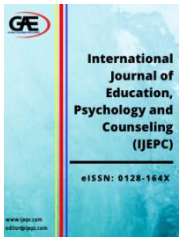
International Journal of Education, Psychology and Counseling
IJEPC
EISSN : 0128-164X
Volume 10 Issue 60 (October 2025) PP. 562-575
DOI 10.35631/IJEPC.1060040



INTERNATIONAL JOURNAL OF EDUCATION, PSYCHOLOGY AND COUNSELLING (IJEPC)
www.ijepc.com

EXPLORING THE COMPETENCY AND CHALLENGES OF PRESCHOOL TEACHERS IN HEALTH EDUCATION: A QUALITATIVE STUDY IN THE CHINESE CONTEXT

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Article Info:

Article history:
Received date: 30.07.2025
Revised date: 13.08.2025
Accepted date: 24.09.2025
Published date: 15.10.2025

To cite this document:

Qian, W., Abdul Rahman, M. N., & Yahya, A. N. (2025). Exploring the Competency and Challenges of Preschool Teachers in Health Education: A Qualitative Study in the Chinese Context. *International Journal of Education, Psychology and Counseling, 10* (60), 562-575.

DOI: 10.35631/IJEPC.1060040

Abstract:

This study explores preschool teachers' competency in delivering health education in China and investigates the barriers they face in implementing it effectively. Qualitative research design based on the interpretive phenomenological approach (IPA) was employed. Semi-structured interviews were conducted with 12 preschool teachers from both urban and rural kindergartens in Henan Province. Thematic analysis was used to extract key patterns from the data. Four major themes emerged: varying conceptualizations of health education, with an emphasis on hygiene and physical care; informal and reactive teaching practices due to lack of structure; inadequate professional training and resource support; and limited institutional and family engagement. Despite recognizing the importance of health education, teachers reported low confidence and inconsistent practices due to systemic constraints. This study provides new empirical insights into the lived experiences of Chinese preschool teachers in promoting child health. It highlights the urgent need for curriculum reform, targeted teacher training, and enhanced collaboration with families to support holistic health education in early childhood settings.

Keywords:

Preschool Teachers; Health Education; Interpretive Phenomenological Analysis; Early Childhood Education; China

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Introduction

In early childhood education (ECE), the foundation of healthy development is built upon a holistic approach that encompasses not only academic learning but also the physical, emotional, and social well-being of young children. During the preschool years, children form critical habits and attitudes that can influence their lifelong health behaviors. Health education in kindergarten settings thus plays a vital role in promoting essential life skills such as hygiene, nutrition, physical activity, safety awareness, and emotional regulation. These foundational skills are not only crucial for individual well-being but also contribute to public health goals and societal development in the long term.

Preschool teachers serve as the frontline implementers of health education. Their ability to effectively model, teach, and reinforce healthy behaviors significantly affects children's understanding and internalization of health concepts. As young children often learn through imitation, interaction, and routine, the teacher's role is not merely to impart knowledge but to create an environment that supports healthy development through consistent practices and responsive caregiving.

Despite the increasing policy-level recognition of the importance of health education in early childhood settings in China, as articulated in national curriculum guidelines , the practical implementation of such programs remains uneven across different regions, institutions, and socioeconomic contexts. Research suggests that the disparity is often linked to the varying levels of teacher competency—including their health knowledge, attitudes, beliefs, and pedagogical skills—in delivering health-related content (Zhu & Wang, 2021). Factors such as inadequate professional development opportunities, lack of teaching resources, and institutional constraints may further hinder effective implementation.

This study seeks to explore the lived experiences of preschool teachers in China as they navigate the delivery of health education in their classrooms. By employing a qualitative approach, the research aims to understand how teachers conceptualize their roles in promoting children's health, the strategies and teaching methods they employ, and the obstacles they face in real-world educational settings. Through thematic analysis of in-depth interviews, this study aspires to uncover the nuanced realities behind policy expectations and actual practice. The findings are expected to inform targeted improvements in teacher training programs, curriculum design, and policy support, thereby enhancing the overall effectiveness and sustainability of health education in Chinese kindergartens.

Literature Review

Defining Health Education in Early Childhood Education (ECE)

Health education is broadly defined as a structured process through which individuals gain the knowledge, attitudes, and behaviors necessary to maintain and improve health, prevent disease, and reduce risky behaviors (Nutbeam, 2000). In the context of early childhood education, health education extends beyond basic information dissemination to include nurturing healthy habits and social-emotional competencies that are developmentally appropriate for young learners. This encompasses areas such as personal hygiene, nutrition, physical activity, safety, and emotional self-regulation.

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Importantly, the conceptualization of health education in ECE is not uniform across global contexts. Cultural norms, institutional values, and educational priorities shape how health education is defined, delivered, and evaluated UNESCO. For instance, Western frameworks may emphasize individual autonomy and psychological well-being, while some Eastern approaches may prioritize collective harmony, discipline, or physical endurance. In China, the integration of health education within the broader ECE curriculum is influenced by both national education policy and traditional health beliefs, such as the importance of balance (yin-yang) in physical development.

Teacher Competency in Health Education

Teacher competency in the realm of health education involves more than subject matter expertise—it requires an integrated set of knowledge, attitudes, values, and practical teaching skills. Sharma et al. (2017) argue that effective health educators must be able to translate scientific knowledge into pedagogically sound practices that resonate with young children. In the ECE context, this means using age-appropriate language, play-based strategies, and routine-based teaching moments to embed health concepts into daily experiences. Lee and Kim (2020) highlight that developmentally appropriate communication, observational sensitivity, and the ability to build trusting relationships are essential competencies when teaching health topics to preschoolers.

Moreover, teachers must be equipped to address diverse health topics in inclusive ways, taking into account the physical, emotional, and social needs of all children, including those with special health needs or from marginalized communities. Professional development plays a key role in enhancing these competencies. However, evidence suggests that many training programs fail to sufficiently address health education as a core domain, treating it as secondary to academic subjects like literacy and numeracy.

Challenges in China's ECE Health Education

In China, while national education guidelines such as the Guidelines for Kindergarten Education (Trial) (Ministry of Education of the PRC, 2012) emphasize the importance of children's health and well-being, the translation of these policies into classroom practice often encounters significant obstacles. According to Wang and Zhang (2022), many preschool teachers lack formal, systematic training in health-related topics during their pre-service education. As a result, their understanding of health education tends to be superficial or fragmented.

In-service training also remains limited in scope and frequency, with most programs focusing on academic subjects rather than holistic child development. This imbalance reflects broader systemic tendencies to prioritize measurable academic outcomes over less quantifiable aspects like health and emotional well-being. Moreover, there exists a notable gap between curricular ideals and the realities of implementation, particularly in rural or underfunded kindergartens (Cai & Xu, 2021). Teachers in these areas often face large class sizes, inadequate resources, and limited institutional support, making it difficult to deliver structured, proactive health education. Health education in such contexts is often reactive—addressing issues as they arise—rather than being planned as a preventive and intentional part of the curriculum (Liu et al., 2020). Compounding these challenges is the inconsistency of parental involvement and family support. While families are critical partners in reinforcing healthy behaviors at home,

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their engagement in health-related school initiatives is often sporadic or minimal, further limiting the potential impact of health education delivered in preschool settings.

Comparative Perspectives: International Insights into ECE Health Education

Globally, there is growing consensus on the importance of integrating health education into early childhood curricula as a means of fostering lifelong well-being and preventing the onset of chronic diseases. Countries such as Finland, Sweden, and Australia have embedded health promotion within national early education frameworks, often adopting whole-child and whole-school approaches that integrate physical health, mental wellness, and social development . In these systems, health education is not viewed as an isolated subject but rather as an essential component of everyday routines, interactions, and classroom culture.

In contrast, while China has made notable policy strides, the actual implementation of comprehensive health education in kindergartens lags behind these global exemplars. The disparity is particularly evident in the areas of teacher preparation, interdisciplinary collaboration, and family-school partnerships. For instance, Scandinavian models emphasize collaboration between educators, health professionals, and families in designing and delivering health content , whereas in China, such cross-sectoral collaboration remains limited and fragmented. This suggests a need for China's ECE system to learn from international best practices while adapting them to local cultural and institutional realities.

Theoretical Frameworks Informing Health Education in ECE

To better understand how health education is implemented and received in preschool settings, it is helpful to consider established theoretical models that explain health behavior and education processes.

One such model is the Social Ecological Model (McLeroy et al., 1988), which posits that a child's development is influenced by multiple layers of environmental systems—from the immediate classroom and family context to broader institutional, community, and policy environments. In this framework, preschool teachers function at the microsystem level, directly shaping children's health behaviors through daily interactions and modeling. However, their effectiveness is influenced by mesosystemic factors such as family engagement, exosystemic factors like school policies and training opportunities, and macrosystemic factors including cultural values and national education mandates.

Another relevant framework is the Health Belief Model (HBM) (Rosenstock, 1974), which focuses on individuals' perceptions of health risks and their beliefs about the benefits and barriers to taking preventive action. When applied to early childhood educators, the HBM suggests that teachers' beliefs about the importance of health education, their confidence (self-efficacy) in delivering it, and their perceptions of institutional support all influence whether and how they integrate health content into teaching. Teachers who perceive health education as essential and feel competent and supported are more likely to plan structured, proactive lessons rather than reacting only when health problems arise. Both models emphasize the importance of contextual and psychological factors in shaping health education practices. Incorporating these theoretical perspectives into the study allows for a deeper understanding of the dynamics at play and provides a foundation for developing more effective interventions at multiple levels—individual, institutional, and policy-based.

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Research Methodology

Research Design

This study adopted a qualitative research design, specifically grounded in the interpretive phenomenological approach (IPA). IPA is a methodology focused on exploring how individuals make sense of their lived experiences, particularly within specific cultural and social frameworks (Smith, Flowers, & Larkin, 2009). This approach was selected to delve into the subjective experiences and meaning-making processes of preschool teachers as they implement health education in their daily professional practice. Given the complex, context-sensitive nature of health education in early childhood settings, IPA offered a robust framework to capture individual variations in understanding, strategy use, and perceived challenges.

The interpretive nature of this study also acknowledges the co-constructed reality between researcher and participants. As such, the role of the researcher was not merely to extract data, but to interpret participants' narratives through a reflexive, empathetic, and theoretically grounded lens.

Participants

Twelve preschool teachers (11 female, 1 male) were selected through purposive sampling, a technique appropriate for IPA studies that focus on obtaining rich, detailed accounts from individuals with relevant experience. Inclusion criteria required participants to (a) have a minimum of 3 years of continuous teaching experience in kindergartens, (b) be actively engaged in classroom teaching at the time of the study, and (c) be willing to provide in-depth reflections on their practice.

Participants were recruited from six kindergartens in Henan Province, representing both urban and rural settings, and a mix of public and private institutions. This sampling diversity allowed for the exploration of variations across geographic, institutional, and socioeconomic lines. Teaching experience ranged from 3 to 15 years, ensuring perspectives from both early-career and veteran educators. All participants held formal qualifications in early childhood education, with some having completed additional in-service training, albeit rarely in health-related domains.

Data Collection

Data were gathered over a two-month period in January and February 2025, through semi-structured, in-depth interviews. Each interview lasted approximately 30–45 minutes and was conducted either face-to-face or via encrypted video conferencing platforms, depending on participant availability and local public health protocols.

The interviews were conducted in Mandarin Chinese to ensure participants could fully express themselves. Interviews were audio-recorded with participants' informed consent, and all interviews were subsequently transcribed verbatim.

A semi-structured interview guide was developed to allow flexibility and depth, encouraging participants to share personal narratives while ensuring consistency in data collection. Core guiding questions included: What does health education mean to you in the context of your teaching? Can you describe how you incorporate health-related topics into your daily teaching activities? What challenges or barriers do you encounter in implementing health education with

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young children? How do you perceive your own preparedness or training for delivering health education? To complement interview data, the researcher took field notes during and after each interview, capturing non-verbal cues, emotional tone, and contextual factors, which supported interpretation during analysis.

Data Analysis

Transcripts were analyzed using the six-phase thematic analysis method outlined by Braun and Clarke :Familiarization: Reading and re-reading transcripts to gain an overall understanding. Initial Coding: Generating descriptive and interpretive codes across the dataset. Theme Identification: Grouping similar codes into broader categories. Theme Review: Checking coherence within and across themes. Theme Definition and Naming: Clearly describing the essence of each theme. Reporting: Synthesizing themes with illustrative quotes and relevant theoretical integration.

Data analysis was managed using NVivo 12 software to organize codes, memos, and emerging patterns efficiently. Coding was both inductive, allowing themes to emerge naturally from the data, and deductive, guided by theoretical frameworks (e.g., Self-Efficacy Theory and Social Ecological Model).Transcripts were analyzed in the original Mandarin to retain cultural nuance. Quotes included in the results were translated into English by the bilingual researcher and verified through back-translation with a native Mandarin-speaking academic.

Trustworthiness and Ethics

To ensure credibility, several strategies were employed: Member checking: Participants reviewed summaries of their interview data and preliminary findings. Minor corrections and clarifications were incorporated based on their feedback. Peer debriefing: Two qualitative research specialists independently reviewed segments of coded data and thematic summaries to validate interpretation. Triangulation: Field notes, interview transcripts, and reflective journals were used in combination to cross-validate insights. For dependability and confirmability, an audit trail was maintained throughout the research process, documenting coding decisions, theme revisions, and methodological reflections. The study obtained ethical clearance from the University of Malaya’s Research Ethics Committee.

Participation was voluntary, and participants were fully informed of the study's purpose, procedures, and their right to withdraw at any time. All identifying information was anonymized and pseudonyms assigned to protect participant identities. Digital data were stored on an encrypted, password-protected server accessible only to the research team. This rigorous methodological process ensured that the findings authentically represent the experiences of preschool teachers while maintaining ethical integrity and scholarly transparency.

Results

Based on thematic analysis of in-depth interviews with 12 kindergarten teachers across diverse educational settings in Henan Province, China, four major themes emerged: Teachers’ Understanding of Health Education, Informal and Spontaneous Teaching Practices, Limited Training and Curriculum Support, and Institutional and Family Constraints. Each theme is discussed below, supported by representative quotes, contextual analysis, and interpretive reflections.

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Theme 1: Teachers' Understanding of Health Education

Participants commonly associated health education with physical health maintenance, personal hygiene, nutritional habits, emotional expression, and child safety. However, their interpretations and practices varied notably depending on their professional experience, regional context (urban vs. rural), and level of teacher training.

While some educators emphasized basic hygiene routines and disease prevention, others integrated socio-emotional learning and safety awareness into their understanding of health education: "We mainly teach them how to wash hands properly, eat well, and avoid colds." – T1 (Urban, 7 years) "Health education is also about how children handle their emotions or conflicts." – T2 (Urban, 5 years)

Some rural teachers framed health education in terms of physical safety and community awareness, while others referenced parental collaboration and even current events as learning triggers: "Sometimes I mention things like virus outbreaks if it's in the news." – T12 (Rural, 5 years)

This variation in conceptualization suggests a lack of standardized health education frameworks in Chinese kindergartens, resulting in fragmented understandings and inconsistent pedagogical approaches. A comparative reading of the interviews shows that urban teachers tend to frame health education more in terms of individual emotional regulation and hygiene, whereas rural teachers place emphasis on safety, illness prevention, and familial behaviors.

Table 1 : Below Summarizes Participants' Background Information And Their Key Conceptualizations Of Health Education

Participant ID	Years of Teaching	Location	Key Understanding of Health Education	Representative Quote
T1	7 years	Urban	Hygiene and nutrition	"We mainly teach them how to wash hands properly…"
T2	5 years	Urban	Emotional health and safety	"Health education is also about how children handle…"
T3	12 years	Rural	Physical safety	"I teach children not to run in the hallway…"
T4	4 years	Rural	Nutrition and healthy lifestyle	"I remind parents not to send spicy chips…"
T5	10 years	Urban	Basic hygiene routines	"We help kids learn how to brush teeth…"
T6	3 years	Rural	Preventing sickness	"When one child is sick, we teach about germs."
T7	6 years	Urban	First aid and emergency response	"I did a small activity about calling 120…"
T8	9 years	Rural	Hygiene, habits, and rest	"Sleep routines are also a health issue…"

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Participant ID	Years of Teaching	Location	Key Understanding of Health Education	Representative Quote
T9	11 years	Urban	Emotional expression and self-care	"I talk to them when they cry…"
T10	3 years	Rural	Routine health checks	"We check their nails and hands before meals…"
T11	8 years	Urban	Parent collaboration and food control	"Some parents send sweets even when we say no…"
T12	5 years	Rural	Community health awareness	"Sometimes I mention things like virus outbreaks…"

Theme 2: Informal and Spontaneous Teaching Practices

Health education was found to be primarily informal and reactive. Rather than being embedded in a dedicated curriculum, it was often triggered by daily observations or events. For example: "When I see a child with a cold, I remind the class to cover their mouth when sneezing. That's how I do health education." – T7.Teachers reported that they frequently relied on "teachable moments" and incidental instruction: "There's no real textbook or schedule for this. We just respond when needed." – T4.This strategy, while responsive, limits continuity and coherence in health education delivery. The absence of structured content makes it difficult for children to consolidate their understanding across settings and time. Despite the informality, teachers showed creativity in leveraging moments of illness, conflict, or mealtime routines to emphasize hygiene and healthy behaviors. Yet, this pattern reflects a deeper issue: the marginalization of health education in the formal curriculum. The lack of integration leaves educators without clear guidance, goals, or assessment mechanisms.

Theme 3: Limited Training and Curriculum Support

Most participants shared that they had received little to no formal training in health education either during pre-service education or in-service programs: "We had training on math and literacy, but health education? Not really." – T1.This resulted in low confidence levels, particularly when addressing emotional or psychological health topics. Teachers expressed uncertainty about developmentally appropriate content and techniques: "Sometimes I'm not sure if what I'm doing is enough or even correct." – T5Some reported seeking information from online platforms or peer discussions to supplement their knowledge. Others relied on common sense or personal parenting experience rather than professional knowledge. This reliance on informal sources highlights the lack of institutional support structures. Only a few participants mentioned receiving any form of health-related in-service training, and even those sessions were typically limited in scope, focusing on physical safety protocols rather than comprehensive health literacy. This finding underscores the urgent need for systematic and ongoing capacity-building initiatives that equip teachers with evidence-based practices and practical tools for classroom integration.

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Theme 4: Institutional and Family Constraints

Participants identified a range of external and systemic challenges that limited their ability to implement health education effectively: Time pressure due to overloaded academic curricula in urban kindergartens; Lack of teaching materials, facilities, or outdoor space in rural settings; Limited family cooperation, particularly in managing children's diets and hygiene habits. "Some parents don't care if their child brings unhealthy snacks. It's hard to change habits without their cooperation." – T11. "Our class size is huge, and there's no space to run activities properly." – T6.In urban areas, teachers cited performance evaluations and administrative demands as limiting their ability to dedicate time to health activities. In contrast, rural teachers faced material scarcity, with no designated classroom zones for health routines or rest. Moreover, family-school communication about health was often informal or nonexistent. Some teachers noted that parents prioritized academic performance over health-related learning, and were resistant to changing routines around sleep, snacks, or emotional expression. This disconnect severely impacted the sustainability and consistency of health messages across contexts.

In sum, these findings highlight the complex and interconnected factors shaping preschool health education in China—from individual beliefs to cultural values, from institutional priorities to infrastructural limitations. Addressing these barriers will require a multi-level strategy that bridges policy, practice, and parental engagement.

Discussion

This study reveals a multifaceted and nuanced picture of how preschool teachers in Henan Province, China, engage with health education in early childhood settings. The interplay between teachers' personal beliefs, institutional constraints, and sociocultural contexts significantly influences how health education is interpreted and practiced. The findings highlight a fundamental tension between the growing policy emphasis on holistic child development and the practical realities faced by teachers on the ground.

Teachers' Conceptual Understanding and Pedagogical Practice

The results show that while teachers generally recognize the value of health education—particularly in areas such as hygiene, nutrition, and emotional well-being—their understanding often lacks depth and is limited to routine care practices. This aligns with previous findings by Liu et al. (2020), who noted that many teachers equate health education with basic physical care. Without a broader framework, such as socio-emotional learning or public health literacy, many health-related activities remain superficial and reactive.

Teachers' practices reflect a gap between policy intent and pedagogical interpretation. Although national guidelines stress the inclusion of health and well-being, the lack of curriculum scaffolding leads to variability in how health education is understood and implemented. Some teachers integrate emotional and social components, while others limit it to illness prevention or hygiene routines. This variation suggests the absence of a unified professional discourse on health education in early childhood.

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Self-Efficacy and Institutional Support

Bandura's (1997) theory of self-efficacy provides a useful lens for understanding the challenges teachers face. Teachers who lack confidence due to insufficient training or experience are less likely to engage proactively in health education. This is exacerbated by the institutional context, where training programs prioritize academic competencies over holistic child development. As noted by Sharma et al. (2017), teachers with low self-efficacy tend to rely on spontaneous and informal teaching practices rather than structured pedagogical approaches.

The interviews revealed that teachers' perceived self-efficacy is strongly influenced by the presence or absence of professional development opportunities, administrative encouragement, and resource availability. Teachers who felt unsupported were more hesitant to innovate or extend health instruction beyond basic routines. Conversely, those with even limited training expressed greater confidence and creativity in embedding health topics into their classroom interactions.

Furthermore, the dependency on "teachable moments" as the primary vehicle for health education delivery—while adaptive—signals a lack of strategic planning and long-term vision in health curriculum design. This reactive model contributes to inequitable learning outcomes among children and hinders the institutionalization of health literacy from an early age.

Cultural and Familial Influences

In the Chinese educational context, societal and parental expectations place a strong emphasis on cognitive development and school readiness. This cultural prioritization leads to the marginalization of non-academic subjects such as health education. Teachers reported difficulty balancing these academic demands with their health-related responsibilities, particularly in urban areas where performance-based evaluation systems are more prevalent.

Moreover, teachers frequently expressed frustration regarding inconsistent or minimal parental engagement. Health education in ECE cannot function in isolation—family reinforcement is critical to sustaining health habits and attitudes developed in school. When parents undermine school efforts (e.g., sending sugary snacks or neglecting emotional issues), the effectiveness of classroom-based health education is greatly diminished.

This misalignment points to the necessity of home-school partnerships built on shared goals and cultural sensitivity. Educators require institutional support to engage families meaningfully, through tools such as family health workshops, communication platforms, or culturally appropriate resource kits.

Urban-Rural Disparities

Notably, the study also uncovers disparities between urban and rural settings. Rural teachers reported more acute challenges related to overcrowded classrooms, inadequate facilities, and fewer professional development opportunities. Urban teachers, on the other hand, faced time constraints and rigid schedules that limit flexibility for health-related activities. This urban-rural divide necessitates context-specific interventions to support health education in diverse preschool environments.

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These disparities mirror broader educational equity challenges in China. While urban schools benefit from more systematic infrastructure and higher parental literacy, they are simultaneously constrained by performance-driven cultures. Rural schools may have greater flexibility but lack material resources, training, and institutional clarity.

Policies aimed at improving ECE health education must account for these regional variations. Decentralized planning, targeted investment, and differentiated support strategies are essential. For example, in rural areas, resource provision (e.g., health toolkits, sanitation supplies) and mobile training units may be effective. In urban settings, time-sensitive teacher workshops and integration of health topics into core subjects could prove more feasible.

Implications for Early Childhood Policy and Practice

The insights gained from this study have several important implications for early childhood education policy and practice in China: Curriculum Integration: There is a need to embed health education explicitly into early childhood curricula with defined learning outcomes, age-appropriate indicators, and suggested teaching strategies. Teacher Training Reform: Both pre-service and in-service training should emphasize health literacy, child psychology, first aid, and socio-emotional learning to enhance teachers' pedagogical confidence. Multilevel Collaboration: Health education should not be seen solely as a teacher's responsibility. Partnerships between kindergartens, health professionals, and local governments can ensure holistic and sustained implementation. Cultural Reframing: National campaigns to elevate the status of health education—as essential, not extracurricular—may help shift cultural attitudes among parents and school leaders. These reflections set the stage for actionable recommendations, discussed further in the conclusion chapter that follows.

Conclusion and Implications

This study contributes to the growing body of knowledge on early childhood health education by offering an in-depth, qualitative exploration of preschool teachers' lived experiences in China. Through thematic analysis of interview data, the study sheds light on how health education is conceptualized, delivered, and constrained in everyday early childhood educational settings. The findings illuminate a clear gap between policy ambitions and practical realities, as well as the complex interplay of personal, institutional, and sociocultural factors that shape teachers' competencies and practices.

Summary of Key Insights

Several key insights emerged from the research: Teachers have a general awareness of the importance of health education, but their understanding often remains narrow, focusing primarily on hygiene and physical health. Broader components such as socio-emotional development, nutrition literacy, and mental health are less commonly addressed.

Health education practices tend to be informal and opportunistic, arising in response to daily events or behavioral issues rather than as part of a structured, developmentally sequenced curriculum. This approach, while adaptive, lacks continuity and may result in missed learning opportunities.

Systemic factors such as limited training, inadequate resources, and curriculum overload restrict teachers' ability to plan and deliver consistent health education. Teachers frequently rely on intuition or personal experience due to insufficient professional preparation.

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Cultural values and societal expectations prioritize academic achievement, often to the detriment of health education. Parents and school administrators may unintentionally undermine health initiatives due to a narrow focus on cognitive outcomes.

Family engagement is inconsistent and often superficial, despite its critical role in reinforcing health behaviors. Teachers struggle to extend health messages beyond the classroom without parental collaboration.

Practical Recommendations

Addressing the barriers identified in this study requires a multi-pronged, context-sensitive approach involving teacher education, curriculum reform, community partnerships, and policy advocacy.

Pre-service Teacher Education Reform

Integrate health education as a core module in early childhood teacher preparation programs. Include training in health promotion theory, child development, basic first aid, and emotional intelligence. Use experiential learning methods, such as role-play and case studies, to prepare teachers for real-life classroom health scenarios.

Professional Development and Capacity Building

Establish regular in-service training focused on practical health education techniques. Provide contextualized content that reflects the unique needs of urban and rural schools. Encourage a peer-learning model, where experienced teachers share successful strategies with colleagues.

Curriculum and Resource Development

Develop and distribute age-appropriate, culturally relevant toolkits that help teachers plan and implement health lessons. Collaborate with local health departments and NGOs to co-create content tailored to community health priorities. Create assessment rubrics and lesson templates to standardize and evaluate health education activities.

Parental Involvement and Awareness Campaigns

Initiate school-based health workshops and campaigns for parents, focusing on practical topics such as nutrition, hygiene, and mental health. Distribute multimedia materials (e.g., posters, videos, apps) to communicate consistent health messages between school and home. Foster bidirectional communication channels that allow parents to voice concerns and contribute to health-related discussions.

Policy Advocacy and Institutional Commitment

Lobby for clear national mandates that designate health education as a fundamental domain in early childhood curricula. Advocate for budget allocations and teacher incentives to support implementation. Promote school-wide wellness models that embed health practices into routines, policies, and environments.

Directions for Future Research

While this study provides valuable qualitative insights, further research is needed to broaden and deepen our understanding of health education in early childhood settings: Mixed-methods research could combine qualitative interviews with quantitative measures of child health outcomes to assess the actual impact of teacher-led health education. Longitudinal studies

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would help trace the long-term influence of health education interventions on both teacher behavior and children's well-being, allowing for evidence-based policy development. Cross-cultural comparative research could illuminate how health education is conceptualized and enacted across different sociopolitical and cultural systems, highlighting transferable practices and global trends. Studies examining the role of digital technology, such as health education apps or e-learning platforms for teachers and parents, may offer innovative solutions to training and communication gaps.

In conclusion, the findings underscore the urgent need to elevate the role of health education in early childhood education—not as an auxiliary theme, but as a cornerstone of holistic child development. Achieving this vision will require aligned efforts across sectors, with teachers empowered, families engaged, and institutions fully committed to promoting health from the earliest stages of life.

Acknowledgment
The authors would like to express their sincere gratitude to all the preschool teachers who generously shared their time, experiences, and insights for this study. Special thanks are extended to the participating kindergartens in Henan Province for their cooperation and support throughout the research process.

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International Journal of Education, Psychology and Counseling
IJEPC
EISSN : 0128-164X
Volume 10 Issue 60 (October 2025) PP. 562-575
DOI 10.35631/IJEPC.1060040

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