How school-based health education can help young people navigate an uncertain world

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Abstract

Purpose – The COVID-19 pandemic has provided us a striking demonstration that the future is dynamic, unpredictable, complex and volatile. It is increasingly important that those working in the field of school-based health education reimagine the possibilities and potential of the subject to rise to the challenges presented and make a difference in learners' worlds. In this paper we explore the potential of health education learning to contribute to aspects of the Organization for Economic Co-operation and Development's (OECD's) Learning Compass 2030 from our perspective in Aotearoa New Zealand. This is a learning framework that uses the metaphor of navigation to demonstrate the competencies young people need in order to thrive in the world and has a significant focus on wellbeing for people and society (OECD, 2019).

Design/methodology/approach – We explore the links between the learning compass and a socio-critical approach to secondary school-based health education learning opportunities by producing and refining our own knowledge of the learning contexts and experiences that could potentially contribute to the elements of compass. We present this as dialogue produced through asynchronous online conversations between the paper's two authors across a three-month period in 2020 – a method befitting our COVID-19 times.

Findings – After employing a deductive thematic analysis we found extensive links between health education learning and aspects of the compass which are congruent with the notion that it is more about how the subject is taught than what is covered in a socio-critical health education. We communicate our findings by organising them into three themes that arose for us in analysis: learners' capability to understand the world, navigate the world and change the world.

Originality/value – We conclude the paper with key questions to consider if we are to reimagine school-based health education in order for learning experiences in the subject to enrich learners' understanding of how to navigate the complex and uncertain times they will face across their lives.

Keywords Health education, Adolescents, Qualitative methods

Paper type Research paper

Introduction

The COVID-19 pandemic has provided us with a striking demonstration that the world we live in is dynamic, unpredictable, complex and volatile. For many of us, the political systems within which we live, work and study have become more visible; and socio-economic disparities have widened (Lupton, 2020). We are all too aware of the need for community and national structures to act with agility in response to the uncertainty COVID-19 has unleashed on us all. As we turn to 2021, life is far from what we used to know as "normal" and we have come to realise that we are indeed living in an age of uncertainty, multiplicity and dynamism (McPhail, 2020).

In 2015, the OCED initiated the Future of Education and Skills 2030 project. As a starting point, the project revisited the OECD's Definition and Selection of Competencies: Theoretical and Conceptual Foundations (DeSeCo) project which was active at the turn of the twenty-first century (OECD, 2019). Four competencies were identified in the DeSeCo project as being critical for young people to live a successful life in a well-functioning society: using tools,

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interacting in heterogeneous groups, acting autonomously and (cutting across the preceding three) thinking (OECD, 2005). The four competencies were taken on in the Aotearoa context (Hipkins *et al.*, 2014) as five "key competencies" [1] which are a central component of the current mandated curriculum policy statement: *The New Zealand Curriculum* (Ministry of Education, 2007). After revisiting DeSeCo, the OECD developed The OECD Learning Framework 2030, which uses a navigational metaphor to highlight the competencies students need to orient themselves towards thriving in the world. This is known as The Learning Compass 2030 (from here "the compass") (OECD, 2019).

The compass comprises seven elements. Core foundations are the skills, knowledge, attitudes and values that provide a basis for developing other elements in the compass. Next are three transformative competencies which the OECD prioritises in order for young people "to contribute to and thrive in our world, and shape a better future" (OECD, 2019, p. 16). The four cardinal points of the compass are knowledge, skills, attitudes and values. These are different from those described in the core foundations element as these are contextualised to, and operationalised in, specific curricular disciplines such as health education. Surrounding the compass is what the OECD term "The Anticipation-Action-Reflection cycle" (p. 17). In context of health education, this can be seen as a process to enable young people to take health-promoting action. The final element is student agency and co-agency with others, which is connected to identity, self-efficacy and a sense of belonging.

It is important to recognise that the educational work of the OECD is not without critique. Criticism exists in relation to the OECD's Programme for International Student Achievement (PISA) and the inaugural measurement of global competence in PISA 2018. While it is beyond the scope of this paper to extensively critique the work of the OECD in this space, we note that the OECD's interest in education is economic in nature, and PISA brings with it great influence internationally (Cobb and Couch, 2018). If the idea of global competence assumes that people can possess similar understandings, attitudes and values that are deemed important in the twenty-first century workplace, then global competence shifts from a focus on social and cultural goals towards economic ends (Cobb and Couch, 2018). Likewise, where the compass accords value to certain competencies at the expense of others, the question of whose worldview(s) are being represented (and whose are not) needs to be asked, and the elements of the compass need to be viewed through a critical lens.

A socio-critical approach is a feature of health education in Aotearoa (Fitzpatrick and Burrows, 2017). Re-development of the New Zealand curriculum statements in previous decades (Ministry of Education, 1999, 2007) moved learning for all subjects away from being about the reproduction of prescribed syllabi of knowledge across the year levels, to being about the big ideas and concepts of a discipline. In an effort to have a future focused curriculum which recognises that knowledge needs to change over time in order to respond to a changing world, and where so many competing knowledges exist, a sustainable curriculum statement had to respond to these challenges (Hipkins *et al.*, 2014; Tasker, 1996).

For health education the foundations for a socio-critical approach came from different directions. The first direction was the need to conceptualise the health and physical education learning area (HPE) for curriculum purposes, which at the time was informed by a wide body of literature as summarised by Tasker (1996, 2004). The second direction was a collection of more broadly focused principles and values that spoke to the very essence and purpose of education being framed by the national curriculum statement. Key to this direction was the inclusion of an effective pedagogy statement and the five key competencies (Ministry of Education, 2007). The effective pedagogy statement requires teachers in Aotearoa to create supportive learning environments, encourage reflective thought and action, enhance the relevance of new learning, make connections to prior learning and experience, facilitate shared learning, use e-learning effectively to develop digitally fluent students and approach all teaching decisions through an inquiry process. Through these practices teachers then provide learning opportunities that

enable students to learn to think critically and creatively, participate and contribute and manage self, alongside relating to others (i.e. the key competencies).

Therefore, the foundations for a socio-critical approach in health education are grounded in teacher pedagogy (expected of all teachers in all subjects) added to by the constructivist approaches to subject knowledge teaching promoted by the original HPE curriculum developers (Tasker, 1996). The health education knowledge developed from this starting point is shaped by four strands with broad learning outcomes, seven key areas of learning and four underlying concepts. Arguably, it is the latter that best give shape to a socio-critical health education in the country (Robertson, 2015). The underlying concepts are: hauora, wellbeing; health promotion, the socio-ecological perspective; attitudes and values. The concepts are drawn from sociology and population health-related knowledge. Respectively, this knowledge is: A Māori (indigenous people of Aotearoa) model of wellbeing, the Ottawa Charter, an ecological model of health and wellbeing and notions of social justice.

In practice this means that when planning learning programmes to meet learners' needs, teachers and students select topics for study relevant to their experiences of the world and use learning area and subject concepts as a way to organise and learn contextual and content knowledge related to these topics. Consequently, the familiar topic matter for which health education is known, such as mental health and wellbeing, identity and self-worth, managing change and building resilience, healthy eating, sexuality and gender, friendships and relationships and alcohol and other drug education, is not a fixed body of understanding transmitted in much the same way to classes all around the country, but a unique programme of learning for every learner in every classroom, and as part of a local curriculum that responds to learners in each school (Ministry of Education, 2019). While we acknowledge the slippage that exists between the statement of official policy and the enactment of curriculum in any context around the world, the limited research that exists has pointed to evidence of a critical health education experience in Aotearoa, particularly at the senior secondary school level (Dixon, 2020; Fitzpatrick and Russell, 2015; Fitzpatrick and Allen, 2019).

Above, we have established a connection between the earlier DeSeCo competencies and the key competencies in *The New Zealand Curriculum* (Ministry of Education, 2007), the components of the learning compass, and a socio-critical approach to health education. We turn our attention now to exploring the extent to which learning experiences of secondary school health education in Aotearoa connect to the compass and alongside it, the potential of learning in health education to help young people navigate an uncertain world.

Methodology

The epistemological position underpinning our research is social constructionism. Burr (1995) provides a clear explanation of the key assumptions underpinning a social constructionist understanding of knowledge: criticality towards taken-for-granted ways of understanding the world, ways of understanding are historically and culturally relative, knowledge is constructed and sustained by interactions between people and knowledge and social action go together. Social constructionism holds that there is no fixed, determined nature to people or the world. Instead, it is through interaction with other people, and through language, that meaning is made, and knowledge is produced. As Burr asserts "when people talk to each other, the world gets constructed" (1995, p. 7). Social constructionism is pertinent in terms of school-based health education and education more generally in the twenty-first century. *The New Zealand Curriculum* underlines the importance of a supportive learning environment and facilitating shared learning, stating that "learning is inseparable from its social and cultural context. . .students learn as they engage in shared activities and conversations with other people" (Ministry of Education, 2007, p. 34). In relation to the educational work of the OECD, learning is "shaped by the context in which it is situated and is actively constructed through social negotiation with others" (OECD, 2012, p. 3).

Participants in the research are the paper's two authors. Our careers in health education in Aotearoa have followed similar trajectories: Beginning as secondary school teachers of the subject, before taking on roles in curriculum and assessment development at a national level, creating resources for teachers, working in professional learning and development for health education teachers, being active in advocacy for the subject through our involvement with the professional association in the country, and (currently) teaching in initial teacher education and health education-related university degrees. As a result, we have a strong understanding of both the intent of health education in Aotearoa and the enactment of teaching and learning in the subject across the country – the realities faced by teachers and learners on the ground. We acknowledge that it is somewhat unconventional to undertake a research study in which the only participants of the study are the paper's authors. However, as connected to the socially constructed nature of knowledge explained above, the epistolary data production method explained below, and finally the unusual circumstances that COVID-19 has brought upon us, the research upon which this paper is based provides an example of how researchers can experiment with new approaches.

Our method of data production was epistolary interviewing (Debenham, 2007), an asynchronous form of online communication. A growing number of authors in the education and health fields have in recent years turned to online interviewing for reasons such as convenience, cost and accessibility. Asynchronous interviewing enables both researcher and participant to be able to write and reply to interview questions at their convenience rather than having to adhere to fixed interview times (Ferguson, 2009; Fritz and Vandermause, 2018; James, 2016). Producing data online provides the ability to interview participants who are geographically dispersed, without the usual associated costs (Hawkins, 2018; Ratislavová and Ratislav, 2014) which opens opportunities to reach diverse participants. Another advantage in terms of convenience and cost is that written transcripts have been created through the online communication itself, requiring minimal preparation to be ready for analysis. Of note when researching health-related issues, online interviewing might be accessible for people with disabilities or chronic health conditions (Fritz and Vandermause, 2018) or for people whom have experienced a traumatic life event. For example, Ratislavová and Ratislav (2014) used the method to interview women who had experienced perinatal loss and concluded that online interviewing enabled them to access participants who would not have felt comfortable in a face-to-face interview, and that participating in a asynchronous conversation over time had some therapeutic effects for the women (in much the same way writing in a journal can help people process situations of change, loss and grief).

Conducting an online conversation to produce research data over time offers both advantages and disadvantages. On the one hand, time enables the participants to reflect more deeply and use supporting references when responding to the interview questions (James, 2016) and enables a relationship to be built (Ferguson, 2009; Ratislavová and Ratislav, 2014). On the other hand, each interview may last weeks or months, which could be a significant time commitment for both researcher and participant (Fritz and Vandermause, 2018). Other notable disadvantages of this method of data production include potential participant attrition (Ratislavová and Ratislav, 2014), the inability to record non-verbal cues (Hawkins, 2018) and the intricacies involved in researchers actively engaging with multiple online conversations over time (Debenham, 2007).

We chose to produce data through online asynchronous conversation for two specific reasons, as connected to the advantages described above. First, we are located in different locations in Aotearoa. Second, we wanted to allow ourselves time to consider our responses to the questions posed and draw on supporting evidence when constructing our replies. Without the constraints of temporality and spatiality inherent in face-to-face in-depth interviewing (James, 2016), we were able to produce and refine our knowledge of the compass and the connections that exist between elements of the compass and health education in Aotearoa

over time and at a distance. Our asynchronous online conversation took place across a three-month period in late 2020. The "conversation with a purpose" (Burgess, 1988) followed a semi-structured approach. Considering the elements of the compass, we developed a list of possible topics to cover. The first interview question was posed by email to "kick off the conversation" and successive questions flowed from the ensuing asynchronous conversation. Our choice of method connected to the social constructionist epistemological framing of the research and was also a data production method befitting of our (COVID-19) times.

Data from the online interview transcripts were analysed using a thematic approach (Braun and Clarke, 2012). Using the elements of the compass as the foundation upon which to focus our analytical attention, we coded our interview transcripts using key ideas from *OECD Learning Compass 2030: A series of Concept Notes* (OECD, 2019). From these codes, we organised our data into themes that connected elements of the compass to health education in Aotearoa. We thus used a deductive form of thematic analysis (Braun and Clarke, 2012) that enabled us to construct knowledge about the connections between our knowledge and understanding of health education and the elements of the compass.

Findings and discussion

After conducting our deductive thematic analysis (Braun and Clarke, 2012), we found extensive links between health education learning and aspects of the compass. Three main themes that arose for us are young people's fledgling ability (through undertaking learning experiences in health education) to develop capability in the following three areas: *understand the world*, *navigate the world* and *change the world*. Learners progress through these areas (each informing the next) as they become in the world.

The connections between health education learning and aspects of the compass are congruent with the notion that it is more about *how* the subject is taught than *what* is covered in a socio-critical health education. Demonstrating this, woven through the themes are findings from our conversation that relate to a critical approach to pedagogy in which knowledge and skills for critical thinking and critical action in health contexts are valued, developed, and practised. We begin our exploration of each theme with an extract from our epistolary interview, to set the scene for the findings therein and to demonstrate the dialogical nature of our data production method.

Understand the world

> The learning compass elements of knowledge, skills, and attitudes and values–with an overarching goal of wellbeing–seems something of a gift for validating our current health education curriculum statement. However, without well-developed cognitive abilities to firstly understand the world, any attempt to achieve what the curriculum intends is fruitless (Jenny).

> In addition to learners' cognitive foundations and the complex environments within which young people are living and learning, what do teachers of health education prioritise as valued knowledge and skills for the young people they work with, and how well equipped are they for this task? (Rachael).

> It's a teacher's job to help students understand aspects of their world they do not yet understand or even know exist (Jenny).

Throughout our conversation, we discussed the numerous ways in which the elements of the compass connect not only to health education in Aotearoa but also the values and the key competencies in *The New Zealand Curriculum* (Ministry of Education, 2007), which thus provides an opportunity for all subjects in the curriculum to connect to the compass. However, the very fact that "students can use the learning compass to find their way towards

wellbeing" (OECD, 2019, p. 25) places a socio-critical health education as a discipline of study (Fitzpatrick and Burrows, 2017) in a strong position to make meaningful contributions to the types of knowledge, skills, attitudes and values and competencies articulated in the compass.

Across our conversation we explored the importance of learning the skills for (and having opportunity through student-centred pedagogies to practise) wellbeing needs analysis, goal-setting, taking action and reflecting upon the action. As part of this, a wide range of skills are developed and refined, such as literacy skills, research skills, communication skills, time and event management, advocacy, problem-solving and decision-making, discerning between conflicting information and mediating between people with different views and ideas. For example, accessing and using data from a New Zealand study on youth mental and emotional health to understand the nature of mental health-related issues for young people, then prepare and present a talk or write a letter advocating for recommendations for (systemic) health-enhancing change. The skills above connect to those articulated in the learning compass in terms of meeting complex demands in situations of uncertainty, being adaptive and reflective and undertaking an iterative learning process that involves critical thought, action and reflection (OECD, 2019). The pedagogical practices that we explored in connection to the above skill development include role plays to rehearse skills, structured discussions and debates, students being given choice on topics and scenario-based discussion in small groups. These are practices that are viewed as relevant and effective in (mental) health education contexts (Dixon, 2020; Fitzpatrick *et al.*, 2018; Sanjakdar, 2019).

However, "*even before the skills there needs to be good quality knowledge"* (Jenny). Valued knowledge in health education in Aotearoa is shaped by teacher inquiry into learners' needs and the intersecting strands, key areas of learning and the underlying concepts of HPE (Ministry of Education, 2007). The compass states that knowledge and skills are interconnected, and the compass delineates four types of knowledge: disciplinary, interdisciplinary, epistemic and procedural. Data in our online conversation predominantly connected to disciplinary (subject-specific) knowledge as an essential foundation for understanding health education ideas, and epistemic knowledge in relation to developing learners' ability to think and act like a practitioner (OECD, 2019). In other words, the importance of developing not only knowledge about health-related contexts but also the need to apply a conceptual lens (in our case, the underlying concepts of HPE) to make sense of health-related issues. For young people outside of Aotearoa, conceptual lenses in health education could include ideas relating to social determinants of health, health promotion, social justice and/or critical health literacy.

As our conversation progressed, we grappled with the dominance of invoking "everyday" knowledge (McPhail, 2020) about health at the expense of developing disciplinary and epistemic knowledge. As Jenny stated, "*it's unfortunate that some of the most critical learning is not the most exciting and so much health education is dominated by the headline-grabbing in the moment topic matter, not the big ideas and transferable knowledge and concepts"*. We know that notions of health and illness are ubiquitous in society, and a lot of health education learning draws upon real-life content and contexts. When young people (and perhaps their teachers) draw upon everyday life experience and knowledge in the health education learning environment, a balancing act is needed. An over-emphasis on what one already knows about the world runs the risk of rendering health education about everything and nothing, and being "for" health rather than "about" health (Fitzpatrick and Burrows, 2017; Quennerstedt *et al.*, 2010; Robertson, 2015). To exemplify this point: teaching about alcohol (mis) use. An "everyday" approach to knowledge might reproduce and perpetuate individualistic and risk-based messages. Applying a conceptual lens however, teachers might enable learners to explore connections between alcohol and wellbeing for self, others and society, determinants of health contributing to a binge drinking culture in Aotearoa and health promotion actions

involved in a harm minimisation approach to alcohol (mis) use. This then moves learning from a moralistic approach (Jensen, 1997; Leahy, 2014) to a socio-critical one.

This is one example to demonstrate how, without a conceptual lens through which to explore health-related contexts, learners may leave health education without having developed disciplinary and epistemic knowledge; and with it, the ability to critically interrogate health-related contexts and achieve deep learning (McPhail, 2020). Implications arise for initial teacher education and in-service health education teachers' professional learning and development (Robertson and Dixon, 2017). Here, opportunities need to be seized upon to not only shape teachers' disciplinary and epistemic knowledge but also their confidence and competence in enacting the pedagogies that are known to be effective in health education learning environments.

Navigate the world

> The trouble is, well informed students who can see and understand the problems of the world (social and environmental) are feeling overwhelmed by it all and this is impacting their own wellbeing–so what is reasonable to expect young people to understand (and be able to do) without feeling the weight of the world on their shoulders? (Jenny).

> I think some of the ' "bigger picture" aspects of health education can be harnessed here. Developing understanding of how social determinants of health and world events contribute to a complex world for us all to negotiate. Fostering skills in searching for, accessing, (and then understanding) a wide range of health-related information and the ability to communicate this confidently and with meaning, so it can be understood to others (Rachael).

The elements of the compass combine to develop young people's ability to orient themselves towards a future for individual and collective wellbeing (OECD, 2019). Therefore, it is unsurprising that our online conversation about the compass and its connections to health education resulted in a theme to this effect. Our findings indicate that young people need to navigate different parts of the(ir) world. Knowledge, skills, attitudes and values can be developed through health education learning and can be transferred across the different parts of the world that young people negotiate. Connected to our finding in the preceding theme around the need to foster disciplinary and epistemic knowledge, the ability to apply health education knowledge and understanding across health contexts, environments and time, is critical.

Here, our conversation centred upon the connection between the transformative competencies of the compass and health education learning, perhaps because the competencies are highly transferable across a range of situations (OECD, 2019). The three competencies are: creating new value, reconciling tensions and dilemmas and taking responsibility. Our findings indicate that health education in Aotearoa is strongly framed around young people's ability to develop capability in these three areas. In our findings and discussion below, we explore one example of practice from health education to illustrate development of each of the three competencies.

The first part of the world in which young people negotiate is the local and (more) familiar: personal and home life, family, friends, own communities, own culture and some aspects of the digital world. In relation to these ideas, we discussed learning experiences across a range of health education contexts, which aim to enable young people to understand the complexity of the issues (through applying the conceptual lens of HPE in Aotearoa). Alongside, we acknowledged the need for young people to possess the resources in their basket to put into action when needed, including knowing how to access additional support when required. Links exist to the OECD's (2019) transformative competencies through the critical thinking required to attribute personal value to the issues explored, balancing sometimes competing ideas and demands placed upon them and taking responsibility for themselves. We discussed

goal-setting for personal wellbeing as an example of creating new value (and as a stepping stone to taking broader health promotion action in the future). Through student-centred learning experiences, young people can undertake a wellbeing needs analysis to plan, act and evaluate to enhance personal wellbeing.

The second part of the world in which young people traverse is the less familiar: future friendships and relationships, identities development, entering the world of work and higher education. Our online conversation indicates that health education learning is able to make a contribution to the development of capabilities congruent with the OECD's (2019) transformative competencies in this part of young people's worlds. For example, thinking critically and creatively to solve arising problems in new situations, balancing an increasing array of competing demands and pressures across all facets of life and reflecting on and learning from life events. As young people develop capability in these areas, they grow in confidence and competence in navigating the never ending situations that life brings. We discussed relationships and sexuality education (RSE) as a prime example of reconciling tensions and dilemmas (OECD, 2019). In RSE, young people negotiate attitudes, values and beliefs that may challenge those from their upbringing. They make sense of RSE learning in relation to their own growth and identities development. Finally, young people explore a range of relationships and sexuality-related situations, for some of which lines can be blurry, and learners will have different perspectives to others. Pedagogically-speaking, a socio-critical approach to RSE is meaningful and student-centred (Ministry of Education, 2019) and involves learning experiences with shared meaning-making and dialogue (Sanjakdar, 2019).

Young people must navigate through the unfamiliar: the wider world, other cultures, other walks of life, other ideologies, other knowledges. The net is cast further here, yet the three transformative competencies (OECD, 2019) again rise to the surface. Learners create new value by posing critical questions of health-related (ethical) issues. They reconcile tensions and dilemmas by understanding multiple perspectives and learning to live with multiple and disparate meanings about health issues, attitudes and beliefs. They take responsibility in a wider sense by understanding their own role in the creation of fair, just and sustainable societies. Once more, components of critical thinking are prominent, and alongside, the need for a socio-critical approach to pedagogical practice. For example, our conversation traversed the need to dig beyond surface-level understandings, challenge assumptions and the status quo, and unpack the source of one's own attitudes, values and beliefs about issues. The health education learning that we explored relating to learners' taking responsibility is closely connected to the "attitudes and values" underlying concept of HPE. Across levels of schooling, young people develop an increasingly sophisticated understanding of the different attitudes and values held by people and society, as well as develop an appreciation of the need for social justice, equity and equitable health outcomes for people in society. In reference to the unfamiliar, this might involve working with international material such as the sustainable development goals or World Health Organization data (for example) to explore attitudes, values and beliefs held by those outside Aotearoa in relation to a wide range of health-related issues. An appreciation of social (in)justices can be a springboard for young people to take critical action to change the(ir) world in a socio-critical health education; the final theme to which we now turn.

Change the world

> A passion for health-related further study and careers. There is opportunity to strengthen the connection between health education at school and the tertiary sector, and the health-related workforce in Aotearoa. . . Activating in young people a passion for people and the world; a hunger for social justice, and the tools in the toolkit to be able to be advocates and activists, but also the ability to think, write, and speak with a critical mindset (Rachael).

> Rather than a passion for health education, which positions interest in the subject emotively and personally (and is therefore subject to whims and changes), with a logical and rational approach [to knowledge], we could instead refocus the benefits of learning on a sense of giving back, contributing to society, and serving a greater good (Jenny).

The quotations above from our conversation encapsulate notions that resonate with aims of health education as a pathway to further study and a career in the health sector, the contested notion of "passion", advocacy and activism and serving the greater good. This final point connects back to the discussion in the previous theme that young people negotiate different parts of the world. A vital part of being a human in our complex times is to take action to help shape the future for themselves, those with whom they interact and communities as a whole (OECD, 2019).

Early on in our conversation we discussed the importance of learners in health education having opportunity to engage in advocacy and health promotion actions to enhance wellbeing for self, others around them and the wider community. Connected to theme one in our findings was a question Rachael raised: *"What then can health education achieve in the limited time it has, to both provide understanding and knowledge around how the world works and then engage in health promotion actions?"* Our conversation traversed the importance of student-centred pedagogies. Here, teachers might provide a platform for their learners to think critically about local wellbeing needs, and support the planning, taking action and reflecting on impact for people's wellbeing, in context of school and societal processes and structures.

We discussed the idea that activism and advocacy, components of health promotion more broadly, are under-done in health education in Aotearoa. This is despite health promotion being both a learning context and an underlying concept of HPE. In terms of connection to the compass we explored resonances between the Anticipation-Action-Reflection cycle (AAR) (OECD, 2019) and the process adopted in health education in Aotearoa for taking health promotion action: the action competence learning process (ACLP) (Ministry of Education, 2004). While other project-based learning, design thinking or inquiry learning processes are also relevant in learning contexts, both the AAR and the ACLP focus on wellbeing as a goal, and critical thinking as a mechanism by which action for wellbeing can be planned, taken and evaluated. The ACLP draws upon Jensen's (1997) explanation of action competence and the IVAC model as connected to environmental and health education in Denmark. The ACLP is introduced in health education as a series of steps, each informing the next, to take health-promoting action. First, students think critically, and use evidence to brainstorm wellbeing-related needs in a population, the vision they have for the group, and the actions that could be taken to enhance wellbeing. From here, they create an action plan, take action and finally evaluate the impact of their action in relation to wellbeing. As an iterative process, the final step would likely provide recommendations for future action related to the health issue, thereby informing the next iteration of the ACLP.

To exemplify a socio-critical health education approach to health promotion in a school setting, we thought about examples that we have seen over the years from teachers in Aotearoa. The difficulty with which we found this task speaks to missed opportunities. Health promotion can bring health education learning to life outside the classroom for the learners, connect more closely and meaningfully with the school or wider community and promote the subject to those who may misunderstand the nature of health education (Dixon, 2020; Fitzpatrick and Burrows, 2017). This difficulty notwithstanding, examples we recalled spanned such actions as improving aspects of a school's physical environment, critiquing a school policy and advocating for changes, working with aged care facilities to support older people's social wellbeing, working with community groups on food insecurity issues and working with the local council to develop a traffic safety plan for a school and its surrounds.

Through our conversation, we came to the conclusion that there exists much scope to better seize upon opportunities arising from health education learning to contribute to career pathways in health-related fields, to practise taking action towards wellbeing within the health education learning environment and in the community beyond the school and to ignite in young people a passion (for want of a better word) for contributing meaningfully to the world.

Conclusion

The three themes arising from our deductive thematic analysis *understand the world*, *navigate the world* and *change the world* have enabled us to establish wide-ranging and meaningful connections between elements of the compass and a socio-critical approach to health education in Aotearoa.

Methodologically-speaking, our epistolary interviewing was a valuable data production method, especially in context of times where alternatives to face-to-face interviewing are needed. We view this as a strength of this small research project because it took place over time, which enabled us to think more deeply about our answers, seek evidence to reinforce (or refute) the points each other made and the fluidity of the approach allowed us to veer off on tangents. Limitations of our method connect to the homogeneity of the participants, as we noted earlier. We would be interested in exploring this method of data production with a range of teachers, over a longer period of time. In doing so, we would be able to get a glimpse into the ways in which the ideas we have discussed in this paper "play out" in the health education learning environment. An interesting avenue for future research internationally would be the relevance of the compass for health education and other school subjects to demonstrate how learning across the curriculum might make a contribution to preparing young people to navigate an uncertain world.

We now conclude with key questions to consider if we are to reimagine school-based health education in order for learning experiences in the subject to enrich learners' understanding of how to navigate the complex and uncertain times they will face across their lives.

(1) How can health education teachers and researchers capitalise on such frameworks as the compass to advocate for the potential of the subject?

(2) To what extent do health education curricula across the world articulate disciplinary and epistemic knowledge (as opposed to "everyday" knowledge) and how does this work in practice?

(3) What implications have our findings raised for initial teacher education, as well as in-service professional learning and development in health education?

(4) To what extent is health education connected to other disciplinary knowledges, and how can the subject be integrated with these without losing its sense of purpose?

If the COVID-19 pandemic has taught us anything, it is that nothing in our world can be taken for granted. Multiple and flexible perspectives are needed to respond to a changing world: what we learned yesterday may not have relevance or be useful tomorrow. In order for curriculum understandings of health education to make a contribution to the wellbeing of individuals and the collective wellbeing of communities and nations, a socio-critical approach to health education is needed. Here, health education has the potential to enable young people to learn for purpose and take action to change the(ir) world, not solely learning knowledge for the sake of knowing. With a socio-critical approach to the subject, health education might be in a stronger position to harness its potential to make a meaningful contribution to young people's understanding of how to navigate a dynamic, unpredictable and complex future.

Note

1. Respectively in relation to the OECD (2005) competencies: using language, symbols and texts, relating to others, participating and contributing, managing self and thinking.

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