28	8.1	257	73.6	64	18.3	349	100

When the Table 4 is considered, it is seen that 8.1% of the parents said "Yes", 73.6% of them said "No", and 18.3% did not answer this question.

4.3. Whether the Parents Need Health Training

Table 5. *Distribution of answers to the question of "Would you like to receive training at your child's school regarding the environmental factors affecting student success?"*

Yes		No		Unanswered		Total	
f	**%**	**f**	**%**	**f**	**%**	**f**	**%**
237	67.9	33	9.5	79	22.6	349	100

According to the Table 5, it can be seen that while 67.9% of the participants responded "Yes" to this question, 9.5% said "No"; and 22.6% did not answer.

Table 6. *Distribution of answers to the question of "When would you like to have training at your child's school regarding factors affecting student success?"*

Weekdays Morning		Weekend Morning		Weekdays Afternoon		Weekend Afternoon	
f	**%**	**f**	**%**	**f**	**%**	**f**	**%**
85	35.5	115	48.5	20	8.4	18	8.5

According to Table 6, 34.2% of the respondents preferred weekday morning, 46.4% of them preferred weekend morning, 10.8% preferred weekdays afternoon, and 8.5% preferred weekend afternoon.

Table 7. *Distribution of answers to the question of "Do you find foods sold in the student cafeteria healthy?"*

Yes		No		No Idea		Total	
f	%	f	%	f	%	f	%
68	20.4	181	54.4	84	25.2	333	100

When Table 7 is considered, 20.4% of the respondents said "Yes" to this question, 54.4% said "No", and 25.2% said "No idea".

Table 8. *The parents who said "Yes" to the question of "Do you find foods sold in the student cafeteria healthy?" were asked about reasons of their point of view. Distribution of their answers was exhibited in the table below:*

	f	%
1. Cafeteria staff treats sensitive to this issue	30	32.97
2. Cafeteria is inspected by the county agricultural directorship	21	23.08
3. The school administration inspects frequently	21	23.08
4. Children say there are good food sold in the cafeteria	12	13.19
5. Unhealthy foods (chips, soda etc.) are not sold in the cafeteria	2	2.20
6. Food sold are in packages	5	5.49

According to Table 8, while 32.97% of the respondents indicated that "Cafeteria personnel's sensitive approach to this issue", 23.08% said "Cafeteria is inspected by the county agricultural directorship" and another 23.08% said "The school administration inspects frequently"; 2.20% said "Unhealthy foods (chips, soda etc.) are not sold in the cafeteria", and 5.49% said "Food sold are in packages".

Table 9. *Distribution of answers to the question of "Why don't you find the food sold in the student cafeteria healthy?"*

	f	%
1. All foods are pre-packaged and they contain additives	57	30.32
2. Cheap and low quality food are sold	45	23.94
3. Hygiene is not paid attention sufficiently	41	21.81
4. Out-dated foods are sold	28	14.89
5. Employees view this only commercial point of view	14	7.45
6. Poor hygiene inspection	1	0.53
7. No idea	2	1.06

When Table 9 is considered, it can be seen that while 30.32% respondents said that "all foods are pre-packaged and they contain additives", 23.94% said that "cheap and low quality food are sold"; 0.53% said "poor hygiene inspection" and 1.06% said "no idea".

Table 10. *Distribution of answers to the question of "If you do not find foods sold in the school cafeteria healthy, what would parents do to make them healthy?"*

	f	%
1. Employees are required to be inspected periodically by the parent-teacher association.	45	28.90
2. Students' awareness about healthy nutrition is required to be raised by their parents.	44	28.20
3. Parents are required to cooperate with school administration.	27	17.30
4. Home-made foods can be offered.	18	11.50
5. No idea	11	7.10
6. We cannot interfere in as an outsider.	10	5.38
7. Foods sold are required be inspected individually.	1	0.60

According to Table 10, while 28.2% of participants said "Students' awareness about healthy nutrition is required to be raised by their parents", 28.9% said "Employees are required to be inspected periodically by the parent-teacher association"; 0.06% said "Foods

sold are required be inspected individually" and 11.5% said "Home-made foods can be offered".

Table 11. *Distribution of answers to question of "if you do not find foods sold in the school cafeteria healthy, in your opinion, what should 1) school administration, 2) teachers, and 3) Ministry of National Education do about this issue?"*

	f	%
School administration		
1. School administration needs to ban sales of unhealthy food	111	61.67
2. School administration must take parents' opinions into consideration	36	20.0
3. School administration must assign a vice manager in charge of school cafeteria	20	11.11
4. No idea about what the school administration could do	8	4.44
5. School administration must cooperate with contractor of the school cafeteria	5	2.78
Teachers		
1. Teachers need to raise awareness of students and parents regarding the issue	107	63.31
2. No idea about what teachers could do	36	21.30
3. Hall monitors must be authorized to make inspection any time	26	15.38
Ministry of National Education		
1. School cafeterias should not be given to contractors determined by central tenders carried out by the Ministry of National Education; instead, they must be given to the contractors determined by parent-teacher association.	65	35.91
2. Ministry of National Education must apply school cafeteria code of conduct and discharge contractors doing misappropriate actions	55	30.39
3. The National Education Ministry must perform strict inspections	50	27.6
4. No idea	22	12.2

When Table 11 is considered, concerning the school administration subject, while 61.67% of the parents were of the opinion that "school administration needs to ban sales of unhealthy food in the school cafeteria", 2.78% think that "School administration must cooperate with contractor of the school cafeteria". Concerning the teacher subject, while 63.31% of parents think that "teachers need to raise awareness of students and parents regarding the issue", 15.38% of them think that "Hall monitors must be authorized to make inspection any time". Concerning the National Education Ministry subject, while 35.91% of parents claim that "School cafeterias should not be leased by the contractors determined by central tenders carried out by the National Education Ministry; and instead, they must be leased by the contractors determined by parent-teacher association; 30.39% think that "the National Education Ministry must apply school cafeteria code of conduct and discharge contractors doing misappropriate actions".

Table 12. *Distribution of answers to the question of "If you do not find foods sold in the school cafeteria healthy, in your opinion, what would municipalities do to make them more healthy?"*

	f	**%**
1. They must inspect and serious fines must be applied.	117	71.78
2. No idea	21	12.88
3. Municipalities have nothing to do with this issue.	11	6.75
4. They must provide financial support.	14	8.59

According to Table 12, while 71.78% of parents said "they must be inspected", 6.75% of them said "municipalities have nothing to do with the subject".

5. Results and Conclusion

In the research, it was revealed that almost all of teachers have received first-aid training. However, according to the observations, school principals meant the first-aid training given during driver license courses. In his study, Karabayır (2004) reported that 57.9% of school principals expressed that they had received training about first-aid. While training studies on regulations were 29.2% of the over all activities in the in-service training plan framework of 1993, budget-investment and equipment-tools subjects were only 10.88%. These results indicate deficiency of teachers and principals in the subject of first-aid. Health education provided by teachers can have immediate impact on students and effect students' behaviors until their adulthood (McGinnis, 1992; Nutbeam, 1992; Nutbeam, 1998). It is strongly possible that healthy students outperform than others (Lavin, Shapiro & Well, 1994); and their learning process can be more extensive, quick and fun. After witnessing these advantages, it can be surprising to face reluctance regarding admitting significance of health education readily. First-aid knowledge is not only important in terms of students' health, but also, it is important extra scholastic life as well. Basic first-aid training is required to be an obligation for school personnel (Rhode Island Department of Health, 2009, 32).

According to Çakır (2005), the fact that there are only 8 health district branches (8.6%) that provide health training to teachers and that these training activities are not on regular base indicates deliberately that parents and teacher factors which have significant roles in basic education are omitted. Research results reported by Bulduk (2002) support this finding. However, if health personnel provide training parents and teachers simultaneously, students who receive basic health knowledge from the most trustworthy individuals at their early ages can conveniently internalize behaviors for healthy life. Professional health personnel must guide students in consolidation of gained behavior patterns by means of training provided so as to create new generations whose basic purpose is to live healthy.

In the schools under the research coverage, majority of school principals stated that they do not provide health training to parents in any subject. Nevertheless, one of the most important applications at schools regarding health services is "Health Training". In the study of Karabayır (2004), women principals stated that effective health training can be provided by teachers and parents together. Parents are one of the target groups of social health services and also they are part of it. This result emphasizes significance of health training provided to parents.

Almost all of the students parents participated into the research indicated that there was no any training provided regarding environmental factors that have impact on student success. Additionally, almost all of school principals and parents answered "No" to the question of "Has any training been provided at your school regarding environmental factors (e.g. nutrition, hygiene, safe environment) affecting student success?" This answer suggests

that answers of school principles and parents were similar to each other. Another study supporting our findings in terms of importance of parents' training was suggested by Fişek (1959). According to this study, providing training to mothers affects children health in a positive way and plays significant role in reduction of child death rate (Dirican, 1990, 17). Schools are responsible for developing life-long learning skills. These education skills have essential importance to accommodate and overcome nutritional changes that can arise because of incidents in life such as an illness or sickness and understand, and to comprehend a discussion about a social issue, for instance genetically modified organisms.

Some researches reveal that students receive health knowledge from their parents. For example, according to study of Hekimoğlu and Ertunga (1990), 42.6% of students receive health related knowledge from their teachers, 26.1% of them receive from health personnel, 15.9% of them receive from parents and 15.4% of them receive from published materials and media. At this point, it is seen that although the authority belongs to the teachers in charge, parents also have great role in health education. Therefore, health personnel need to provide training to parents and their students simultaneously. According to the study of Yiğit (1990; 1991), which was conducted on mothers of 225 student attending a primary school, it was exposed that their knowledge concerning hand hygiene, dental health, nutrition order, nutrition of primary school students, infectious diseases, determination of conditions of health impairment and reasons for taking children to the health check-ups were usually insufficient (Yiğit, 1992). This result indicates their need for health training. According to the study conducted by Çakır (2005), the fact that there are only 8 health district health offices (8.6%) that provide health training program for teachers and irregular characteristics of these trainings reveal clearly that parent and teacher factors who have significant roles in the basic education of students are omitted. Research results reported by Bulduk (2002) also support this finding. Nevertheless, if health personnel provide training to students together with parents and teachers simultaneously, students who receive basic health knowledge from trustworthy individuals at their early ages would internalize healthy behavior patterns more conveniently.

Majority of parents stated that there was no training about environmental factors affecting student success; almost one fifth did not answer. Schools aim to elevate results of education to the highest possible levels for students. It is required to remind that essential activity of schools is education and their competency level regarding health issues are at the lowest profession level. Researches deliberately report that there are strong correlations between poor health and educational success (Lavin, Shapiro & Well, 1992; Devaney, Schochet, Thornton, Fasciano & Gavin,, 1993; Igoe, 1993; World Bank, 1993; WHO, 1996b).

Whereas majority of parents do not find foods sold in the cafeteria healthy, almost one fifth of them have contrasting idea. One forth of parents stated that they do not have any idea about this subject. As basic reasons to find cafeteria foods healthy, parents indicate their faith in cafeteria personnel's sensitivity and ongoing inspections.

As basic reasons not to find cafeteria foods healthy, parents indicate sales of artificial, pre-packaged, cheap and low quality foods, and lack of confidence in cafeteria personnel's hygiene understanding. It is also interesting that 13% of parents are of the opinion that there are expired foods are sold in the student cafeteria.

Almost one third of parents recommend that cafeteria employees should be inspected by parent-teacher organization at the school; and another one third recommends that awareness of students should be raised by their parents. The last proposal suggests that parents do not have sufficient knowledge about how healthy foods should be. If they should have known about healthy food, they would have informed their children about this issue.

Majority of parents expect from school principals to ban sales of unhealthy foods and to make cooperation with them; again, majority of parents expect from teachers to inform students about healthy food and to participate into inspection of school cafeterias; and almost all of parents expect from the MNE more strict rules and more inspection. Other studies reveal similar results that parents have the same point of views. For example, 64.1% of parents in Ohio stressed importance of not to sale chocolate, chips and soda in school cafeterias. 69.8% of the parents in Ohio consider teachers' role important in teaching benefits of healthy nutrition (Murnan, Price, Telljohann, Dake & Boardley, 2006). Opinions of these parents support parent participated into the present research.

Majority of parents who find foods sold in the school cafeteria unhealthy indicate that municipalities must be authorized to carry out inspection and to charge fines.

Nutrition is more sensitive for the students who shop from school cafeterias because of their ages compared to other groups. When the fact that majority of students shop from school cafeterias is taken into account, it can be seen that school cafeteria has significant place in nutrition of children in this age group (Gündoğan, 2008, 4). Since students supply almost one meal from school cafeterias daily, these places have primary place students' consumption patterns. It is required that nutritious, hygienic and packaged foods are sold in school cafeterias; and food sales should not be allowed in school garden without proper facility. Sanitation of schools and cafeterias are required to be inspected frequently and health check-ups of the cafeteria personnel must be implemented (İbili & Yıldız, 1999, 46). It is recommended that nutritious foods (low-fat foods, fruits and dairy products) should be sold in school cafeterias instead of food with no nutrition value (for example; cookies, candy bars, and potatoes chips etc.) or of with low nutrition value (e.g. soda and chocolate) in school cafeterias (Murnan, Price, Dake & Boardley, 2006, 502-511).

6.Suggestions

- Schools can required to arrange training activities in the health subjects (e.g. nutrition, hygiene, safe environment and etc…) for parents to increase success of students at school based on needs analysis. This training must be provided at the appropriate times for parents.

- Ministry of National Education can required to ban sales of unhealthy and low nutritious food in cafeterias and to increase frequency of inspection of school cafeterias.

- Ministry of National Education can required to provide training to the contractors who operate school cafeteria in subjects of healthy food and hygiene.

-Ministry of National Education can required to provide training to teachers and school principals about health-related subjects (e.g. first-aid, nutrition, hygiene, safe environment and etc…) effective on student.

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