In search of the socially critical in health education

Exploring the views of health and physical education preservice teachers in Australia

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Abstract

Purpose – Health education still tends to be dominated by an approach designed to achieve individual behaviour change through the provision of knowledge to avoid risk. In contrast, a critical inquiry approach educates children and young people to develop their capacity to engage critically with knowledge, through reasoning, problem solving and challenging taken for granted assumptions, including the socially critical approach which investigates the impact of social and economic inequalities on, for example, health status and cultural understandings. The purpose of this paper is to explore the conditions of possibility for a socially critical approach to health education in schools. It examines the ways in which preservice health and physical education (HPE) teachers talked about their experiences of health education during their school-based practicum.

Design/methodology/approach – In total, 13 preservice HPE teachers who were about to graduate with a Bachelor of Health and Physical Education from a university in New South Wales, Australia were interviewed for the study. Five group interviews and one individual interview were conducted. The interviews were coded for themes and interpreted drawing on a biopedagogical theoretical framework as a way of understanding the salience of particular forms of knowledge in health education, how these are promoted and with what effects for how living healthily is understood.

Findings – The HPETE students talked with some certainty about the purpose of health education as a means to improve the health of young people—a certainty afforded by a medico-scientific view of health imbued with individualised, risk discourses. This purpose was seen as being achieved through using pedagogies, particularly those involving technology, that produced learning activities that were “engaging” and “relevant” for young people. Largely absent from their talk was evidence that they valued or practiced a socially critical approach to health education.

Practical implications – This paper has practical implications for designing health education teacher programmes that are responsive to expectations that contemporary school health education curricula employ a critical inquiry approach.

Originality/value – This paper addresses an empirical gap in the literature on the conditions of possibility for a socially critical approach to health education. It is proposed that rather than challenging HPE preservice teachers’ desires to improve the lives of young people, teacher educators need to work more explicitly within an educative approach that considers social contexts, health inequalities and the limitations of a behaviour change model.

Keywords Teacher education, Schools, Health education

Paper type Research paper

Introduction: what is a socio-critical health education?

Unlike the disciplinary knowledge and skills associated with literacy, mathematics and science, health education derives its disciplinary knowledge from a diverse range of disciplines. As Leahy et al. (2016) write: “Teachers can, and […] should draw insights from politics, sociology, psychology, religious studies, history, bio-medical science, cultural studies, geography, architecture and art (amongst others) to help students examine the range of issues that powerfully shape their lives, and the lives of others” (p. 5).

Traditionally the main purpose of health education in schools, however, has tended to be much less sophisticated than Leahy’s comments suggest. It has traditionally operated within an individualised health behaviour change model, educating young people about...
the dangers associated with their behaviour in order to change that behaviour (Leahy, 2014; Lupton, 1999; Leahy et al., 2016). However, as St Leger (2015) and others (Leahy et al., 2016) have pointed out, the main purpose of schools is to “build educational outcomes” (St Leger, 2015, p. vi) and, in this context, health education cannot be nor should it be expected to solve wider social health issues. Instead there has been a greater emphasis since the Ottawa Charter (World Health Organisation, 1986), on student empowerment through democratic pedagogies and ecological principles. In the European context, there is also a close relationship between health promotion and education for sustainability. All of this has prompted conversations about pedagogies that are seen as having the potential to build capacity to think critically about knowledge, practices and social action (Young, 2015), shifting views of the purpose of education to not only increasing pupils’ knowledge but also attending to “the critical, affective and action domains of learning”, with the pupil seen as an active participant in the process (Young, 2015, pp. 20-21). In this context health education, or rather health promotion, is seen as being concerned with “developing real-life competencies that help young people become engaged citizens who can make a difference through their actions” (Simovska, cited in Young, 2015, p. 28). Again in this context, health education or health promotion is understood more widely as a component of a whole school approach to health that requires partnerships with key players and stakeholders within schools and communities; it may also include a dedicated subject.

Australia and New Zealand, in contrast, have tended to take a different direction in relation to health education. Here the emphasis has been, particularly in the secondary school, on health education as a mandatory key learning area, usually aligned with physical education. Traditionally health education in this context has been underpinned by a “risk” discourse (Leahy, 2014) that focusses on personal health and individual responsibility for avoiding risks by making health enhancing choices. In recent iterations of the Australian Health and Physical Education (HPE) Curriculum and in the New Zealand Curriculum, however, there has been a clear move away from an individualised health behaviour change model to a more critical and “educative” approach based on a social model of health. For example, in New Zealand this has been achieved through a focus on well-being through the Maori philosophy of Hauora and a socio-ecological perspective (Ministry of Education, 2014). The Australian HPE Curriculum is underpinned by a commitment to “an educative purpose” and “critical inquiry” is written into the curriculum as a key proposition. The commitment to a critical inquiry approach is described as follows:

The Health and Physical Education curriculum engages students in critical inquiry processes that assist students in researching, analysing, applying and appraising knowledge in health and movement fields. In doing so, students will critically analyse and critically evaluate contextual factors that influence decision making, behaviours and actions, and explore inclusiveness, power inequalities, taken-for-granted assumptions, diversity and social justice (Australian Curriculum and Reporting Authority, 2014, p. 1).

A critical inquiry approach to curriculum is not new – most Australian State and Territory curricula have been underpinned by the notion that educating children and young people requires developing their capacity to engage critically with knowledge as part of schooling. Critical inquiry covers pedagogies that involve processes of reasoning and problem solving and pedagogies that involve “questioning the taken-for-granted”. It involves examining one’s own and others’ beliefs, through challenging assumptions and claims to universal truths (Leahy et al., 2013). With Fitzpatrick (2014), we argue that a socially critical inquiry approach is also necessary if health education is to take account of health inequalities and the potential for social action as suggested above by Young (2015) and Simovska et al. (see Simovska and Mannix-McNamara, 2015). A socially critical approach would involve investigating how social and economic inequalities impact on the
health potential of individuals and social groups, and examining how social and cultural
groups make sense of health, physical activity, sexuality, mental health and so on,
differently from one another.

While these shifts may not seem so radical, if health education is to move in this direction
it will mean a considerable adjustment for most Australian health education teachers as
"many in the field simply make use of the existing terminology from the health promotion
truths that dominate the field" (Leahy et al., 2016, p. 17).

As a starting point to help us understand the possibilities and constraints for the
 adoption of a socially critical perspective in health education, we report here on the results of
a study that investigated preservice HPE teachers’ understandings of health education and
their role as health educators. We discuss how their responses may provide insights into the
possibilities but also the constraints for teaching in ways that capture the intentions of the
Australian Curriculum: HPE, specifically in terms of its educative purpose and its focus on
critical inquiry. On the basis of these findings, we suggest ways in which teacher education
might provide an environment which enhances the possibilities of socially critical
approaches in health education classrooms.

To assist us in identifying the conditions of possibility for a socially critical approach to
health education, we have found the notion of biopedagogies (Wright, 2009) useful as a way of
prompting questions about how preservice teachers see the purpose of health education and
their role as health educators. Biopedagogies as a concept is derived from Foucault’s concept
of “biopower”, that is, the governance and regulation of individuals and populations through
practices associated with health and the body (Wright, 2009). From this perspective, health
education becomes a biopedagogy predicated on particular “truths” about health and about
how to live one’s life as a healthy citizen. What becomes important in this process is
identifying what “truths”/ways of knowing have the most currency, how they are promoted
and with what (likely) effects for understanding one’s own and others health (Wright, 2009).

The study

The paper draws on data collected for a qualitative study that were designed to investigate
the ways specialist HPE preservice teachers understood the purpose of health education
and their role as health educators in New South Wales (NSW) secondary schools.
The description of the study begins with an explication of the policy and curriculum context
in which these preservice teachers had learned to be health education teachers,
and concludes with a section on the methods employed to collect and analyse the data.

The teacher education context

Preservice teacher education in health education varies across Australian states but it is
most often coupled with physical education, especially in the Foundation to Year 10
curricula. In NSW, health education has been part of the combined physical and health
education curriculum in different forms since the late 1960s. In 1981, it was formalised in the
Personal Development and Health component of the PDHPE syllabus. From the 1960s,
the main teacher education institutions included subjects or strands in health education as
part of the physical education programmes.

At the university in which this study was conducted, the health education strand had
been allocated almost equal time in the HPE programme as PE, so that preservice teachers
studied at least one health content subject each semester, up until third year when pedagogy
subjects were shared with PE. As St Leger (2006) points out, the underpinning assumption
of most school-based health education programmes (in Australia and elsewhere) has been
that knowledge will change behaviour. While this has been very influential in the health
education programmes in the university in which the study is based, there has also been a
more realistic notion that knowledge of risks will not necessarily result in “healthy” choices.
In response to this uncertainty about the efficacy of health education to make a difference, the approach taken in most of the topic-based health education subjects has been to emphasise the need to persuade and engage students emotionally if they are to apply health knowledge and develop skills to assist them in making the “right” choices.

Pedagogically, most of the health subjects emphasise the importance of a student-centred approach that contribute to the development of skills (i.e. problem solving, decision making and knowledge appraisal skills). The assessment tasks place considerable responsibility on the preservice teachers to research topics and design learning activities, such as scenarios, stories or role plays, apply health knowledge to their own lives or the lives of others, in order to engage their peers, with the further intention that the activities would be suitable for use in schools.

The preservice teachers would have been exposed to a socially critical approach, but in isolated pockets rather than integrated throughout their programme. Only one subject, taught by one of the authors, entitled “Socio-critical perspectives on physical activity and physical education” deals with it explicitly. In this subject, preservice teachers are assessed on their ability to implement a critical inquiry pedagogical approach to develop learning experiences on, for example, gender, ethnicity, social class and sport. They also explore the dominance of, and consequences of, risk-based and individualised health discourses in HPE. Like most other subjects studied in their course, this subject is not linked with the professional experience (PEx) in schools, where learning is expected to occur through the experience of teaching and the mentoring of the supervising teacher.

For the participants in this study, the majority of their core health subjects would have been dominated by a “risk-based” approach, focussing on specific “topics” such as drugs, road safety, nutrition, obesity, heart disease and sex education. The salience of such an approach would also have been confirmed during their PEx in schools, where units on risk taking and learning to make decisions to avoid risk in areas such as sexuality education, road safety and drug education were common.

Method
The preservice fourth year Bachelor of Health and Physical Education participants were recruited following their final PEx (an extended internship of 35 days) in NSW high schools. Students were verbally invited to participate during the last lecture of their coursework by the lecturer and potential participants registered their interest by signing a consent form with contact details. The intention of the original research design was to undertake group interviews, however, because of the difficulties in participant recruitment, the project team made an exception for the opportunity to recruit an additional participant.

In total, 13 preservice teachers (4 men and 9 women) volunteered to participate. There were two group interviews that had three participants each; three group interviews that had two participants each; and one individual interview. The group interviews lasted between 100 and 120 minutes, with the individual interview lasting 60 minutes. The interviews were semi-structured and each began with inquiries about how health education was taught and organised in their PEx schools and the schools’ approach to health education. The second section moved on to the participants’ experiences of teaching and their ideas about the purpose of health education, how it should be taught and what content was important. The interviews were recorded and then transcribed professionally.

The transcripts of the interviews were coded using QSR NVivo under the broad themes of: “PEx experiences”, “health education in schools”, “preservice teachers’ professional identities”, “knowledge” and “pedagogies”. Further coding included word searches for terms like “technology”, “relevant/relevance” and “engage/engaging”, as themes related to these terms became evident from a close reading of the results of the first round of analysis.
Findings and commentary

The findings are organised around two main themes that emerged from the analysis. The first of these, “making a difference in young people’s lives”, provides an analysis of the “truths” upon which the preservice teachers’ convictions about health education and their role as health educators are founded. The second, “pedagogies of engagement”, describes the “actions” or pedagogies they describe as necessary to successfully fulfil this role.

In terms of the overall approach taken by the respondents, we suggested in the introduction that the experience of the participants would of been characterised largely by a “risk-based” approach, focusing on specific “topics” such as drugs, road safety, nutrition, obesity, heart disease and sex education. Aron’s description of the health education programme in his school confirmed this, and was typical of most of the students’ experience of health education on their PEx:

All they did in year 7 with drugs, I think, while I was there anyway, was smoking […] then they did risk taking, and what is a risk and it was more focused on things like summer safety, going to the beach, not wearing sunscreen, walking home, things like that. And then year 9 did a risk taking one as well but that was more focused on safe partying, how you’re going to plan a safe night out, planning parties, drinking responsibly things like that (Aron, individual interview 1).

Making a difference in young people’s lives: creating future healthy citizens

Most of the preservice teachers we interviewed were passionate about teaching health education. This passion was premised on the well-documented and powerful idea that young people are a group particularly at risk from range of ill-considered health practices (Rich and Evans, 2009; Montero and Kelly, 2016). Their role was to make a difference in young people’s lives by educating them about such risks to their health and well-being now and in the future. They described health education as essential to young people’s development as (healthy) citizens, in that it provided the knowledge and skills that young people need and want (and often cannot get anywhere else) to know how to live. Aron’s quote below is typical of a position shared by most of the preservice teachers:

Like obviously the aim of […] and health education is to try and create future citizens that are healthy and that sort of thing, but I think health education is more about giving them the skills to try and have that healthy life (Aron, individual interview 1).

The need was seen to be greatest where the students came from families which did not provide the guidance and information that enabled them to make better decisions – that is, “to question if it’s safe or not”. While Matt recognised that health education might not change his students’ lives, at the same time, in response to the questions from the interviewer, “Do you see [health education] being able to fulfil its purpose”, he responded, “I can’t see anything else that’s going to do it”. For Matt, this was particularly the case for those students who lacked the knowledge and guidance they needed to make safer decisions. He contrasted the students...
at his previous “really easy” schools who “just knew it”, with those at his last PEx school who, from his perspective, were particularly in need of health education:

[…] like if these kids are so ignorant or uneducated or haven’t been given the resources to notice the information about certain topics, then they’re just going to head down this path that could lead them in some bad situations and maybe follow their parents – follow the same path sort of thing (Matt, group interview 3).

An ongoing dilemma in discussions around health education is whether it can indeed have an impact on young people’s decision making (Gard and Pluim, 2014). In general, the preservice teachers in this study were optimists: they saw themselves as ideally positioned to make a difference through their capacity to make health knowledge relevant and engaging. This was in part because they assumed they understood their students’ lives though the similarity in age and because they could access and use more contemporary technology. Their optimism was based on the perception that they were providing health knowledge and skills that were relevant to their students’ everyday lives, if not now, in the future. These were knowledge and skills that would give their students the confidence to respond “appropriately” in risky situations and protect their students from making faulty (unhealthy) decisions. This position is very explicitly expressed in the following quotes from Jacqui and Aron:

[…] like you go through puberty whether you like it or not. So learning about it along the way just makes it so much easier and you know, learning about relationships, learning about sex, before you have to be thrown into a situation where you know nothing about it, it gives you that head start and it gives you that ability to make educated decisions about what you’re going to do with your own body and, and like how you can deal with things in the future (Jacqui, group interview 5).

I definitely think it has a high value, just for the fact that it’s going to be really relevant in their current lives, so drug education, sex education, road safety, they’re topics that they’re going to experience now, mental health is another one. If they don’t experience it now, it’s likely that they’re going to experience it in the future. So that’s why my philosophy is about giving them the skills so that they can attempt to deal with it in their current lives and then when these issues are confronting them in the future, then they’ll hopefully have the skills to deal with that, and firstly prevent it in first place, stop it happening in the first place, but then if they get into that situation then they know how to respond (Aron, individual interview 1).

The need for such decision-making skills was almost always coupled with references to the magnitude and/or consequences of the risk of particular behaviours in the young people’s lives. Like much of the mainstream literature discussing young people’s health (Burrows and McCormack, 2014; Leahy and Wright, 2016), the preservice teachers constituted the young people they would be teaching as a group by virtue of their age as being “at risk”. For example, Amber described how girls, who were “ab i tb o yc r a z y”, needed sexuality education which included scenarios demonstrating “the risk taking levels, like [a] continuum of what’s most risk taking, what’s less risk taking” (Amber, group interview 5). As Amber and Jacqui explain in the following exchange, demonstrating the magnitude of the risk and the usually horrendous consequences of making risky decisions was seen as a way of catching the students’ attention and thereby motivating them to change:

Amanda: I think you need to have a bit of risk in there so it’s, they understand […].

Jacqui: they need to understand the consequences.

Amanda: Yeah they need to know the consequences and what they can catch and show them the pictures and things like that, or the car accidents and the statistics […] (Group interview 5).

Amanda goes on to say that this information has to be relevant. She argues that when the information is relevant it works “better because it’s like, okay, so what’s going on in your life, like can you use these scenarios and that to help yourself kind of thing".
Since content was often about demonstrating risk, the preservice teachers frequently drew on the authority of “statistics” as evidence of the risk and their health consequences for young people. They used these statistics, generally derived from medico-scientific sources, such as morbidity or mortality statistics, to illustrate the relevance and magnitude of the risks to their students. The internet was a major source of such content. The use of the internet was taken to be an indication of the currency of information and the preservice teachers seemed to rarely question the “factuality” nor appropriateness of these knowledge sources. As other scholars have demonstrated (Bartlett and Miller, 2011; Gard and Pluim, 2014), such resources vary considerably in their quality and young people, (including teachers) are not necessarily adept at assessing their veracity. The web was used in preference to textbooks or journals as an immediate source for any knowledge that you might need for content or engagement. As Jacqui said, “there’s always Google” (Jacqui, group interview 5).

For all of the participants, the “truth” that all young people were at risk and that it was their role to assist their students understand and engage emotionally with the magnitude of the risks to their health, as well as provide them with the skills to make “healthy” decision now and in future, was taken for granted. At no stage did they challenge the efficacy of such a position or suggest alternative understandings of health education.

PEDAGOGIES OF “ENGAGEMENT”

The preservice teachers valued those teachers who were able to develop a rapport with their students, who got to know them and who were genuine in their interest in their students. As Megan and Tam said of the teachers they worked with on their practicum, “You could tell that the teachers generally care for the students too, so I think that helped in making health more valued and regarded more highly, it was really good” (Megan, group interview 1); and “Yeah and I think that comes as well from them genuinely caring for their students and they’re willing to kind of put in the extra effort or they’re willing to kind of relate it back to the students’ lives and working in a positive environment” (Tam, group interview 1).

Like other HPE teachers (see e.g. McCuaig et al., 2013), the preservice teachers saw the kinds of topics they covered, and the opportunities to share their own experiences, as productive of the special “caring” relationship that HPE teachers can have with their students (“kids kind of see you a bit differently, they see the other side of you” (Amber, group interview 1)). Again they perceived this relationship as adding to their capacity to make a difference in their students’ lives and is a considerable part of why they like being HPE teachers:

“I think it would lose a lot of meaning if you did without [the special relationship]. Especially because you are teaching them like safe relationships and who you can tell things to, and really as a teacher you should be someone who has a safe relationship with a kid, like if they are dealing with mental health issues that they should be able to come and tell you as a PE teacher, maybe they don’t want to do that with their maths teacher, but because you know so much about it they feel comfortable there, so you have that over teachers who teach other subjects (Jacqui, group interview 5).

On the other hand, the preservice teachers distanced themselves from those “older” teachers who used “old fashioned” or “out-dated” methods and content that they have been using for years, such as worksheets or overhead transparencies. This distinction extended to teachers who instructed from the front of the room rather than using activities. These teachers were differentiated from younger teachers (like themselves) who were more likely to engage in “student-centred” teaching methods and the contemporary technologies they described as more likely to engage students by capturing their interest. In the following quote, Jocelyn recites some of the themes already mentioned of engagement and relevance and links these to both more student-centred approaches, such as discussion and the use of ICT:

“Yeah, I think you had to make it so student-centred, like especially, I think it depends on, so and what you’re teaching, but just like on the engagement side of things and the motivation side of
things, if you’re up there going, oh […] this […] on lifestyle, like there’s these components, they’re just going to sit there and go, yeah and how does that relate? So, I think like, I think discussions are really good, particularly for like year 9 and 10 because they just want to have their opinion heard, like – yeah, so I think just student based approaches, […] I don’t know, I think like having variation like having ICT, having like teacher directed, having students, and having like exploratory activities is […] important. Yeah, I think, especially because you want it to be relevant to their lives as well (Jocelyn, group interview 4).

The use of ICT seemed to encompass everything from using PowerPoint presentations to YouTube and segments from popular videos. There was no mention of using Web 2.0 technologies or student led productions, rather technology was a resource to provide content and sometimes to provoke discussions. It was valued for its relevance and capacity to entertain and engage their students’ attention through an appeal to the emotions.

In the following quote, Matt describes how he changed the approach that had been used previously (“everything by the book […] I don’t believe in that”) by bringing in videos and using PowerPoint and prompting discussion:

When I go to year 8 once again PowerPoint presentations otherwise it would just be reading from the book, too much just looking down and I don’t believe in that, we need to have some discussion okay. At the same time I guess I infused a bit of sense of humour. So we looked at CPR [cardiopulmonary resuscitation] and I found a video of Mr Bean, so I got them to just briefly analyse that, it only went for 2 minutes, 2 or 3 minutes you know Mr Bean he’s doing something funny. But I got them all, what was he doing and what should he have been doing. And then in that sense it kind of was like an assessment of what they have learnt, so that worked really well […] There was too much passive learning in the book and so I altered it just a little bit to make it more active, have some active engagement (Matt, focus interview group 3).

Matt’s example certainly illustrates how video can help make learning CPR entertaining and perhaps memorable, but some other examples point to how preservice teachers were impressed by advertising campaigns without interrogating their effects, or even their “relevance” to the young people in their class. For example, Ella describes below how the use of News Ltd campaign “Real Heroes Walk Away” (RHWA) as a focus for unit on was a highlight of her PEEx:

I really thought it was really relevant to the kids and it was all about this whole like sucker punch [unexpected knockout punch]; king hitting violence that’s going on; drunken violence that’s going on especially in like your cities and things like that around Australia. So I loved that […] So that was what stood out for me (Ella, group interview 3).

The RHWA campaign was developed in response to the death of Thomas Kelly, 18 years of age, when he fell and hit his head, following an “apparently unprovoked attack” which involved a “king-hit [a violent knockout punch] in the face as he talked on his mobile phone” (Quilter, 2013, p. 443). The video is organised around a set of statistics (see McIlveen, 2012), presumably on the premise that their shock value will motivate change (e.g. the numbers of assaults, the numbers of people hospitalised, the numbers repaired through cosmetic surgery, the numbers who died following assaults and the costs of assaults to the Australian economy). Those who present the statistics are “authorities” such as various neuro and cosmetic surgeons, police leaders, an economist, then Prime Minister Julia Gillard and the then Opposition leader Tony Abbott. This is interwoven with segments (again citing statistics) illustrating the magnitude of his family’s grief and loss from the father of another young man, Matt Stanley who died in circumstances similar to Thomas Kelly.

As is clear from her quote above, Ella was very much taken by the video as a resource for discussing the “drunken violence” that is going on in our cities around Australia. Why do we have a problem with this example? First, we see the video as promoting a simplistic message that socialising and alcohol is a risky business for young people, and this primarily from the
point of view of a series of authority figures citing statistics to demonstrate the magnitude of the problem. As numerous researchers have pointed out, such messages about risk do not engage with young people’s own life experiences; they offer few points of identification and fail to engage with the complexity of the reasons young people might drink and/or why they might engage in violence (see Lindsay et al., 2009). As Quilter (2013, p. 444) says of this campaign, “there is at least one voice that has been virtually absent from the field. And that is the young people who are often the ones visiting Kings Cross [known as Sydney’s red light district]; the ones in danger both of offending and being attacked”. She goes on to point out:

In all of the positive discussion about how to make Kings Cross “safer”, its venues more responsible – to “clean it up” – it begs the question: what is the drive, the desire, particularly of young people, to go to Kings Cross? (p. 444).

These are all useful questions to inform a socially critical discussion around the resource and the practices that it warns against. However, such considerations were absent from Ella’s description of how the video was used in the health education classroom at her school.

Neither Ella nor her peers make mention of how they might provide content about various risks, including alcohol consumption, in the context of research about young people’s meanings of particular practices or wider cultural meanings associated with in terms of culture or the meaning of practices for young people. For example, again in relation to alcohol consumption, Lindsay et al. (2009, p. 3), on the basis of their interviews with young people, report on the way “drinking to intoxication is not only a common feature of socialising for young people” but “is viewed as an important and largely pleasurable social experience”. They conclude that, “[i]n a context where there is a strong imperative to drink, the idea that young people should be ‘responsible’ ‘low risk’ drinkers at all times is problematic” (p. 3). We, like Lindsay et al., are left suggesting that, “[i]f young people are to recognise themselves, their friends, and the things that are important in their lives in these policies, programs and interventions […] (including schools), then they need to be addressed or engaged in ways that recognise the complexities” (p. 5) of what is taking place in young people’s everyday life. This includes media stories as well as more immediate family and friend relations.

Finally, Aron’s description of his approach very clearly summarises the simple linear connections between content knowledge (statistics), emotional stimuli generated by illustrations of the consequences (a speeding campaign), connecting the risks to “real life” and the assumption that this will generate behaviour change (“I should stick to the speed limit”), that characterised the preservice teachers’ descriptions of most of their lessons:

My approach is to try and give them the content and the skills. So give them the content first and then try and design your activities so that it expands on that content and then makes it more realistic. Because if you just give them the content, then they’re not going to learn it as much, so that’s why I especially enjoyed doing road safety because if you give them the content then you could throw up a graph, and then say this is how many people who were killed by speeding, then you throw up an advertising campaign about speeding, and then that’s making those links more clearer. So then they’ve got the foundation and the theory, and then they’ve got those other extra things to cement it and show that it’s more real life and trying to give them those skills, so that when they go out and they’re on their own, they go, oh, we know the risks of speeding now, and we’ve got the skills now to say well, if I go too fast, I’m more likely to have an accident so I should stick to the speed limit (Aron, individual interview 1).

There seems very little room in such a neat association of pedagogical connections for disturbing the logic that knowledge plus a dose of affective engagement will bring about a change of attitude and consequently a “healthier” decision. For many of the preservice teachers, their pleasure in teaching health was generated by the feeling of having taught a “good” lesson – that is a well-organised lesson in which the students were engaged.
One exception to this pedagogical approach was that expressed by Amber in her description of how health education is different from other subjects. Although she was also very certain about the value of health education in shaping “well-rounded citizens”, and in other places in her interview invokes individualised discourses of risk (see above), in the following quote, Amber talks about knowledge as contingent. She acknowledges different perspectives and allows for a more open pedagogy (of discussion) in response to the different experiences and social-cultural contexts that students bring to health education classes:

[… ] I think our subject’s lucky where you can spark discussion on morals and values and family backgrounds and things like that, where they won’t just learn things about health but they learn things about different cultures and different opinions and how you can talk about different opinions and how you can respect them and bullying and things like that, like yeah (Amber, group interview 5).

Of all the preservice teachers interviewed, Amber was the only one to describe an approach to teaching health education that resonated with the ideas of a socially critical approach.

Discussion
The preservice teachers that we interviewed were enthusiastic about teaching health education, on the basis that they could make a difference in their students’ lives. In biopedagogical terms, they described pedagogies that draw attention to how young people might understand themselves as being “at risk”, so that they could take action to enhance their health by minimising “risk” both now and in the future. This emphasis on personal change and individualised responsibility left little room for a socially critical or an inquiry-based sensibility. The preservice teachers looked to the “certainty” afforded by a medico-scientific view of health and medico-scientific sources of knowledge, as represented in the media sources they chose as knowledge resources, to demonstrate and emphasise health risks to their students.

These findings are of no surprise given the dominance of risk approaches in the health education of both the schools in which they completed their PEx, and in the health and science-based subjects in their teacher education programme. Both schools drew on a traditional health promotion approach, that is, an approach designed to achieve individual behaviour change through the provision of knowledge (see Macrae, 2015; Montero and Kelly 2016). On one hand, the findings suggest limited possibilities for teaching from a socially critical perspective. However, the participants’ responses can also be read as pointing to possibilities for approaches and strategies in teacher education which build on the preservice teachers’ enthusiasm for their subject, their espoused commitment to student-centred learning and their facility with contemporary technologies.

In arguing for an educative and critical approach, we are not in the words of Wolf (2010) “against health”. We are interested in young people experiencing positive health and leading flourishing lives. However, like Wolf and others we suggest that the notion of teaching health education with a view to saving young people, without attending to social and cultural contexts, is likely to impede the very ends the participants’ desire. Following Leahy et al. (2016), we draw on Berlant’s notion of “cruel optimism” to suggest that the participants’ desires to improve their students’ health “diverts […] attention from important ethical, social and political questions” (cited in Rasmussen, 2015, p. 192). The participants’ commitment to one way of thinking, one framework, silences other possibilities for what and how they might teach health education in schools.

As a way forward, an essential basis for a socially critical and educative approach requires an explicit demonstration in teacher education that health knowledge is contested, and there are multiple perspectives from which to understand and teach about health. What is important here is making these different perspectives visible, to see each as a “discourse” or set of ideas which looks to different (and sometimes overlapping) sources of knowledge.
Each way of understanding health has effects or consequences for how individuals, social groups, institutions and governments come to know themselves, or those they govern, and act in relation to health. Taking such an approach makes it possible to see a behaviour change model as one approach among many and provides the means to identify and reflect on the approaches that currently dominate health education teaching. By contrasting approaches, the risk-based narrative that often underpins health education can be called into question as one that might not best serve the interests of the young people in health education classrooms.

A socially critical health education involves learning about health not only to save lives as an end point, but also to interrogate health in the present as messy, complicated, difficult, dependent and formed in a context broader than the individual. In doing so, young people may well be better placed to understanding health and what shapes it. If they were to understand the structures and contexts that uphold and make possible basic health, then they are also better placed to advocate, speak out or protest when health rights or the structures that uphold health are taken away.

The preservice teachers’ espoused commitment to student-centred learning and innovative approaches also offers possibilities for a socially critical health education. Their responses, and indeed health education in Australia generally (see Leahy et al., 2016), emphasise individual rather than collective action, a localised practice of students collaborating or discussing in classrooms, rather than looking outwards to communities. Despite references to advocacy, for example, in the new Australian HPE Curriculum (Australian Curriculum Assessment and Reporting Authority, 2014), there is a limited tradition and an even more limited pedagogical framework for student action in and through health education in Australian classrooms. There is considerable room for expanding on more limited notions of student-centred learning to engage students as researchers, problem framers as well as problem solvers in terms of health knowledge (see Wright, 2014). From a socially critical perspective, this could involve collecting data which bring the voices of people of all ages, ethnicities, abilities and social classes into the classroom and into discussions around health experiences, policy and strategies.

Further models are provided by European approaches to health education. For example, the Investigation-Vision-Action-Change approach, espoused by Simovska and Jensen (2009), provides a model for facilitating participatory work with young people. In this model, students are provided with opportunities to identify a local health issues that is important to them, to research the problem, envision possible solutions and take action to address the issue. Simovska and Jensen (2009) emphasise that, “regardless of the level or scope of participation, it is imperative that participation of young people in decision-making in the domains that affect their everyday lives is ‘consequential’: that is, it provides meaningful possibilities for young people to make a difference to their own lives” (p. 1). We would also add in the lives of others in their communities, however, widely this might be defined.

Despite their enthusiasm for technology, the participants did not describe, nor did they seem to think of using blogging or the interactive potential of the web and social platforms to conduct discussions, making no use of the affordances of technology for making and creating digital texts (Gauntlett, 2011). There seemed to be very little interest or concern about how and by whom these texts were produced, nor their likely effects on students beyond engagement with the texts to educate about risks. There was little evidence of what, Pangrazio (2016, p. 172) refers to, as “a critical disposition toward digital media”. We argue that this is an area that requires a more specific focus in health teacher education. While there are some frameworks for interrogating/bringing a critical focus to traditional media texts (print, advertising and film) (see Wright, 2004), health education teachers need to be better equipped with tools to engage with social media, to facilitate their own evaluation of media texts and for “empowering” their students to critically engage with these texts.
Making visible different discourses/narratives, as suggested above, is a starting point for demonstrating how knowledge is contingent and shaped within relations of power, and how these power relations play out in the ambiguous context of Facebook, blogs, tweets and so on. This, however, is an underdeveloped area in the health education literature that requires considerably more attention, and where other disciplines such as media and communication could well be drawn on for thinking and teaching differently.

Conclusion
Teaching health education in contemporary classrooms is a challenging endeavour. However, the preservice teachers we interviewed expressed considerable enthusiasm for their role. The challenge is to assist them to direct this enthusiasm beyond risk-based approaches which focus on individual responsibility and behaviour change, an approach that many point out is unlikely to succeed (Gard and Pluim, 2014; Leahy et al., 2016). Health education knowledge is multidisciplinary and requires an understanding of health as a social and cultural phenomenon.

In Australia and New Zealand, the coupling of HPE means that those preparing to teach these subjects in secondary schools are required to take foundational subjects in anatomy and physiology and other science-based subjects but not in the social sciences or humanities. Yet, the health knowledge they draw on and are expected to teach in an educative fashion can best be understood, we argue with some grounding in sociology and/or cultural studies. Such a grounding provides the tools to examine knowledge, including health knowledge as contingent, as shaped by social and historical circumstances, and with particular consequences for individuals and the ways they are governed. It also provided the means to think about health inequalities and consider ways in which they might make a difference in their students’ lives that go beyond shocking them into changing their behaviour.

References


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Further reading

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