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School health education and promotion: current approaches and critical perspectives: part 2

Introduction

This is the second of two special issues that focus on the critical perspectives in health education. As we suggested in our first editorial (Leahy and Simovska, 2017), critical health and well-being education research interrogates the politics, purposes and practices of health education. In the original call for papers, we placed a focus on the research that adopted a “critical approach” to school health and well-being. Such analyses can include historical, conceptual and empirical studies that examine curriculum content and teaching strategies. This work necessarily requires the revisiting of the underlying epistemological and methodological assumptions of research in the field with a view of exploring the many complexities involved in the field of health education in schools. Given health education’s continuing role in policy and curriculum and the rise of well-being agendas in schools, we suggest that it is crucial that we continue to question the everyday taken for granted assumptions that both characterize and drive the field. This work, rather than being simply understood as critique, requires all of us engaged with the empirical and theoretical development and implementation of health education and health promotion to continuously revisit, rethink and develop our research, policy and practice as we work to ensure better health and well-being education.

Connection with European Educational Research Association (EERA) research network

This special issue of Health Education is the second in the series of special issues planned under the framework of a collaboration between Emerald and the European EERA Network 8, Research on Health Education. EERA consists of more than 30 member associations and is organised in topic-based research networks with members from all over the world, representing broad range of the interdisciplinary field of educational research. EERA’s annual conference is attended by about 2,500 participants from across the globe.

Overview of the papers

There are six papers in this special issue. The papers utilise different approaches to critical scholarship and provide insights into school health and well-being education across a range educational contexts from the USA, Denmark, Finland, Spain, Australia and Canada.

The first paper by Martinson and Elia entitled “Ecological and political economy lenses for school health education: a critical pedagogy shift” provides an examination of school health education in the USA. In this conceptual paper, the authors draw insights from ecological models to highlight the limitations and opportunities for the improvement of health education. They reveal the dominance of individualistic approaches of health education and trouble how such approaches mean that programmes rarely engage with, or integrate the social determinants of health. For the authors, and many others engaged in the field, in areas such as research, scholarship, practice, policy making and implementation, this raises serious questions about the work that is sometimes done under the guise of health education. Martinson and Elia suggest that one of the ways forward is to ensure that versions of taught health education are grounded in ecological and political economy understandings of health and in critical pedagogies that allow students to more
comprehensively and accurately understand the complex nature of health, how their own socio-psychological worlds influence health, and their own potential for agency within those worlds.

In the second paper, Wright, O’Flynn and Welch search for a “Socially critical health education by exploring the views of health and physical education preservice teachers in Australia”. As in Martinson and Elia’s paper, the authors take issue with the continued dominance of individual behaviour change approaches in the field of health education. They suggest that a counter-model to this is a critical inquiry approach. They argue that this approach could shift the educative focus of health education towards developing students’ capacities to engage critically with knowledge through reasoning, problem solving, and challenging taken for granted assumptions. Given this desire, the paper looks at what is currently happening within health education at grassroots level in teacher education, and questions whether or not critical ambitions are indeed possible in this context. The authors draw from data collected from 13 preservice health and physical education (HPE) teacher interviews that were related to school practice in health education, using the concept of “biopedagogies” to analyse the interviews. For their participants, the purpose of health education was essentially about risk reduction, improving the health of young people by attempting to reduce the risks that young people were exposed to. Given this focus, there was a little space for critical approaches. The authors conclude by suggesting that teacher educators need to work more explicitly within an educative approach that considers social contexts, health inequalities, and the limitations of a risk reduction, behaviour change model.

In the third paper, LeAnne Petherick offers an analysis of race and culture in secondary school HPE in Ontario, Canada. Petherick’s paper “Race and culture in the secondary school health and physical education curriculum in Ontario, Canada: A critical reading” utilises critical race theory to analyse the secondary HPE curriculum. Her analysis highlights how the new curriculum provides multiple entry points for students to learn more about culture and race. For example, she highlights the fact that the areas of food, substance use and movement are considered to be key areas where issues of culture and race can be addressed. The acknowledgement in the curriculum of First Nations, Métis and Inuit people is significant when compared to other recently revised HPE curriculum from around the globe. She argues that this curriculum appears to offer more opportunity to educate people about how culture and identity affect health than is the norm.

Roien, Graugaard and Simovska in their paper “The research landscape of school-based sexuality education – systematic mapping of the literature” review the characteristics of the international research on school-based sexuality education. The purpose of the mapping is to discuss the overall characteristics of the research, with a particular focus on the framing of critical approaches. The review reveals that the international research landscape in this field is dominated by research conducted in schools in English-speaking countries. The authors find significant diversity in terms of the theoretical and methodological approaches, but despite this, they also find an overall lack of conceptual research. They also conclude that research that examines sexuality education aimed at younger children is generally a neglected field of study. Based on their findings, the authors make several recommendations. First, they call for research that engages with more diverse sociocultural, political and geographical contexts. Second, they suggest that there is a need for more conceptual research that utilises social theory. Finally, they suggest that there is a need for more research focussing on the potentials and challenges linked to critical sexuality education for younger pupils.

Cala and Soriano in their paper entitled “School and emotional wellbeing: a transcultural analysis on youth in Southern Spain” assess and compare emotional and school well-being among Romanian, Moroccan and Spanish youth in Southern Spain, and explore the relationships between them. The authors utilise a cross-sectional research method with
cluster sampling. They demonstrate that there are significant differences around emotional well-being relating to gender, with girls showing less emotional well-being than boys. The study also found that emotional well-being was lower in Moroccan students. However, levels of school well-being were higher in Moroccan students and girls. Emotional well-being and school well-being are presented as related and co-linear variables with a predictive power over one another. However, as their mixed and apparently somewhat contradictory findings show, understanding cultural expressions in heterogeneous cultures is a complex task and the cross-cultural approach deployed here allows for a questioning of the well-being framework that dominates modern western culture. The paper suggests that gender and culture remain decisive determinants for adolescent health, with both positive and negative effects. The authors argue that it would be useful to develop educative strategies to implement transcultural emotional and school well-being that build on the strengths of different communities.

The final paper “Subjective health literacy among school-aged children” explores Finnish adolescents’ subjective health literacy and its association to school achievement, learning difficulties, educational aspirations, and family affluence. In the first nationally representative study on health literacy, Paakkari and colleagues analysed Finnish data that were collected as a part of the International Health Behaviour in School-aged Children study. The sample consisted of a total of 3,833 adolescents from seventh and ninth grade from 359 schools. Analyses of data revealed that approximately one-third of the sample manifested a high level of HL, around 60 per cent had a moderate level of HL, and about one-tenth had low HL. Analysis also revealed that there were age and gender differences. For example, HL level was lower for boys than for girls, and lower for seventh graders than for ninth graders. In the total sample, the authors found that the strongest explanatory variables for HL were school achievement in the first language and educational aspirations.

Endnote
This second special issue portrays six different takes on critical health and well-being education in different geographical, socio-political and educational contexts. With this portrayal, we hope to continue to contribute to, and advance, debate related to the often taken for granted role that school health education is afforded and the mechanisms by which it is enacted. Different forms of critical research can also be valuable in providing more nuanced analyses and evidence which can inspire further development of health education practices in schools as well as related professional competences of teachers. Finally, we hope that such critical research can set the agenda for policy and curriculum development that consider the wider determinants of health and aim at the development of pupils’ comprehensive health-related competences instead of the regulation of their behaviour.

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Reference
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.
It is this finer grained analysis that provides the material for this paper. To this analysis we brought a biopedagogical lens (Wright, 2009) to ask the following questions: what “truths” about health were drawn on as the preservice teachers talked about health education and their role as health educators in schools; what kinds of actions (interventions/ pedagogies) were thought to be necessary to carry out this role effectively; and what authorities were drawn on to substantiate the value and credibility of the knowledge they described as important? The answers to these analytical questions provide the material to consider whether and how these constitute (or not) conditions of possibility (Foucault, 1970) for teaching with an “educative purpose” and engaging a socially critical health education pedagogy.

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, focussing 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.

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Further reading


About the authors

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Ecological and political economy lenses for school health education: a critical pedagogy shift

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Abstract

Purpose – The purpose of this paper is to critically examine school health education in the USA and present alternative approaches for more critical and comprehensive health education.

Design/methodology/approach – An ecological model framework is used to identify the limitations and opportunities for improvement in school health education in the USA. An argument is made for school health education that embraces ecological approaches, political economy theory, and critical pedagogies.

Findings – US schools have been tasked with providing health education that is primarily rooted in individualistic approaches. Often missing from this education is recognition of the social and structural determinants of health that greatly influence one’s ability to practice the health behaviors promoted in schools. This raises pedagogical and ethical concerns, which can be addressed by teaching health education that is grounded in ecological and political economy understandings of health and in critical pedagogies that allow students to more comprehensively and accurately understand health, how their worlds influence health, and their agency within those worlds.

Practical implications – This paper offers justification for a critical model of school health education and for the professional preparation of school health educators that is grounded in critical pedagogy and ecological approaches.

Originality/value – This work complements other research on critical health education by adding explicit integration of the ecological model and the political economy theory within critical pedagogies.

Keywords Teaching, USA, Educational practice, Health education, Schools, Social change

Paper type Conceptual paper

Introduction

Schools carry a particular role in supporting child and adolescent health across the USA. As described in Gard and Pluim’s (2014) critical history of US school health education, schools have long been used as instruments for public health interventions that are focused on individual behavior change. Schools are tasked with addressing complex health and social problems that get reduced to individual behaviors. Today, we have school health education curricula focused on decreasing rates of, for example, smoking, drug use, obesity, and pregnancy – and primarily through behavior change strategies. School health education is ripe for critical exploration that reconsiders what we are teaching students about health. More specifically, how might we best teach students to think critically about the complexities of health and all that influences health outcomes?

This paper approaches these critical questions using the lens of an ecological model to identify the opportunities for improvement in US school health education. We propose that school health educators integrate the ecological model, political economy theory, and critical pedagogies so that students learn about the complex interactions between structural, social, and individual influences on health. Also, we consider how to prepare school health education teachers to teach in ways that support this kind of learning about health.

Using an ecological model

An ecological model allows for more critical approaches to health that go beyond superficial understandings of individual behavior as being the sole determinant of health (see Figure 1).
The ecological approach that we propose here is grounded in two key assumptions: health and health behaviors are influenced by factors at the individual, interpersonal, community, institutional, and public policy levels; and these factors influence each other across the different levels (McLeroy et al., 1988; Sallis et al., 2008).

This ecological model allows for critical understanding not only of health outcomes, but also of the social and structural determinants of health inequities (e.g. inadequate and unsafe housing, low wages and underemployment, incarceration, food insecurity, environmental toxins, racial segregation, low-quality education, and violence) (Adelman et al., 2008; Bailey et al., 2017). Understanding why one's address is one of the most predictive determinants of health requires an analysis of the policies and institutional practices that systematically discriminate against and segregate communities of color, low-income communities, immigrants, LGBT communities, people with disabilities, and other marginalized groups (Galea et al., 2011). An ecological approach reveals relations of power, privilege, oppression, and resistance and their influences on health outcomes.

While US schools have been slow to incorporate the multiple influences on health in health education curricula, ecological models of health have long been embraced by organizations focused on understanding and addressing health inequities. For example, the Centers for Disease Control and Prevention (CDC) and the World Health Organization use social ecological approaches to critically examine the inequities embedded in a range of health issues – from cancer to violence – and to create appropriately comprehensive interventions (CDC 2013, 2015; Dahlberg and Krug, 2002). The World Health Organization explains that an ecological framework inextricably links health to social justice as it reveals the unjust systems that create avoidable disparities in health:

Having health framed as a social phenomenon emphasizes health as a topic of social justice more broadly. Consequently, health equity (described by the absence of unfair and avoidable or remediable differences in health among social groups) becomes a guiding criterion or principle (Solar and Irwin, 2010, p. 4).

Ecological approaches allow for deeper understandings of the social injustices and structural inequities that lead to health disparities, and change is then focused on creating a
more just and equitable society. Providing this kind of critical health education for students moves their thinking upstream, identifies the intersectional aspects of socially constructed determinants of health (e.g. race, gender, sexuality, national origin, socioeconomic status, education, etc.), examines the structural forces that create those social determinants (e.g. public and private sector policies and practices), and reveals the complex and inequitable conditions in which individual and community health occur.

For example, an ecological analysis of student nutrition reveals the many influences on what a student eats, such as: the foods they like (individual); the foods provided to them by their family (interpersonal); the foods eaten by their peers (interpersonal); the foods made available and affordable to children in schools (institutional) and to their families in their neighborhoods (community); the products made by food producers and the targeted advertising of particular foods to this student population (institutional); and the laws and regulations that guide food production, prices, safety, and distribution (public policy). As noted by the ecological model, these multi-level factors also influence each other. For example, the US Farm Bill (public policy) subsidizes the production of corn, which incentivizes food manufacturers (institutional) to produce cheap snack foods sweetened with high fructose corn sirup; these snack foods in turn are distributed disproportionately in low-income neighborhoods (community) and schools (institutional) where low-income families are more likely to buy them (interpersonal) and children are more likely to eat them (individual) (Nestle, 2002). This analysis could be extended to include many other factors that influence nutrition, but the key point here is that nutrition cannot be understood solely as an individual behavior determined by individual choice (Sallis et al., 2008). Therefore, to truly understand healthy nutrition, students need to learn about the full ecological contexts of nutrition.

**Limitations and harms of an individual focus**

Despite ongoing calls for ecological approaches in US health education – from Jane Addams and John Dewey in the early twenty-first century (Gard and Pluim, 2014) to countless educators of present day (Minkler, 1999; Sallis et al., 2008) – school health education curricula remain primarily focused on behavior change. One oft-repeated critique of behavior-focused health education concerns the unrealistic expectations and damaging effects of its suggestion that individuals are solely responsible for their health. As Minkler (1999) argues, “an overriding emphasis on personal responsibility blames the victim, by ignoring the social context in which individual decision making and health-related action takes place” (p. 126). Furthermore, simply teaching students about healthy behaviors has not proven effective in changing behaviors or, in the long run, in decreasing morbidity and mortality rates (Gard and Pluim, 2014; St Leger, 2004).

Fitzpatrick and Tinning (2014) warn that teaching uncritically with behavior-focused aims contributes to the phenomenon Crawford (1980) coined as healthism – “the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles” (p. 368). This healthism is infused with moral judgment, as represented in definitions of “good” and “bad” health behaviors. It becomes the individual’s obligation to maintain their health through their behaviors, while the political and economic forces that have far-reaching impacts on health and health behaviors remain unacknowledged (Freudenberg, 2014; Nestle, 2002).

**What is health education for?**

If behavior-focused curricula represent an inadequate approach to school health education, then what does a more comprehensive approach look like? To answer this, we first ask a critical question which has been raised by others (see Fitzpatrick and Tinning 2014;
Leahy et al. (2016) – as health educators, are we educating for health and/or about health? Is our main purpose to teach students how to behave in ways that promote health, or do we aim to provide an education with health viewed as a subject of study through which students learn about their world and grow? As educators ourselves, we propose that teaching solely for health and not about health in its full ecological contexts is insufficient in the context of educational environments that purportedly aim to increase critical thinking, knowledge of disciplines, and understandings of the social and physical world. Quennerstedt et al. (2010) call for health education that shifts away from imposing pre-formed messages about individual health and moves to “an approach to health education that takes as its starting point the learning that occurs in the lives of young people” (p. 97), including the ecological influences in their own lives. Teaching about health in ways that consider all of the influencing contexts allows students to better understand the effects of social structures and systems and consider how those systems may be influenced for the betterment of individuals, communities, and society.

Political economy as framework for health education

An ecological approach in school health education requires a theoretical framework that explains how social structures and systems influence health. Political economy theory provides a helpful framework for understanding these upstream influences and, in particular, how they create inequities that influence health. Framing health inequities as the result of the unequal distribution of power and wealth, using a political economy lens highlights four key constructs for best analyzing health outcomes: a historical analysis of the political and economic contexts of current health outcomes; the role of the state in framing, legitimating, and addressing health problems, the influences of organizational and structural power in creating, perpetuating, and countering inequities; and the relevance of consciousness raising for social change (Minkler et al., 1995). Overall, a political economy lens uses historical and structural analyses to identify the broader structural forces of power that disproportionately produce ill health among marginalized populations. Importantly, it also names the relevance of raising the public’s critical consciousness and mobilizing people as a “cohesive political force” to challenge the inequities created by corporate and state power (Minkler et al., 1995, p. 117). One recent example is the emergence of the Black Lives Matter movement in the USA, which has effectively raised critical consciousness about the disproportionate use of police violence against African Americans and has resulted in numerous actions across the country calling for police reform and even police abolition.

Freudenberg (2014) employs a political economy analysis to understand the systematic production of illness and premature death through corporate practices in six US industries – food, tobacco, alcohol, pharmaceutical, gun, and car production. His research details how these health-harming industries represent “the triumph of a political and economic system that promotes consumption at the expense of human health” (p. viii). Political economy analyses can similarly be applied to examine how and why numerous other industries have gained and manipulated power in the pursuit of profits while harming the public’s (and planet’s) health, for example, the coal industry, the prison industry, war industries, and health care industries. Starting from a political economy analysis of racial inequities, researchers have examined how structural racism – as manifested in systems of housing, transportation, education, labor, criminal justice, and immigration – detrimentally impacts the health and well-being of people of color (Krieger, 2003; Williams and Mohammed, 2013). Health education that truly educates students makes visible these powerful political economy influences on individual health and helps “link ‘personal troubles’ with ‘public issues’” (Minkler et al., 1995, p. 119). Without such political analyses, students of health education are given false impressions that health is only influenced by individual behavior and not by the world around them.
If we are teaching students about health, then we must encourage them to think critically and at a more macro level about how structural conditions influence health. Even if we are teaching students for health, then being honest with students about all of what health encompasses means not reducing it to simple formulas of health behavior change. Integrating ecological and political economy approaches into school health education curriculum gives students a more comprehensive sense of health as something that is best supported by “creating conditions in which people can be healthy” (Institute of Medicine, 1988, our emphasis).

Pedagogical approaches for critical health education
Teaching critical understandings of health through ecological and political economy analyses requires pedagogical approaches consistent with such analyses. Furthermore, while teaching about the upstream influences on health is imperative, if we leave students with a sense that the doom and gloom posed by structural inequities perpetuated by powerful institutions and political systems is insurmountable, we risk damaging their sense of possibility, capacity, and control in their lives. Such lack of control can be toxic to individual and community health (Wallerstein and Bernstein, 1988) and certainly would not serve the aims of health education. Therefore, we need pedagogical approaches that allow students to not only gain critical understandings of these upstream influences on health, but also gain confidence in their agency and ability to effect change where possible. Importantly, this approach must be walked with care to avoid contradicting an ecological understanding of social determinants by suggesting that they can all be overcome through individual action.

To inspire this possibility for change, health educators can connect these ecological and political economy approaches to the lived experiences of students themselves and the particular cultural contexts of their families, neighborhoods, and schools. For critical understandings of health, students must be able to connect with health issues through their own particular ecological contexts including: their individual behaviors and beliefs; influences of family and friends; social norms, values, and resources in their community; practices and policies of institutions with which they interact; and public policies and ideologies that affect their lives in obvious and less obvious ways. Simply put, deeper learning happens when curriculum is relevant to young people’s lives (Dewey, 1916; McLaren, 2015; Rodriguez, 2013). Furthermore, connecting curriculum to students’ lives creates opportunities for students to envision actions that can affect their worlds. In doing so, students increase their sense of control and agency – something that is integral to health, growth, and education (Wallerstein and Bernstein, 1988).

Critical pedagogies
Critical pedagogies, which draw from critical theory and cultural studies, encompass a range of pedagogical approaches that encourage students to understand their worlds and challenge the taken-for-granted assumptions in those worlds. As described by Shor (1992), critical pedagogy facilitates:

 […] habits of thought, reading, writing, and speaking which go beneath surface meaning, first impressions, dominant myths, official pronouncements, traditional clichés, received wisdom, and mere opinions, to understand the deep meaning, root causes, social context, ideology, and personal consequences of any action, event, object, process, organization, experience, text, subject matter, policy, mass media, or discourse (p. 129).

Critical pedagogies help students deconstruct health knowledge, which, as Wright (2014) argues, “is not constructed from a neutral position but from ideological or discursive positions, some of which are more apparent than others” (p. 246). In a school setting, where
“knowledge” is valued and reproduced, critical pedagogies allow students to explore where that knowledge comes from, whose knowledge is valued and represented, and what kinds of knowledge are invisible or demeaned in the production of incomplete and even inaccurate “truths.” Indeed, school settings and processes can themselves become sites for historical and cultural analysis as they often reproduce the same unequal relations of power (e.g. race, class, gender) that produce social and health inequities (Duncan-Andrade and Morrell, 2008). More specifically, the ideological positions of neoliberalism and individualism that have informed the individual behavior focus of traditional health education become prime targets for examination and disruption through critical pedagogies in health education.

Critical pedagogies engage students in facilitated processes of deconstructing sources of knowledge, co-creating knowledge through reflection and dialog grounded in their lived experiences, and engaging in praxis, which Freire (1970) defined as “reflection and action upon the world in order to transform it” (p. 36). Praxis positions students as teacher learners who engage in dialog with each other about their concerns, while exploring the broader social and political contexts of those concerns, and engaging in social action to influence those contexts (Wallerstein and Bernstein, 1988). This praxis “creates a cycle of awareness, action, and reflection whereby people are empowered constantly to analyze and act upon the material conditions of their own lives” (Duncan-Andrade and Morrell, 2008, p. 27). Critical pedagogies that build praxis into the learning processes foster critical thinking, value collaborative learning, and involve students actively in curriculum that values, and is grounded in the contexts of their own lives. These experiences support students in becoming informed and engaged citizens by fostering agency, social action, and empowerment. In contrast to traditional forms of health education, critical pedagogies ensure that “learners have an opportunity to critically engage with health information rather than to simply be passive recipients of it” (Matthews, 2014, p. 600).

At the root of critical pedagogy is the practice of critical thinking. As Hooks (2010) describes, “The heartbeat of critical thinking is the longing to know – to understand how life works” (p. 7). Arguably, one of the roles of health educators is to inspire among our students a longing to know about how health happens, not just in one’s own body on a physiological or psychological level, but also in one’s neighborhood and across communities. Unfortunately, Hooks (2010) continues, “children’s passion for thinking often ends when they encounter a world that seeks to educate them for conformity and obedience only” (p. 7). As noted here, and by many others previously, much of health education is delivered in the service of conformity and obedience to particular health behaviors, body types, and narrow, damaging, blaming, and stigmatizing definitions of health (Leahy, 2014; Simpson and Freeman, 2004; Wright, 2009). Critical pedagogies not only move away from this kind of “education for obedience,” they directly challenge it.

Critical pedagogies that put students’ lives and knowledge at the center of learning, and that challenge oppressive social and structural processes, ultimately contribute to creating more equitable education environments. Airhihenbuwa (1994) argues that while much health promotion privileges white, middle class, patriarchal discourses serving goals of neoliberal individualism, critical approaches to health education center marginalized lives in the curriculum “and affirm differences in cultural expression, thus empowering learners to produce knowledge based on their social and cultural experiences” (p. 346). While traditional health education approaches often ignore, stereotype, or even stigmatize students of color, students in poverty, LGBT students, and students with disabilities (Elia and Tokunaga, 2015), critical pedagogies value and make visible the lives of all students, shift power relations, highlight the injustices of systems of oppression, and encourage students to challenge such injustices (Matthews, 2014). The centering of otherwise invisible, marginalized lives is essential in the pursuit of meaningful learning about and for health equity and social justice.
There are a number of practical critical pedagogical learning activities that can be employed in health education in schools. One such activity involves having students work in small groups to critically examine popular press (television, magazine, newspaper, and/or online) advertisements for food and drink marketed to youth. The students could identify such aspects as the type of food or drink advertised, to whom specifically (e.g. gender, race, age, class) such items are marketed, the political economy contexts (e.g. history, power holders and relations, role of the state, public’s consciousness of these contexts, who benefits and who is harmed by these products), and any health effects of such products. The aim of such a group activity would be to not only increase students’ media literacy as they collectively deconstruct the potential health implications of the advertised items themselves, but also to consider the social and structural forces that construct these messages and how corporate entities and the state view (and control) specific communities, their bodies, and their social positioning.

Critical health education approaches have been integrated into curricula in Australia, New Zealand, and the UK, to name a few. For example, the new Australian Curriculum: Health and Physical Education (AC: HPE) includes a critical inquiry approach as one of its key pillars (Leahy et al., 2013). Notably, the aims of critical inquiry are contested and its varied implementation sometimes loses its critical edge. As Leahy et al. (2013) warn, a truly “critical” critical inquiry approach does not mean that students identify specific risks in their environments so that individuals can avoid those risks – a common interpretation of critical inquiry in which “students are continually asked to engage critically with barriers and then expected to overcome them” (Leahy et al., 2013, p. 182). Instead, they call for a socio-critical inquiry approach that explores the taken-for-granted beliefs about health and physical education, systems of power that create inequalities, and influences of social and cultural contexts on meanings of health. This socially informed critical inquiry counters the tendency to misuse critical approaches in the service of neoliberal discourses that individualize risk and, instead, better serves “the educative intentions of the AC: HPE” (Leahy et al., 2013, p. 182).

Critical thinking and social justice
Within health education, critical pedagogies can contribute to social justice by challenging the body surveilling, behavior focused, pre-packaged health education messages that perpetuate narrow views of health, reproduce inequities, support submission to the status quo, and presume “that students can only acquire knowledge but not produce it” (Airhihenbuwa, 1994, p. 349). Critical pedagogies foster thinking that challenges “health education’s fascist tendencies” to impose messages and strategies in schools “that reinforce the discipline and control of the body” (Fitzpatrick and Tinning, 2014, p. 132). Such disciplining health promotion agendas are often imposed upon school health education settings with standardized health messages about obesity, sex and pregnancy, alcohol and drug use, that often blame and stigmatize individuals and communities without acknowledging the broader contexts of health (Elia and Tokunaga, 2015; Leahy, 2014). These messages are internalized by teachers and students who then reproduce individual behavior change discourses of safety, risk, insecurity, stigma, and fear. For many young people, these health education discourses are “the source of damaging self-evaluations and positionings” (Wright, 2014, p. 245). As Wright (2014) argues, critical health education provides students with the opportunity to discuss and interrogate these discourses, define health in their own terms, and in ways that are relevant to their lives.

Overall, critical health education pedagogies aim to do more than “fill in” the incomplete portrayals of health that are focused on individual behaviors; they directly challenge those incomplete portrayals, identify the ways in which such portrayals influence students themselves, recognize who these portrayals serve and who they harm.
in the service of discipline and oppression, and inspire a re-thinking and re-creation of health discourses.

Take, for example, the behavior-focused health education mantra to get more exercise. A recent study published in *The Lancet* reported the $67.5 billion global price tag of health care costs due to “a pandemic of physical inactivity” and called for individuals to do one hour of exercise daily to prevent such health care costs (Ekelund *et al.*, 2016). As the *New York Times*, *National Public Radio*, and other news agencies described the study findings, there was no mention of why so many people across the globe get so little physical movement in their day. A critical health education approach would pose questions to students about how they experience and perceive this information: What are the key messages here, and what is not being said? What supports or inhibits your own level of activity? From an ecological perspective, what conditions exist in your families, neighborhoods, and communities that influence activity levels? From a political economy perspective, how have political and economic conditions and pressures changed over time to create this increase in sedentary lifestyles, and what entities have been most influential in those changes? How have decades of stagnant wages and increasingly high costs of living influenced the number of hours people spend at work? How have working conditions which require people to sit most of the day either working or commuting made an hour of exercise a day difficult to achieve, let alone prioritize? How much of the high cost of physical inactivity is due to price gouging by the medical and health care industries? Overall, what are the root causes and contexts of this increase in sedentary behavior and the costs associated with it? Furthermore, a critical health education approach would also ask why these study findings were presented in such a narrow framework in the first place. Who is served by such reporting, and who is harmed? Finally, given what we have learned through this critical dialog, how might we as a society better support healthy environments for all? A critical pedagogy approach provides students with comprehensive education about the political, economic, social, ideological, and individual contexts of health, and it challenges individual-focused approaches that stigmatize behaviors and people who engage in those behaviors.

In summary, utilizing critical pedagogies in school health education would support: understanding of political, economic, cultural, and ideological contexts of health and related systems-level thinking about structural conditions that influence health and health behaviors; exploration of who defines “health” and “illness,” why they are defined that way, who benefits from these constructions, and, importantly, who may be harmed by them; explicit integration of the specific contexts and lived experiences of students themselves in the learning (and teaching) of health education; and praxis that allows students to put this critical understanding of health into meaningful social action.

Professional preparation for critical health education teachers

For health educators to employ these critical pedagogies in school settings, they must be prepared in their university education. This means not only learning about the ecological and political economy contexts of health and health inequities, but engaging in that learning within the contexts of critical pedagogies and reflective praxis that they will facilitate with their future students in school health education settings. Doing so means that involving aspiring health educators in a practice that encourages critical thinking about health in all of the ways previously described. This includes critical self-reflection about power, privilege, and the social positions (e.g. race, class, gender, age, role) that teachers themselves hold in the contexts of schools and their students. Recognizing their own identities and social positions – and the intersectionality of those positions – is essential if health educators are then expected to engage their own students in critical education and self-reflection processes. To challenge social conditions that produce inequities, one must be aware of their own participation and positions within those conditions.
A commitment to education, equity, and ethics
We have argued here for critical health education that embraces ecological approaches, political economy frameworks, and critical pedagogies. Ultimately, we see the imperative of critical health education in its support of three key values that we hold dearly in health education work — education, equity, and ethics.

Education
Leahy et al. (2016) point out that health education and research on its effectiveness have long been misguidedly focused more on health behavior changes than on the core tasks of education itself. That is, health education in schools has primarily served as a vehicle for health promotion rather than as a subject of study that offers a wealth of opportunities for critical thinking, problem solving, literacy, and other learning through a subject that is relevant to everyone’s life — health. In the USA, public schools have been repeatedly critiqued for not creating conditions that prepare students to think critically in democratic societies (Dewey, 1938; Ozer and Wright, 2012; Sarason, 1996). Focusing attention on education requires us to carefully consider this: what are we educating students for? To us, health education provides a learning space to enhance critical thinking through the exploration of the ecological contexts of health in a way that is grounded in the lives and social contexts of students themselves. Furthermore, as Fitzpatrick (2014) explains, critical pedagogies provide a place for people to critique narrow forms of health education that focus on behavior change and body surveillance in restrictive, unrealistic, and often stigmatizing ways. Such critical reflection allows students to “speak back to, or at least unravel, discourses of healthism” (p. 185) that can actually harm their health. Importantly, critical pedagogies create educational environments where students learn about health in ways that set them up to act upon their worlds and to create conditions that are not only good for health, but are also good for democracy.

Equity
As professors in a public university, we work with students daily who experienced the detrimental inequities in elementary and secondary public school systems long before they arrived in our classrooms. We believe that it is our duty to provide students with high-quality education that is relevant, that honors their lives and skills, and that supports their sense of agency and possibility in the world. Critical health education contributes to a movement toward educational and health equity by valuing the knowledge, skills, and capacities of all students and by putting them at the center of a learning environment that is built on practices of equity and social justice. As students, they do not just study equity; they practice it through their engagements with each other as teacher learners and through critical and collective action. Similarly, as teachers, we do not just teach equity, we practice it through the facilitation of learning environments that value and support the lives of our students and our shared roles as teacher learners.

Ethics
We noted here the limitations of individualizing health education discourses that present incomplete information by ignoring the conditions and systems that influence health. These discourses often stigmatize people who do not fit narrow definitions of healthy behaviors and healthy bodies. This calls forth the ethical dimension of our work in health education, given that stigmatization inflicts harm on people’s identities and their sense of value in the world. Obesity discourses in health education provide particularly alarming examples. As Fitzpatrick and Tinning (2014) describe, an “obese body in
contemporary times is held up as an example of both illness and ugliness” (p. 139). It is no surprise that obese children are among the most likely to be bullied in schools (Lumeng et al., 2010). Health education that focuses on individual behaviors and narrowly constructed messages about health can be particularly damaging to young people who may exhibit preoccupations with appearance and body shape (Wright, 2009). Such stigmatizing messages do not support the health or education of our students. As health educators, we should be facilitating learning environments that support students’ sense of self, value, and strength rather than elevating some narrowly defined “healthy” group while casting out those who fall outside of that box due to body size, lunch box contents, or aerobic capacity.

Critical health education provides quality educational experiences for critical thinking and transformative learning. It promotes equity by engaging students in the praxis of using their critical thinking to create individual and collective actions in support of health equity. Finally, it attends to ethics by moving away from blaming or judging individuals, and instead valuing all students for what they bring to the collective process of teaching and learning about health. Overall, critical health education replaces a focus on individualism with a focus on education as it inspires students to discover their collective agency in building healthy communities.

Conclusion
As we began this paper in the fall of 2016, US presidential candidate Donald Trump was stirring up a toxic frenzy of hatred toward immigrants, Muslims, women, African Americans, disabled people, and others through his bigoted and inflammatory campaign speeches. The millions who supported his candidacy embodied a rising level of distrust, desperation, and fanaticism that was (and is) fueled by ideological discourses of fear, individualism, racism, and xenophobia. As we complete this paper in the summer of 2017, Donald Trump has been elected as the President of the USA. As reported by the Southern Poverty Law Center (2016), within the first 10 days of his election, there were 867 reported incidents of harassment or intimidation across the country, and “many harassers invoked Trump’s name during assaults, making it clear that the outbreak of hate stemmed in part from his electoral success.” White nationalistic and white supremacist groups, embolden by his election, now tour college campuses to recruit members and sometimes incite race riots (Southern Poverty Law Center, 2017). In the meantime, the Trump administration’s policies regarding immigration, the environment, criminal justice, and international relations demonstrate that his campaign promises were not just words; they are now policies. Similar trends have been seen in Europe, Australia, and elsewhere as global austerity, and the rise of far right and neo-fascist entities play out in the banning of Muslim immigrants, repeals of anti-racism legislation, attacks on labor unions, and nationalistic discourses (Passant, 2016).

Walking into our classrooms during these challenging times presents important questions for us as teachers. Given the pain, fear, anger, and uncertainty that many of our students feel in their lives and in our world, what is our role as educators in health education? How do we teach about health in the midst of violence and vitriol spewing from the ends of guns, the policies of the state, the actions of corporations, and the mouths of politicians and their supporters? We teach with an eye on social justice and equity. We teach with an eye on critical thinking, civic engagement, and the role of social movements and social change. As we consider how to best educate our students to meet these challenges, let us consider how best to educate them so that they understand the full contexts of health and of their world more broadly, and so that they feel equipped with the sense of what can be done individually and – most importantly – collectively to support equity, health, and well-being in communities and society.


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Race and culture in the secondary school health and physical education curriculum in Ontario, Canada

A critical reading
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Abstract
Purpose – The purpose of this paper is to explore issues of race and culture in health education in the secondary school health and physical education (HPE) curriculum in Ontario, Canada.

Design/methodology/approach – Using Ontario’s secondary school curriculum as a point of analysis, this paper draws from critical race theory and a whiteness lens to identify how cultural and race identities are positioned in contemporary health education documents. The curriculum document and its newest strategies for teaching are the focus of analysis in this conceptual paper.

Findings – Within the curriculum new teaching strategies offer entry points for engaging students in learning more about culture and race. In particular, First Nation, Métis and Inuit identities are noted in the curriculum. Specifically, three areas of the curriculum point to topics of race and culture in health: eating; substance use, abuse and additions; and, movement activities. Within these three educational areas, the curriculum offers information about cultural practices to teach about what it means to understand health from a cultural lens.

Social implications – The HPE curriculum offers examples of how Ontario, Canada, is expanding its cultural approaches to knowing about and understanding health practices. The acknowledgment of First Nations, Métis and Inuit health and cultural ways of approaching health is significant when compared to other recently revised HPE curriculum from around the globe. The teaching strategies offered in the curriculum document provide one avenue to think about how identity, culture and race are being taught in health education classrooms.

Originality/value – First, with limited analysis of health education policy within schools, the use of critical theory provides opportunities for thinking about what comes next when broadening definitions of health to be more inclusive of cultural and race identity. Second, curriculum structures how teachers respond to the topics they are delivering, thus how HPE as a subject area promotes healthy practices is highly relevant to the field of health education. This paper provides an important acknowledgment of the educative work being undertaken in the revision of HPE curriculum.

Keywords Culture, Race, Health education, Curriculum, Schools, HPE

Introduction
Health education officially joins physical education in the school curricula of many countries. The USA, New Zealand, Scotland, Australia and Canada, for example, have combined the subject fields into one area where curriculum documents formally outline how the subjects are to be taught (Fitzpatrick and Tinning, 2014). This paper focuses on the recently revised Ontario, Canada, health and physical education (HPE) curriculum to explore how meanings of race and culture are presented in the document as curriculum informs pedagogy and shapes the knowledge, skills and experiences gained about health in school settings.

Although not completely aligned, the overarching emphasis on the body, human movement and health seems to unite the fields. Both health education and physical education aim to provide knowledge and skills that enable young people to learn about their bodies while at the same time take responsibility for their health practices. It would seem...
that society would benefit from the goal of providing individuals with the tools to take care of themselves. Currently, the dominant processes of self-care emerge as a form of health consciousness whereby attentiveness to the body, its form and function, simultaneously support an individualist approach with the additional goal of alleviating any undue pressure on the health care industry (Ayo, 2012; Crawford, 1980).

With an individualist model and an economic focus, it is not surprising that the two fields historically and currently have investments in biomedical approaches to health intervention (Gibney, 2015; Thomson and Robertson, 2014; Singleton, 2009). Historically, physical education has operated in the militaristic training of bodies, encouraged mass fitness regimes, and promoted sport participation, all the while touting the virtues of regular physical activity and other health practices to enhance everyday healthy living (McCuaig et al., 2013; Quennerstedt et al., 2010). Similarly, as a tool for disease prevention, beginning in the 1970s health education was focused on stopping the spread of non-communicable disease through a series of behavioral change approaches (Nutbeam, 2000).

Today, scholars would suggest that both physical education and health education use behavioral change approaches, and many behavior modification programs have gained recognition specifically through their pioneering efforts in schools (Nutbeam, 2000; Thomson and Robertson, 2014). Vertinsky (2017) suggests “across the twentieth century until today, ways of knowing associated with the active body/human movement and related forms of professional training have relied in different measure upon both the gymnasium and the laboratory” (p. 140).

Behavioral models aim to measure specific health-related practices to demonstrate some sort of positive change. The current messages in HPE in schools ultimately shape how people come to learn about, see and experience health. The more recent and explicit curricular emphasis on the development of personal, social and political aspects of health aims to promote a holistic and inclusive approach to educating the population about their own health and the health of others (Nutbeam, 2000).

Through school-based educational opportunities, HPE strives to engage all students in learning how to become a healthy, active and engaged citizen. It is the notion of engaging all students that becomes an important entry point to consider how race and culture are conceptualized in HPE curriculum as a means of providing an inclusive approach within educational policy. Nutbeam (2000) asserts “to promote greater interdependence and empowerment among individuals and communities we work with – we will need to acknowledge and understand the political aspects of education” (p. 267). With HPE curricula across the globe moving toward engaging and promoting healthy living as a resource for lifelong learning about the body and well-being, the exploration of how diversity and culture figure into contemporary curriculum documents is a valuable path to consider.

Students’ cultural and racial background informs how they engage with and participate in physical activity and how they come to understand health (Pang and Macdonald, 2016). Within some of the most recently revised curricula, such as in Ontario, Canada, the emphasis has shifted from preventing illness and disease to health promotion strategies that aim to build hope and resilience in youth so that they can “thrive in an ever-changing society” (Health and Physical Education (HPE), 2015, p. 6). With the move away from disease prevention to intervention, health education messaging is also shifting (Hoffman-Goetz et al., 2014). Healthy ideals are no longer just about surviving in a healthy body; the messages now focus on thriving in a complex world. Within this approach, who thrives better than someone else and how diverse people interpret an ever-changing world remains underexplored in health education research. As health education and physical education unite within schools, attention can be given to the ways in which culture appears in curriculum as our “ever-changing society” influences understandings of health.
There is no doubt that being healthy and understanding concepts that constitute health is important to thriving in a dynamic, changing society. As many societies shift to consider the diverse cultural, heritage and race backgrounds of people, strategies of inclusion are being adapted to the realities of population growth, migration, immigration, and First Peoples (Dei, 2012; Kanu, 2014).

Research in the areas of religion, race and culture in sport and physical education settings, using critical race theory, has documented the contestable nature of what is considered inclusion and specifically how strategies for inclusion play out for young people in different contexts (see Azzarito and Hill, 2012; Benn et al., 2011; Stanec et al., 2016). Minimal research attention, however, has been given to cultural aspects of curriculum in school settings. Aside from Dowling and Flintoff (2015), who examine how cultural traits, behaviors and attitudes are expressed in physical education policy texts, there is limited examination of how curriculum documents open or foreclose ideas about culture in health education within schools.

Curriculum documents are important sites of examination as the policies they represent influence teachers and the school community. Educational policy scholar Stephen Ball (1994, 2012) chronicles how curriculum constructs what educators do, how they think and how they teach. The curriculum is a textual representation of struggles, compromises and interpretations (Dowling and Flintoff, 2015). In many ways, teachers are supportive and creative enactors of policy (Ball et al., 2011) as they interpret documents presented to them. Yet, educational curricula are legal documents that influence the construction of a learning context. Thus, curriculum becomes a powerful site of analysis as teachers are guided by curricular expectations when delivering health education to today’s students.

Exploring how race and culture are written into curriculum in specific areas while leaving race and culture unspoken or removed from others becomes a relevant point of inquiry, as the premise of educational policy is to inform, guide and direct educational learning. Policy analysis enables an examination of what is included within texts as well as what remains overlooked (Ball et al., 2011). This paper turns a critical lens on the healthy living messages within the Ontario, Canada, HPE curriculum, looking specifically at how health information is constructed in relation to race and culture. Seeing curriculum this way provides a lens to explore how race and culture are used in erasing or recognizing health and health practices. Identifying how curricular knowledge and skills either exclude or include diverse social and cultural backgrounds of students is a focal aspect of this paper.

Highlighting the ways in which culture is a prominent component of HPE enables a perspective that is more attentive to the ways in which social categories of race and culture are positioned in all educational spaces (Darder, 2002, 2010; DeCuir and Dixson, 2004). Places like the gymnasium, classroom, pitch and arena are spaces where HPE comes alive, but these are also locations where students, with varying backgrounds, heritage and experiences, come to learn and understand societal values, beliefs and expectations about health and subsequently healthy bodies (Burrows, 2004; Burrows and McCormack, 2011).

This paper focuses on the policy text of the secondary school curriculum to explore how language and culture combine “operat[ing] to silence and deny certain experiences, histories and identities” (Dei and Doyle-Wood, 2006, p. 16) while enabling other stories to dominate. It expands upon the recent scholarship in HPE studies that interrogates race, whiteness and ethnicity in educational settings (see Azzarito, 2009; Benn et al., 2011; Hylton, 2015) and more specifically expands the critical analysis of curriculum documents (Dowling and Flintoff, 2015).

Critical race studies in HPE
To date, there are notable but relatively few Canadian studies that examine HPE curriculum using critical race theories (Millington et al., 2008; Vertinsky et al., 1992). Millington et al. (2008) examined the experience of Chinese Canadian males in HPE to find the myths of Asian men’s
physicality and weakness as exclusionary practices in the organization of school sport and HPE classes. Vertinsky et al.’s (1992) study revealed that if Indo-Canadian secondary school girls choose not to participate in HPE, the explanations provided by administration and educators perpetuated stereotypical views of Indo-Canadian women as being weak, repressed and traditionally conservative. The young women in the study noted that many girls of diverse cultural backgrounds withdrew from HPE in secondary school. For these young women, the binary cultural practices of HPE were not always exclusionary or incongruous with traditional beliefs, but the institutional racism of the HPE experience suggests the undercurrents of racism have ripple effects with the school.

Both the Indo-Canadian and Chinese Canadian community provided organized sport opportunities for the young men and women in these studies, thus exemplifying how individuals will turn to cultural communities when racist ideologies limit their opportunity. In these Canadian studies, racism and racialization persists and suppresses the opportunity for equal participation in a subject area designed to promote engagement. Racism often results when groups of people are defined by their skin color and treated unfairly and discriminatorily.

Racialization ascribes particular characterizations to a group that leads to unequal treatment of people usually with one group being positioned as superior to another. Different groups are affected differently by racialized processes. For example, white people are racialized but this often goes unnoticed or remains invisible such that white people do not see themselves as part of race but still have the authority to name and racialize others. Both racism and racialization work because of power imbalances occurring both at an individual and cultural level.

Internationally, there is a burgeoning body of research examining issues of how racialization and racism operate in overt and covert ways in physical education and school environments (see Azzarito, 2009; Fitzpatrick, 2013; Flintoff et al., 2015). In an effort to highlight how race functions in HPE, these scholars point to the increasing recognition of cultural difference and identity; however, such recognitions often result in a homogenization of difference. In this process, the binary logic of “us” vs “them” unfolds, re-entrenching the marginalized other while simultaneously re-establishing dominant cultural practices of health as the norm, and thus only recognizable, version of health education. For example, Azzarito and Hill (2012) show how young British Asian women move in and out of spaces with difficulty as their understandings of health shift between home and school. The young women in their study asserted that physical activity was important and valued in their lives, but how the information was presented in school challenged some of their family’s beliefs about health and wellness. Not seeing themselves as sporty, the young women expressed how they felt alienated in school physical education classes.

Dagkas (2014) also points to the intersections of social class, racialization and health. Using epidemiology data from British black and minority ethnic groups, Dagkas identifies the ways “United Kingdom Asian populations are joined together to include groups as diverse as Indian, Pakistani, and Bangladeshi” which ignores the cultural diversity and heterogeneity of these groups (p. 78). Ethnic categorization can become an organizing technique. If this organizing technique is then associated with disease or ill-health the homogeneity of the group is not only false it may cloud other issues of health status such as social class, economic instability and job security.

Ahmad and Bradley (2008) assert that health data can be presented in ways that associate biology and culture with an inferior ranking of some ethnic minority groups. Yet, other researchers indicate the value of cultural identity being vital to the health and well-being of young people (Kirmayer, 2015). The inclusion of difference or the homogenizing of a culture’s belief system without an accompanying rich and meaningful unpacking of these tapestries may inadvertently result in tokenistic and stereotypical representations of culture, which risk further straining of students’ experiences of schooling (Kirmayer, 2015).
Marginalized youth navigate difficult terrain as they move between western worlds of schooling and diverse cultural understandings of identity and knowledge (Nakata, 2005, 2010). Research in physical education and sport suggests youth navigate their understandings of health from multiple perspectives (Hylton, 2015). Within the western context, the position from which identity and knowledge is constructed is often in relation to ideologies of whiteness.

**Whiteness**

Whiteness “is a dominant cultural space with enormous political significance” such that “white people are not required to explain to others how ‘white’ culture works, because ‘white’ culture is the dominant culture that sets the norms” (Frankenberg, 1993, p. 21). Whiteness is not a color but an ideology.

For HPE, whiteness benefits those who are positioned in such a way that the dominant approach to healthy living befits traditional, Eurocentric values and skills. Basic ideas, beliefs, values and perceptions are part of the everyday occurrences, and for those who directly share these same approaches to life, their daily activities and choices align. It is as though these common, everyday encounters are raceless and cultureless. These sometimes benign everyday choices are seen by some to be healthy, but for others these choices and options are not part of their values or belief system, thus not a component of their everyday approach to health.

According to scholars, who help point to the ways education engages with race relations, the mono-cultural references to minority populations or the lack of identification of race and culture in schools preserve the supremacy of whiteness (Rollock, 2012). If cultural groups, or race, are associated with specific traits or when biological illness is combined with these ascribed traits, dominant ideologies and mythologies form. In HPE, whiteness benefits those who already engage with Eurocentric practices of health, share similar values about healthy living, and more generally follow western practices of physical activity, leisure or sport. Those who are not part of a white cultural ideal, who may practice health differently, are in need of explaining their actions and justifying their values and beliefs in ways those who follow dominant white health practices do not.

An individual’s connection with cultural values and beliefs shapes how they learn to care about themselves and others (Kirmayer, 2015). Ideologies of “racelessness” shape expectations about health and physical activity. But healthy living is not a mono-cultural notion, even though dominant Eurocentric notions of health underscore the concept. Health ideals, like educational policy, are not neutral or value free.

Within HPE, the teachers, curriculum and pedagogical strategies are generally embedded within a white privilege ethos characteristic of dominant groups in Eurocentric societies. In post-secondary institutions, senior roles in faculties of HPE tend to be dominated by white bodies (Douglas and Halas, 2013), and racial minority youth experience their HPE secondary school classes in relation to dominant ideologies of whiteness (Fitzpatrick, 2013; Flintoff et al., 2015; Stride, 2014).

Recent research by Dowling and Flintoff (2015) found that whiteness remains an invisible assumption within the physical and health education curricula of England and Norway. In particular, Norway’s identification of physical cultural practice ignores the Indigenous people of Scandinavia, the Sami and their traditional practices within Norway’s culture. Similarly, the Euro-Western physical education programs of England follow a sport-based model in which the activities and skills primarily promote white, middle-class, heteronormative ideas of sport culture dominant in the UK (Dowling and Flintoff, 2015). An analysis of curriculum documents in HPE from Australia and Scotland (McEvilly et al., 2014) revealed how students’ socio-economic and cultural identities are discounted within recent curricular reform.

The intersections of race, culture, social class and gender are significant contributors to individuals’ experiences in school health. Limited but valuable research captures how policy, teachers’ interpretation of curriculum and students’ experiences are plagued by the
implicit whiteness that erases conscious awareness of white privilege from health practices. The erasure of identity happens even though there is a concerted effort and commitment to social justice within HPE. Whiteness is maintained through dominant ideologies of race and ultimately difference, such that unconscious or conscious racial positioning continues unnoticed. In the next section, attention will be given to the ways in which identity plays out in educational policy.

An analysis of Ontario’s HPE curriculum
Education is a provincial jurisdiction in Canada, and the province of Ontario’s latest curricular change in 2015 is based on a vision of providing students with the knowledge and skills to help them develop the competency, capacity and commitment to live in a complex world. Objectives of the Ontario HPE curriculum were bold; thus, the document became a controversial government approach. There was much discussion over the sexual health education content; specific concerns aimed at the inclusion of masturbation and consent occurred much earlier in the curriculum than previous iterations (Bialystok and Wright, 2017; McKay et al., 2014). Issues of culture and identity are not at the forefront of curriculum, but in regards to the knowledge presented to students about healthy living cultural and racial identities figure centrally into the promotion of health initiatives.

Learning outcomes in Ontario’s HPE curriculum
Curriculum is organized by grade level in Ontario, Canada. Within each grade level, there are a series of intended learning outcomes. These outcomes might also be considered grade-level expectations and are referred to in the document as specific expectations. The specific expectations found in all grade levels are broken down into three broad areas: active living, healthy living and movement competence. Active living expectations focus on physical activity, fitness and safety. Healthy living expectations focus on three areas: understanding health concepts, making healthy choices and making connections for healthy living. Movement skills, concepts, principles and strategies comprise movement competence.

Teaching tools embedded in curriculum
To support the implementation of specific grade-level learning expectations, the HPE curriculum contains teaching strategies that aim to enhance student learning and prepare teachers to deliver curricular content. Teachers specifically requested these teaching strategies during policy development. The teaching tools are called Teacher Prompts and Student Reply and they act to showcase “more depth and complexity to the specific expectations within each grade as deeper knowledge and skills” (HPE, p. 92). Teacher Prompts are framed as questions that can be posed to the class. Following a Teacher Prompt, a student response, Student Reply, is offered to illustrate the types of follow-up points students might make or discussions that may transpire.

In this following section, particular attention is given to the narratives presented in the Teacher Prompts and Student Reply teaching tools. The examples illustrate how these new teaching strategies and the curriculum itself enables some things to be seen, said and heard, with other contextual details remaining unseen, unspoken and absent.

Student identity within the curriculum
Together, the Teacher Prompts and Student Reply teaching tool aims to provide deeper understandings about curriculum policy expectations and support the delivery of content. In total, there are 212 Teacher Prompts and Student Reply examples within the grade 9-12 levels of the policy. Of the 212 Teacher Prompts and Student Reply examples, the race or
ethnic identity of students are described 14 times and all 14 of these references identify First Nation, Métis and Inuit, with no other ethnic or racial identity specifically identified.

Indeed, the representation of First Nation, Métis and Inuit identity to the exclusion of all other racial or ethnic identification gives the distinct impression that the other 198 Teacher Prompts and Student Replies are raceless and cultureless, an impression that is decisively resisted in this paper. Rather, the lack of race or ethnic diversity represented in the Teacher Prompt and Student Reply examples point to the way in which dominant and normative cultural knowledge tends to masquerade as universal knowledge (Dei, 2012). Given the lack of identity recognition beyond specific groups of people, this is an example of how whiteness or “racelessness” works. In this regard, the underpinning assumption is that many physical cultural practices and dominant health knowledge are devoid of cultural meaning.

Macdonald et al. (2009) suggest that the dominant views of physical activity, health, fitness and exercise are divorced from the meanings and values of diversely situated students. Yet, these examples illustrate how the Teacher Prompt and Student Reply tool used in the curriculum assumes identity is only relevant in specific instances, while in the majority of instances the knowledge, skills and attitudes represented about student learning are situated as being homogenous and cultural-less activities. It is these examples of how and when student identity is marked within curriculum that illustrate the privilege afforded to Eurocentric knowledge about healthy living, physical activity and health practice while simultaneously only marking culture through the recognition of First Nation, Métis and Inuit students in the curriculum. This marking of students’ identities within the Teacher Prompt and Student Reply draws attention to some bodies at specific moments, whereby other bodies occupy unmarked positions. Furthermore, students are the only group identified by their cultural and race category as teachers remain race- and cultureless.

Eating and food-related practices
In the healthy living learning expectations, students are taught about eating patterns and how to make the best choices possible. The policy overviews and emphasizes the social and environmental impact of food and its subsequent influence on individual health. For example, one of the specific expectations, in healthy living, is that students learn to “analyze the influence of social and environmental factors on food and beverage choices (e.g. financial status, culture, religion, media influence, peer influence, family food traditions, accessibility of different kinds of food, restaurant choices, proximity to where food was produced, environmental impact of food production methods)” (p. 104). The following is an example of a Teacher Prompt and Student Reply to support teachers in meeting this expectation:

Teacher prompt: “What are some social and environmental factors that affect a person’s food choices?”

Students: “Families in which the adults work long hours may have less time for meal planning and preparation. It can be harder to make healthy choices when you have less time and less money.” “Things like food production, transportation, and packaging can have a serious impact on the environment. To reduce my carbon footprint and other environmental impacts, I try to choose local fresh foods.” “I belong to an Inuit family that lives in the city. I haven’t grown up eating traditional foods such as game and arctic char. Because these foods are important to our culture, I would like to learn about them and ways of preparing them.” “Food choices may not be the same in every part of Ontario because of differences in the kinds of foods that can be produced in or easily shipped to different areas, like the Far North, rural areas, or cities” (p. 106).

The breadth of material offered in this example expands students’ understanding of the socio-ecological aspects of health. Economical, environmental, ecological and cultural factors influencing and impacting healthy food choices are used to illustrate the factors that enable and constrain choice. The cultural example of Inuit traditional food practice and its significance to culture acknowledges something important. The inclusion of cultural identity
and the impacts of living in a location far from traditional lands and land-based food practice is a noteworthy acknowledgment of the realities facing many of Canada’s First Peoples. This entry point does have limited explanation when compared to other descriptions offered in the same example. The recognition of traditional foods denotes a value placed on traditional food harvesting and food access, but the example offers limited insight into what traditional foods actually mean from a health and healthy living perspective.

Other examples provided in the Student Reply offer some explanation of the geographical location, transportation challenges and environmental impacts of food processing, which is welcome. Thus, it seems that the introduction of cultural practices of health with limited elaboration or context shifts the educational possibilities of the type of knowledge being recognized in the Student Reply. By contrasting the environmental aspect of this example with the culturally relevant food of Inuit people, the excerpt illustrates how the cultural component of the passage remains vague in comparison to the environmental or ecological components of food, food systems and choice. In this regard, the possibilities of teaching values, beliefs and practices related to cultural health are limited even though cultural identification is recognized.

Another healthy living, healthy eating example further illustrates an attempt to teach about cultural practices and health behaviors; a cultural approach is referenced through the identification of Canada’s Food Guide[1]. Students are expected to “demonstrate the ability to apply health knowledge and living skills to make reasoned decisions” (p. 105). Knowledge and skills can be acquired from any number of sources, but the recommended resource noted by students in the Teacher Prompt and Student Reply is the national document for food and nutrition information, “Canada’s Food Guide”:

Teacher: “Where can you get information that can help you develop your healthy eating plan?”

Student: “Canada’s Food Guide is one of the most useful sources. It has been translated into many different languages (e.g. Arabic, Punjabi, and Spanish), and there is also a version for First Nation, Inuit, and Métis users. In addition, I can get a lot of good information from registered dietitians, the local public health unit, and credible and accurate nutrition websites.”

In this example, the cultural variations of Canada’s Food Guide are identified with language translations for Arabic-, Punjabi- and Spanish-speaking individuals. Having access to health information in multiple languages will enhance teachers’ work. Researchers in food science have suggested that Canada’s Food Guide is helpful but offers no information about the symbolism or cultural aspects of food and eating which are pivotal to healthy lifestyles for many people (Lillico et al., 2014). Canada’s Food Guide becomes an example of how whiteness works in presenting food information in ways that are indeed cultural but often not visible to those who follow dominant food consumption practices (i.e. follow western food grouping and eat foods typical of western diets).

Thus, it seems that by translating the information into different languages, the assumption is that diverse cultural groups will adapt their traditional eating practices to Canada’s Food Guide and its systematic classification of foods. What seems implied in the Student Reply component of this example is the transfer of other cultural contexts into a Eurocentric food consumption practice. By changing the language only, cultural foods and food preparation are ignored in favor of transferring “Canadian” knowledge into a different language.

In the Student Reply, it is noted that “There is also a version for First Nation, Inuit, and Métis users.” Canada’s Food Guide is not translated into Indigenous languages, but the format and organization of the Guide is altered to reflect First Nations food harvesting, cultivating and eating practices. The First Nation, Métis and Inuit version of Canada’s Food Guide identifies traditional foods but in relation to the systematic organization of food grouping and eating patterns presented by the Canadian Government. Thus, the organizational structure of food consumption remains the same. However, the Canada Food Guide does identify the importance of traditional practices and how these have
changed in current times or how people’s lives are affected by cultural eating practices. Unlike the language translation versions of the Guide, the First Nation, Métis and Inuit version of Canada’s Food Guide is a model that offers information about culture and cultural foods. For example, the Guide identifies how to categorize the wild game, fish and berries within the existing Eurocentric approach to food categorization.

From one perspective, identifying the First Nation, Métis and Inuit Food Guide is a progressive approach to providing information about culture, food and healthy living. The First Nation, Métis and Inuit Food Guide do review traditional foods and food harvesting processes in ways that are culturally responsive and different from the Eurocentric document. However, the food and land practices of diverse First Nations, Métis and Inuit are lost with the Guide offering limited information about Nation-specific food harvesting practices or local, place-specific foods. It would seem that the referral to the Canada’s Food Guide is helpful for educators, and more could be offered to guide educators to local or regional resources to learn more about healthy food consumption of various Canadians. Even mentioning this trajectory as an option would be helpful within the Food Guide. The value in the Teacher Prompt and Student Reply rests with its direction for expanding healthy food discussions in the classroom.

From another perspective, the translation of Canada’s Food Guide into other languages denies an opportunity to learn further about the cultural and social significance of food within diverse cultural groups. The assumption seems to be that language is the only translation piece needed for some racial or cultural groups to identify with healthy eating in Canada. For teachers, implementing the knowledge provided in the curriculum about why, how or what might be different for specific groups remains absent, let alone the diversity within these groupings, as the directive offered in the curriculum in the Student Reply emphasizes the identification of an additional resource only. Learning more about cultural food practices, protocols and food preparation could further build social relations between cultural groups and expand ideologies of healthy living within school settings.

Substance use, addictions and related behaviors

Within healthy living expectations, substance use, addictions and related behaviors is another sub-theme or learning area. Students are required to “demonstrate an understanding of the impact of substance use and addictive behaviours on all aspects (e.g. physical, emotional, cognitive, spiritual, social and economic) of a person’s health and well-being” (p. 121). Substance use and its effects on health and wellness are addressed at the individual and community level. In this sub-theme, across all grades, culture continues to be only recognized in relation to First Nations, Métis and Inuit. In this area of the curriculum, the association between cultural identity and addictions is problematic. For example, as a response to addiction behavior, what is represented in the curriculum is a cultural approach to healing. But in order to learn about healing processes and practices, students are given examples in the curriculum that position First Nations, Métis and Inuit people as a homogenous group who have relationships with addictions. The following example illustrates this perspective:

Teacher prompt: “First Nation, Métis, and Inuit cultures often consider the broad-based community impact of addictions in their approaches to healing and treatment. What are some dimensions of healing in these cultures?”

Student: “Having an understanding of who you are and being proud of your heritage are an important part of being healthy and are also important in healing. Elders and/or traditional healers from within the community and often from other communities and regions provide support for individuals, families, and the community to help them heal. The idea is that one person’s healing connects to the well-being of the community. Songs, dances, games and activities, stories, prayers, and ceremonies are some community-based healing methods that are used” (p. 122).
The Teacher Prompt and Student Reply open by directing attention toward and acknowledging the community approach to understanding addictions. Here, culture is used to illustrate holistic and communal approaches to ill-health and stresses the importance of individual healing within the broader community context. Through movement-related activities (i.e. song, dance, games and ceremony), the importance of a holistic approach to health becomes evident. Also, the Student Reply opens with a strong sense of identity and its importance for health. This example is similar to the findings presented by Kirmayer (2015) where culture is identified as an essential component to developing a sense of wholeness and health.

Addictions are complex phenomena resulting from a complicated web of factors both individual and structural, and we might reflect on why the only example and detailed illustration of First Nation, Métis and Inuit cultural practices are organized in relation to addictions. Why is the stereotypical image of First Nation, Métis and Inuit communities as experiencing addictions the entry point to speak about cultural healing practices? Indigenous scholars have noted that when it comes to Indigenous peoples, health interventions are almost always premised on a deficit model (deLeeuw et al., 2010), where the objective is to “close the gap” between the health of Indigenous and non-Indigenous peoples (see Hokowhitu, 2014).

Although a seemingly benevolent objective, such a framing ultimately reifies the gap itself, thereby naturalizing the binary construction of the non-Indigenous norm defined over and against the Indigenous other. This binary is further entrenched in three significant ways. First, by focusing on the “cultural” healing practices of First Nations, Métis and Inuit, western biomedicine is implicitly rendered cultureless. Second, in framing culture in relation to addictions, culture comes to be understood as a cure in the western biomedical sense, and not an integrated and holistic aspect of life and everyday practice of living well. Third, First Nations, Métis and Inuit addictions are written about as isolated health problems that First Nations, Métis and Inuit people have. This serves to obscure the historical and ongoing role colonialism has played in the destruction of Indigenous societies and the associated consequences this has had for Indigenous health and well-being. By framing the discussion on Indigenous health in binary terms, Indigenous peoples are marked as thoroughly cultured, and thus identifiably different from the unmarked and cultureless norm of whiteness, at the same time that the ongoing legacy of colonialism is erased from the narrative.

Concluding reflections
The province of Ontario and the curriculum writers should be commended for the direction the HPE curriculum is moving and the specific addition of the cultural identification of Canada’s First Peoples. The new Ontario curriculum has provided a doorway to learn more about students’ culture in relation to health. McEvilly et al. (2014) who identified a lack of student identity in curriculum reform documents from Sweden suggested that this disconnection between identity and health continues to alienate students from seeing themselves as healthy, thus limiting their involvement in HPE classes. The specific acknowledgment of holistic approaches to health and the physical cultural practices of Canada’s First Peoples also separates this curriculum from others in Norway and England (Dowling and Flintoff, 2015). Not uncommon within the health field, the acknowledgment of unhealthy activities and their association with First Nation, Métis and Inuit identity is a narrative that continues within western bioscientific medicine; thus, with the starting point coming to be a pathologization of Indigenous peoples, the justification for health interventions ensures (deLeuw et al., 2010). In this way, in health education, dominant Eurocentric practices are positioned as being more evolved or advanced, subsequently minimizing the meaning of Indigenous culture and cultural health practices (Hokowhitu, 2014; Norman and Hart, 2016).
Healing practices are indeed central to Indigenous epistemologies and ontologies, and with more information offered in the curriculum or a reorganization and expansion of the information offered in the curriculum, more could be done to disrupt and challenge dominance of Eurocentric approaches to health and well-being. Cultural practices that aim to foster positive health and well-being are part of a daily practice for some people, thus mentioning cultural practice as a form of healing meanings and understandings of the value, belief and actions of various cultures remain less understood.

The overall integration of First Nation, Métis and Inuit culture is moving toward a culturally relevant and responsive approach to teaching, which specifically includes cultural references in aspects of learning (Ladson-Billings, 1994). Curriculum is an official government policy, thus the province of Ontario’s acknowledgment of First Nation, Métis and Inuit is a valuable move to recognize the culture of Canada’s First Peoples. While the effort is applauded, the recognition of culture and cultural practices are divorced of a larger contextual framing by the selective identification of cultural practices in which some cultural groups may continue to be seen as inferior to others and other groups remain absent all together.

The limited entry points to dialogue offered in the Teacher Prompt and Student Reply could potentially turn into broader discussions about how health practices have historically and contemporarily been altered or erased by dominant, white, Eurocentric ways of approaching and understanding health. For example, historically the Canadian Government forbade sun dances, potlatches and sweat lodges, traditional Indigenous healing protocols for various Nations across the country (Battiste, 2013). More could be shared about this within the teaching tools to give context to the narratives offered in this curriculum. However, the province of Ontario has now officially recognized traditional First Nation, Métis and Inuit culture and ways of living, which is commendable. Further incorporation of these teachable moments will require more supports for educators.

Ontario’s HPE policy writers should be lauded for their attempt to expand cultural references to First Nation, Métis and Inuit. Disrupting the dominant trend of what is culture and how cultural bodies are marked and represented in the HPE curriculum is paramount to fracturing the cultural assumptions within education documents. The examples included in this paper are reminiscent of Macdonald et al.’s (2009) research, which contends that exercise and physical activity are culturally loaded behaviors, and the sooner understandings of health shift to consider the social relations involved in health enhancing activities, the stronger our teaching and learning practices can become in supporting cultural diversity. Identifying the specific moments when culture is made visible in the education document illuminates how often culture remains invisible. The whiteness that frames how health is conceived, delivered and taught becomes more apparent when culture is only recognized in relation to student identity. Analyzing what is presented and how this information is framed in relation to cultural practices of health suggests that there is no simple or straightforward path to follow. The ways in which culture and race operate as unspoken identity categories in much of the Ontario curriculum speak to the dominant view of bodies in HPE, but also the predominant perspective from which healthy behaviors are promoted.

The limited race and cultural examples in the Teacher Prompt and Student Reply teaching tools illuminate the form whiteness takes in these educational spaces. Schools are filled with diversely situated learners; thus, by failing to explicitly identify how race and culture work in HPE, whiteness remains invisible, the “norm to which other races are judged in the construction of identity, representation, decision-making, subjectivity, materialism, knowledge production and the law” (Moreton-Robinson, 2006, p. 388). These comparisons and judgments become apparent in Ontario’s HPE curriculum as the document only addresses the culture of First Nation, Métis and Inuit students at specific moments. In some moments, these references emerge from a deficit-based orientation and in others, entry
points are offered to recognize the social relations involved in eating and food knowledge, aspects of substance use and abuse and movement activities. Yet, the racial and cultural identities of any group other than First Nation, Métis and Inuit remain absent in the entire curriculum document. This analysis of Ontario’s HPE curriculum reifies the work of other educational scholars in highlighting how dominant notions of health education in school settings are deemed more universal than varied (Azzarito, 2009; Macdonald et al., 2009).

Moving forward
The Ontario HPE curriculum is working to interrupt the “racelessness” of curriculum (Dowling and Flintoff, 2015) with its references to First Nation, Métis and Inuit identities. With more efforts aimed at disrupting the reductionist references to culture in pedagogical practice and continuously interrogating how whiteness operates in HPE, even more can be done to enhance ideas of healthy living. Research with youth in physical education suggests that more positive learning about the self and others occurs when culture is recognized and can be seen by students (Fitzpatrick, 2013). Culturally relevant teaching has a legacy in other curricular areas (Ladson-Billings, 1994), thus building these educational approaches into HPE will advance the field. Currently, dominant health practices are promoted, and thus naturalized in curriculum fashioning a construction of healthy living that disguises its own cultural underpinnings of health as the norm from which health knowledge and actions can be understood. The analysis indicates that some bodies and healthy practices become more visible than others within educational policy.

Kirmayer (2015) asserts that mainstream approaches to health, especially in relation to youth, should be endorsing cultural practices to assist youth in strengthening their cultural identities and, consequently, their health. The Ontario curriculum takes up this call. In education settings, Battiste and Youngblood Henderson (2009) assert that the supports for diverse approaches to education that recognize Indigenous knowledge are long overdue. However, a simple integration of Indigenous health practices will not be sufficient. Generations of Indigenous scholars have been working in this area for decades, identifying how traditions and ceremonies are part of an educational process that is meaningful, occurs in various settings and across the life span: “Indigenous scholars and educators have been working to affirm and activate holistic paradigms of Indigenous knowledge to reveal the wealth and richness of Indigenous languages, world views, teachings and experiences, all of which have been systematically excluded from Eurocentric knowledge systems” (Battiste and Youngblood Henderson, 2009, p. 5). Health education could be activated in taking up a rich approach to healthy living. Moving beyond exclusion of Indigenous knowledge is a strength of the Ontario HPE curriculum, and with the inclusion of First Nation, Métis and Inuit identities more knowledge about food, food harvesting, active living, understandings of physical, social, emotional and spiritual health can expand to legitimize and validate diverse understandings of healthy living within educational spaces.

To conclude, the current Ontario HPE curriculum acknowledges culture and does identify cultural practices of health. The effort to recognize diversity in the educational setting, Teacher Prompts and Student Reply cultivates an awareness of some bodies and their cultural practices, shifting the messages in health education from illness and disease beyond health behavior change to more proactive health engagements. Providing teachers with guidance to support students’ abilities to thrive in a complex world are evident within the policy document. From this framework, more recognition of the positive health enhancing components of cultural practices and diverse cultural ideologies of health can unfold. In thinking about the future of health education and culture, Dei (2012) reminds us that the dominant approach to education “is not about bringing people into what already exists; it is about making a new space, a better space for everyone” (p. 12).
Note
1. Canada’s Food Guide is produced by Health Canada, an agency within the Federal Government of Canada.

References


Further reading


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The research landscape of school-based sexuality education

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Abstract

Purpose – The purpose of this paper is to map and discuss the overall characteristics of international research on school-based sexuality education, published in academic journals, with a particular focus on the framing of non-conservative approaches including sexuality education research targeting young pupils 6-12 years of age.

Design/methodology/approach – The paper draws upon the methodology of systematic research mapping and presents a broad overview of research on sexuality education in a school setting for pupils aged 6-16. The authors searched the leading bibliographic databases in the field, i.e., ERIC, PsycINFO, PubMed, Scopus, Australian Education Index, British Education Index and Education Research Complete, using the search terms “sexuality education” and “school” and “children” or “adolescents.” The mapping focused on articles published in peer-reviewed journals in English, German, Danish, Swedish or Norwegian, in the period 2000-2016.

Findings – Out of 3,769 papers identified in the search process, a total of 576 papers were found to meet the inclusion criteria of the mapping. The mapping portrays a research landscape that is diverse and nuanced in terms of contextual, theoretical and methodological approaches, but also characterized by limitations. The findings point to the clear dominance of research on schools in English-speaking countries, conceptual research is scarce, and school-based sexuality education aimed at the youngest children seems to be neglected. The mapping identifies gaps in the literature that justify a call for more research from diverse sociocultural, political and geographical contexts, more conceptual research using social theory, and more research focusing on the potentials and challenges linked to sexuality education for younger pupils.

Originality/value – This paper offers a rare, if not the first, comprehensive overview of research on school-based sexuality education including a focus on younger school children 6-12 years of age.

Keywords Child and adolescent health, Literature, Sexual health promotion, School health promotion, Sex and relationships education

Paper type Literature review

Introduction

There is little doubt that sexuality education is a controversial and contested field, in terms of both educational practice and scientific research. The field ranges across the boundaries of sex and relationships education, disease prevention, sociality, ethical reflectivity, sexual rights, family planning, identity formation, and health and well-being promotion in schools. Moreover, sexuality education in schools navigates between, within and across two major, often conflicting, domains delineated in antiquity by Aristotle as: “Oikos” – the private, family, and household domain, and “Polis” – the public and political domain. The distinction between public and private domains is rather complex and has been debated often, mostly with a view to determine an appropriate realm of governmental authority, including authority through formal education, as opposed to the realm of self-regulation and personal decisions. This is emblematic and challenging for education in general and for health education in particular, but it is even more contentious in regard to school-based sexuality education.
The tensions are typically related to determining whose rights, knowledge, beliefs, and responsibilities count and in which ways the power to influence the curriculum is distributed among different stakeholders, including children, young people and their families (Monk, 2001; Simovska and Kane, 2015). Consequently, the practices and policies related to sexuality education in school take various forms; they are embedded in historical, sociocultural and political macro contexts, but they are also shaped by local school traditions and cultures (Aggleton et al., 2014; Zimmerman, 2015; Ponzetti, 2016).

The research literature addressing sexuality education points to very little, if any, consensus concerning its purposes, desired outcomes, teaching strategies, or legitimate curriculum content (Jones, 2011a, b; Elia and Tokunaga, 2015). The global research landscape can tentatively be described using two general paradigms, each designated with a number of signifiers: the conservative paradigm, which is also portrayed as preventive, biomedical, restrictive, moralistic, and behavior-regulating; and the non-conservative or liberal paradigm, also known as democratic, socio-ecological, critical, norm-critical, participatory, inclusive, comprehensive and positive. Occasionally, attempts have been made to further differentiate and nuance the plural discourses of sexuality education across and within these two paradigms. For example, Jones (2011a) suggests four (instead of two) general discursive orientations – conservative, liberal, critical and postmodern – and further portrays a total of 28 sexuality education discourses related to each of these orientations.

Against this backdrop, the purpose of this paper is twofold: to map the overall characteristics of research on school-based sexuality education internationally and to portray the framings of sexuality education research that is categorized within a non-conservative paradigm, including research targeting young pupils 6-12 years of age. In light of the growing focus on sexuality education for the youngest pupils (aged 6-12), and of evidence suggesting that this age group of children faces a number of specific challenges and potentials concerning sexual health (Graugaard and Roien, 2007; Mattebo et al., 2013), the questions we address in this paper include the following:

**RQ1.** Which discourses are dominant in the international research on school-based sexuality education?

**RQ2.** What characterizes the research within non-conservative sexuality education approaches?

**RQ3.** How is sexuality education research for the youngest pupils (6-12) positioned in the global landscape of school-based sexuality education research?

Our ambition is to capture the plurality of available research and to provide insight into contextual, theoretical and methodological approaches characterising research on school-based sexuality education. We aim not only to elucidate the existing literature but also to identify issues that are neglected or only scarcely addressed. We begin by outlining the research mapping method employed in this study. Next, we present our findings, first by exploring patterns related to the overall characteristics of school-based sexuality education research, and then by examining the body of research related to non-conservative or liberal sexuality education approaches in schools and how these liberal approaches to research are reflected in the literature related to the youngest pupils (age 6-12). We conclude by presenting perspectives and implications based on our findings.

**Methodology**
The paper draws upon the methodology of systematic research mapping (Gough et al., 2012, 2017). While there is little scholarly consensus regarding the typology and terminology of systematic reviews (Grant and Booth, 2009; Gough et al., 2012), the definitions of systematic research mapping seem to agree that it should provide a
A comprehensive overview of a research field (Gough et al., 2012). A research map should depict the existing literature on a particular topic and identify gaps from which to commission further reviews and inspire primary research (Grant and Booth, 2009). Details of mapping protocols vary according to specific research aims, but they typically do not include narrative or statistical syntheses of the findings. This is the main difference between systematic literature mapping and systematic reviews of quantitative or qualitative evidence, respectively. Literature mapping aims to analytically portray a research landscape rather than synthesize the best available evidence. Consequently, literature mappings, unlike reviews of evidence, include primary studies regardless of the strength of evidence that their findings represent (Gough et al., 2012, 2017).

Systematic literature mapping is a relevant methodological approach for the purposes of our research, as it provides a broad overview of the field of research related to school-based sexuality education. It also enables clarification and categorization of the nature of the existing research in terms of methodologies, contextual features, questions asked, and theoretical frameworks employed, as well as the absences of and gaps in these. The findings of the mapping provide a foundation to draw from when planning in-depth systematic follow-up reviews of the issues identified as noteworthy, contested, deficient, or inconclusive.

Following the accepted methodology of systematic mapping (Gough et al., 2017), the protocol we employed consisted of the following stages: searching, screening, and data extraction and analysis.

**Searching**
We searched the leading bibliographic databases in the field, i.e. ERIC, PsycINFO, PubMed, Scopus, Australian Education Index, British Education Index and Education Research Complete, using the search terms “sex education” and “school” and “children” or “adolescents.” Papers were included if they reported on sexuality education in a school setting, focused on children and adolescents aged 6-16, and were published in peer-reviewed journals in English, German, Danish, Swedish or Norwegian between January 1, 2000 and January 1, 2016. We piloted the searches in spring 2015, adjusted the search strategy in autumn 2015 and conducted the final searches on January 11, 2016. As is usually the case with literature mapping which aims at rapid portrayal of a research field, our method did not aim to identify all existing and relevant research: it was limited to journal articles published over the last 15 years; it only included papers available online; and it did not include hand-searching of journals, contacting key researchers in the field, or reference searching. Although this strategy set clear limitations to the study, it allowed for a credible snapshot into the field which can point to the gaps and inform further extensive systematic reviews and data synthesis. We used “sex education” as a standardised thesaurus database search term, assuming that it encompasses “sexuality education,” “sex and relationships” education and other similar terms used in the literature which was confirmed in the pilot. Although there may be differences in the discourses using different terminology, these differences are not the focus in this paper. We use “sexuality education” throughout the paper as a generic term.

**Screening**
We screened the identified papers through two processes, i.e. title and abstract screening, followed by full text screening. Papers were excluded if they were categorized according to one of the following criteria. Wrong format: book reviews, comments and editorials. Wrong language: papers not published in English, German or Scandinavian languages. Wrong population: papers not exclusively focused on populations of pupils between 6-16 years of age. Wrong setting: papers not exclusively focused on schools. Wrong focus: papers not exclusively focusing on, or only briefly mentioning, school-based sexuality education,
In this round of analysis, we selected a number of markers that could help characterize research on school-based sexuality education. These included: journal name and disciplinary area (education/public health or medicine/sexology/psychology/sociology/gender studies/other); paper type (conceptual/empirical/review); research design (quantitative/qualitative/mixed methods/not applicable); national context (country in which the study was conducted); population in focus (pupils/teachers/school management/school nurses/multiple/etc.); age of learners (exclusively 6-12 years/exclusively 13-16 years/across age groups/unspecified); and sexuality education approach (conservative/non-conservative). The articles were coded as belonging to the conservative sexuality education approach if they clearly adopted a public health perspective focusing exclusively on biomedical sexual health, risks and prevention. The articles where this was not the case, that is, where the perspective embraced was health education or health/well-being promotion focusing on socio-ecological sexual health, whole-school approaches, sexual rights, competences, identities and subjectivities, were coded as belonging to the non-conservative (or liberal) approaches. All data were systematically coded and analyzed with the use of EPPI Reviewer 4 software.

The coding was performed independently by the first and the last author on the same random sample of approximately 100 papers. The two authors compared the codes, which resulted in a high level of agreement. Where disagreement occurred, the paper in question was discussed, leading to a shared interpretation of the categories. Then, the first author coded the full sample of papers, supplemented by occasional checks and consultations with the last author. All three authors analyzed, together, the data extracted from all included
papers with the aim of looking for possible patterns or deviations and developing a broad characterization of the landscape of sexuality education research in schools.

In the second round of analysis we looked more closely on the selection of papers identified as belonging to the non-conservative approach, including the papers that specifically addressed school-based sexuality education related to children in the age group of 6-12 years. As mentioned earlier, the aim of this analysis was to see how the research broadly characterized as non-conservative was framed, which topics and target groups characterized this research, and how sexuality education for the youngest pupils was positioned within these frames.

Results
Disciplinary areas and research designs
Mapping revealed that research on sexuality education in schools was published in a wide range of journals covering a multitude of professional disciplines. Table I presents the key disciplinary areas in which the journals were categorized, examples of specific journals, and the number of papers in each area.

<table>
<thead>
<tr>
<th>Disciplinary area</th>
<th>Percentage (number of papers)</th>
<th>Examples of journals with most published papers</th>
</tr>
</thead>
</table>
| Education                  | 41% (n = 235)                 | Sex Education: 21% (n = 120)  
Health Education Research: 4% (n = 25)  
American Journal of Sexuality Education: 2% (n = 13)  
Gender and Education: < 1% (n = 5)  
Health Education: < 1% (n = 5)  
Health Education Journal: < 1% (n = 4)  
Pastoral Care in Education: < 1% (n = 4)  
Educational Research: < 1% (n = 3) |
| Public health or medicine  | 41% (n = 234)                 | Journal of Adolescent Health: 4% (n = 23)  
Journal of School Health: 4% (n = 23)  
AIDS Education and Prevention: 2% (n = 11)  
BMC Public Health: 1% (n = 7)  
Journal of School Nursing: 1% (n = 7)  
Scandinavian Journal of Public Health: 1% (n = 7)  
African Journal of Reproductive Health: < 1% (n = 5)  
AIDS and Behavior: < 1% (n = 5)  
AIDS Care: < 1% (n = 5) |
| Sexology                   | 6% (n = 33)                   | Sexuality Research and Social Policy: 1% (n = 6)  
Canadian Journal of Human Sexuality: < 1% (n = 5)  
Journal of Sex Research: < 1% (n = 4)  
Journal of Sex and Marital Therapy: < 1% (n = 3)  
Sexualities: < 1% (n = 3) |
| Psychology                 | 5% (n = 32)                   | Psychology in the Schools: < 1% (n = 4)  
Adolescence: < 1% (n = 3) |
| Sociology and social sciences | 2% (n = 12)                 | Journal of Adolescence: < 1% (n = 3)  
Research on Social Work Practice: < 1% (n = 2)  
Social Science and Medicine: < 1% (n = 2)  
Gender and Society: < 1% (n = 2)  |
| Gender studies             | 1% (n = 5)                    | European Journal of Women’s Studies: < 1% (n = 1)  
Gender & Behavior: < 1% (n = 1) |
| Other (evaluation; policy, law) | 4% (n = 25)     | Evaluation and program planning: < 1% (n = 3)  
Journal of Policy Analysis and Management: < 1% (n = 2)  
Brigham Young University Education and Law Journal: < 1% (n = 2) |

Table I. Journals and disciplinary areas
The 576 papers included in this study were published in 224 different journals. With very few exceptions, all were English-language journals. The majority of the papers were published in journals with a disciplinary focus on either education (41 percent) or public health/medicine (41 percent), equally distributed between these two categories. Approximately 6 and 5 percent of the papers were published in journals on either sexology or psychology, respectively, and the rest were divided between sociology and social sciences (2 percent), gender studies (1 percent) and other (evaluation, policy, law) (4 percent).

A look at the wide range of journals shows that Sex Education can be singled out as the journal with the largest number of published papers (21 percent), followed by Health Education Research (4 percent), Journal of Adolescent Health (4 percent) and Journal of School Health (4 percent).

The characterization of the types of papers and the research designs used is presented in Table II. As shown in the table, the vast majority of papers reported on empirical research (88 percent); 48 percent of these were based on quantitative research designs, 38 percent on qualitative research studies and 14 percent on mixed method approaches. Conceptual papers accounted for 7 percent of the papers, and 5 percent were reviews.

Geographical contexts
The mapping showed that a large majority of the papers (92 percent) were studies that addressed one single geographical/national context, distributed across a total of 54 countries. Only approximately 5 percent of the papers addressed multiple geographical and cultural contexts, and in 2 percent of the papers, no specific countries were mentioned. As Table III shows, studies from American and British contexts were dominant. The majority of papers (35 percent) focused on school-based sexuality education in the US, followed by papers addressing the UK context (16 percent).

<table>
<thead>
<tr>
<th>Research characteristics</th>
<th>Percentage of total number of papers (number of papers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Paper type ((n = 576))</td>
<td>Empirical paper: 88% ((n = 506))\nConceptual paper: 7% ((n = 42))\nReview paper: 5% ((n = 28))</td>
</tr>
<tr>
<td>Empirical research design ((n = 506))</td>
<td>Quantitative: 48% ((n = 242))\nQualitative: 38% ((n = 193))\nMixed: 14% ((n = 71))</td>
</tr>
</tbody>
</table>

**Table II.** Paper type and research design

<table>
<thead>
<tr>
<th>Top ten countries in focus</th>
<th>Percentage (number of papers)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. USA</td>
<td>35 ((n = 201))</td>
</tr>
<tr>
<td>2. UK</td>
<td>16 ((n = 91))</td>
</tr>
<tr>
<td>3. Cross-national</td>
<td>6 ((n = 34))</td>
</tr>
<tr>
<td>4. South Africa</td>
<td>5 ((n = 27))</td>
</tr>
<tr>
<td>5. Australia</td>
<td>4 ((n = 25))</td>
</tr>
<tr>
<td>6. Canada</td>
<td>4 ((n = 21))</td>
</tr>
<tr>
<td>7. Nigeria</td>
<td>4 ((n = 21))</td>
</tr>
<tr>
<td>8. China</td>
<td>2 ((n = 13))</td>
</tr>
<tr>
<td>9. Tanzania</td>
<td>2 ((n = 12))</td>
</tr>
<tr>
<td>10. New Zealand</td>
<td>2 ((n = 11))</td>
</tr>
</tbody>
</table>

**Table III.** Geographical contexts
Research participants
The mapping showed a clear tendency for research to focus on pupils rather than on adults including teachers and school nurses, or other educators, including pupil peer-educators. As shown in Figure 2, the majority of papers focused primarily on pupils (46 percent) or had a multiple-target group that included pupils (31 percent). Research exclusively addressing teachers was less frequent (11 percent) and addressing student teachers was very infrequent (1 percent).

Most papers (80 percent) reported on research targeting pupils in the adolescent age group of 13-16 years (Figure 3). Only 7 percent of the research focused on pupils 6-12 years of age. A closer look at the research categorized as “across age groups” showed that this research mostly addressed school-based sexuality education related to older children and adolescents. In approximately 5 percent of the included papers, no specific age group was mentioned.
Conservative vs non-conservative approaches

The mapping showed that 53 percent of the papers belonged to the non-conservative paradigm, while 47 percent of the papers were characterized as belonging to the conservative paradigm. It is important to note, however, that we defined the non-conservative paradigm in broad terms to include all the papers that were not explicitly focused on behavior regulation within biomedical and preventive discourses of sexuality education.

Spotlight on non-conservative discourses

A closer look at the literature categorized within non-conservative or liberal discourses of school-based sexuality education for pupils aged 6-16 showed that the research focus was wide ranging, and revolved around the following, sometimes interrelated, topics (Table IV):

- teaching and learning strategies: curriculum issues, sexuality education programmes, specific teaching strategies, resource materials related to sexuality education or issues relating to classroom practices;
- pupils’ perspectives: pupils’ views of and experiences with school-based sexuality education, including recommendations for improvements;
- policy: global, national or local policies related to sexuality education in schools and policy enactment in diverse contexts; and
- professional competencies: values, beliefs, knowledge, skills, competencies and experiences of teachers and other educators engaged in school-based sexuality education.

The analysis also identified some research that reported on school culture, contextual issues, collaboration with local community, pupils with disabilities, LGBTQ pupils, other marginalized pupils, historical perspectives, evaluation of interventions, pre- and in-service teacher training and research methodologies. A few papers were conceptual, addressing sexuality education theory, i.e. the purposes, approaches, theoretical and analytical perspectives, methods and implications of liberal sexuality education in school.

The mapping pointed to a substantial lack of research on sexuality education targeting younger pupils (aged 6-12), but also indicated that when younger pupils were the focus, the research mostly belonged to non-conservative sexuality education discourses, although with

<table>
<thead>
<tr>
<th>Research focus</th>
<th>Age group 6-16</th>
<th>Age group 6-12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teaching and learning strategies</td>
<td>17% (n = 54)</td>
<td>37% (n = 12)</td>
</tr>
<tr>
<td>Pupil perspective</td>
<td>12% (n = 40)</td>
<td>3% (n = 1)</td>
</tr>
<tr>
<td>Policy</td>
<td>11% (n = 34)</td>
<td>6% (n = 2)</td>
</tr>
<tr>
<td>Professional competencies</td>
<td>10% (n = 31)</td>
<td>21% (n = 7)</td>
</tr>
<tr>
<td>School culture</td>
<td>6% (n = 19)</td>
<td>6% (n = 2)</td>
</tr>
<tr>
<td>Collaboration out of school</td>
<td>6% (n = 18)</td>
<td>12% (n = 4)</td>
</tr>
<tr>
<td>Social context</td>
<td>6% (n = 17)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Theory</td>
<td>6% (n = 17)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Pupils with disabilities</td>
<td>6% (n = 17)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Other (not specified)</td>
<td>5% (n = 15)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>History</td>
<td>4% (n = 12)</td>
<td>3% (n = 1)</td>
</tr>
<tr>
<td>LGBTQ pupils</td>
<td>3% (n = 9)</td>
<td>6% (n = 2)</td>
</tr>
<tr>
<td>Preservice and in service training</td>
<td>3% (n = 8)</td>
<td>6% (n = 2)</td>
</tr>
<tr>
<td>Research methodology</td>
<td>3% (n = 8)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Evaluation of intervention</td>
<td>1% (n = 4)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Ethnic or religious minority pupils</td>
<td>1% (n = 4)</td>
<td>0% (n = 0)</td>
</tr>
<tr>
<td>Total</td>
<td>100% (n = 307)</td>
<td>100% (n = 33)</td>
</tr>
</tbody>
</table>

Table IV.
Research topics within non-conservative discourses
somewhat narrower content. As shown in Table IV, the scope of topics addressed in research on sexuality education for younger children was substantially narrower than the scope of topics addressed in general, with research mostly addressing teaching and learning strategies, professional competences and collaboration between the school and the community.

Discussion
The mapping of the literature helped to portray the research landscape of school-based sexuality education. The following key tendencies were identified:

- dominance of research addressing Anglo-Saxon contexts;
- limited conceptual/theoretical research; and
- lack of research related to sexuality education for younger pupils (aged 6-12).

These tendencies pose a number of challenges in terms of the extent and quality of knowledge generated by research and in terms of policies and practices in varied contexts that might be building on that knowledge. In the following, we consider some of these challenges.

Challenges of the dominance of the Anglo-Saxon sphere
What becomes quite clear from the mapping is that research on school-based sexuality education in English-speaking countries is overwhelmingly more abundant than research in other cultural contexts. Although we included all the Scandinavian languages in the search, the review showed that research on school-based sexuality education in the Nordic countries is very limited from a global perspective. Only one paper addressed sexuality education in Denmark, and one did so in Finland; two papers investigated sexuality education in Sweden, and an additional two papers were identified on Norwegian sexuality education.

Research reporting on schools in the USA, UK, Canada, Australia and New Zealand alone accounted for approximately 60 percent of all included papers, with USA and UK contexts dominating. This is not necessarily a surprising finding given that most international academic journals are published in English and are therefore more easily accessible to English-speaking researchers doing research within their own country than to non-English-speaking researchers. Undoubtedly, this issue is not limited to sexuality education but applies to educational research in general. The challenges it poses in relation to research-based knowledge on sexuality education in schools are pronounced. Although heterogeneous, school systems within Anglo-Saxon countries are characterized by comparable educational traditions. The theoretical, political and ideological underpinnings of these traditions shape, not only how schools are organized, but also the very definition of what schools are for, and consequently, fundamental pedagogical approaches to schooling. The determination of the educational purposes of the formal school system; the position of the pupils in schools; the roles of the curriculum, teachers, and teaching methods; and cooperation with parents, external agents and the local community are all constitutive dimensions of schooling. The ways in which these are delineated and enacted shape how sexuality education is conceptualized, prioritized, organized, taught, and evaluated.

Further, the country-specific socio-historical context in relation to values and norms on sexuality, sex, gender, bodies, families and relationships – in addition to the view of children and adolescents and their sexual health, rights, and development – plays a significant role in shaping school-based sexuality education. Although certain societal tendencies influence these values and norms globally (Simon, 1996; Giddens, 1997; Bauman, 2003), national contexts impact on sexuality education policies and practices in a number of ways. For example, whether sexuality is approached from mainly heteronormative or more diverse...
perspectives in school is largely dependent on national legislation, the prescribed curriculum, and the wider governmental and non-governmental frameworks concerning (sexual) rights and gender equality (Jones, 2011b; Elia and Tokunaga, 2015). Another example concerns the first sexual experiences and the possible sentiments, challenges and agency of children and adolescents in this respect. A society’s legal frame as well as general values in this respect interacts with sexuality education in schools in a plethora of ways.

National and local dynamics influence both the purposes of sexuality education in schools and what is seen as “legitimate” content and teaching strategies applied. A knowledge base drawing mostly from Anglo-Saxon traditions (despite their internal heterogeneity), although valuable and significant, is insufficient to inform research, policy and practice in other contexts. More research is needed that would provide contextualized and nuanced insights from a variety of socio-political, cultural and educational settings. This points to the need for researchers, as well as journal editors and editorial boards, to conduct and encourage research, respectively, in more diverse contexts, which would pave the way for possible new perspectives on how sexuality education is constructed through plural societal discourses, policies and practices.

Limitations of exclusively empirical research

The mapping showed a clear dominance of empirically based research and a paucity of conceptual/theoretical work. Conceptual research may indeed exist, but it is more likely to be published in books, dissertations or other formats that allow extensive theorizing. Nevertheless, given that the most influential journals in the field, such as *Sex Education* or *Health Education Research*, invite both empirical and theoretical contributions, the publication format cannot, as such, be considered the only explanation for the lack of conceptual papers. Regardless of the cause of this disparity, conceptual and theoretical work within school-based sexuality education is necessary and should be strengthened. Theoretical frameworks, particularly social theories, bring other types of questions, explanations and nuances into the debate by focusing on themes such as the nature of social life, the links between subjectivity and society, the structure of social institutions including schools, the role of predominant sociocultural discourses, power negotiation processes, and the significance of social transformation.

With regard to research on sexuality education in schools, some of the theoretical questions that are absent from the literature reviewed include the following: How is sexuality positioned in a (post)modern globalized society? What are the boundaries between the responsibilities of the individual, family, school and society in regard to sexual health, well-being, conduct, identity, and schooling? Where and how do these boundaries intersect, and what are the related implications and challenges in terms of policy and practice? What are the desired learning outcomes of sexuality education if the overall purpose is construed as gender equality and sexual rights? How can these learning outcomes be operationalized and enacted within the complexities of school practices, and how can they be evaluated? What models can theoretically justify the selection of relevant content and methods of teaching and learning if the educational aims include subjectification, inclusion, and sexual citizenship rather than solely disease prevention and socialization to the dominant norms concerning sexuality and sexual health? Lack of engagement with these and similar questions within the liberal discourses constrains the scope and nuances of the empirical research. Consequently, such research risks remaining within the instrumental domains of the status quo, despite its transformative aspirations.

The neglected potential of early sexuality education

We argued above that different approaches to school-based sexuality education influence the age groups of pupils that are considered to be relevant target groups. Although this
research mapping shows a general lack of published research regarding children aged 6-12, among papers involving this target group, we have identified more papers based on non-conservative than conservative approaches. It is beyond the scope of this paper to unfold the potentials of liberal approaches to school-based sexuality education aimed at younger pupils. However, in the context of contemporary society, where a great deal of sexuality-related information and other contents of varying quality, including pornography, is readily accessible through different media, sexuality education in primary schools can be considered a vital source of knowledge, competences and values for children if they are to develop the capacities to critically reflect on, assess, select, and use information as well as to learn to make safe, responsible and meaningful choices in relation to sexuality and sexual health (Graugaard and Roien, 2007). Early sexuality education in schools has extraordinary potential with regard to the personal, relational and social development of young children. Such education could enable them to engage with present and future challenges, such as sexual consent, sexting, sexual identities and rights, to mention but a few. This potential, as well as the specifics of the content, teaching strategies and expected learning outcomes of sexuality education for younger children, seem to be seriously neglected by the existing research.

Concluding remarks
On the basis of systematic mapping of literature, in this paper we have discussed the overall characteristics of international research published in academic journals on school-based sexuality education, with an added spotlight on the framing of non-conservative or liberal approaches. There are limits to the mapping protocol, which does not involve narrative or statistical synthesis of the findings but rather allows for general portrayal of the research landscape. However the study points to a few gaps in the existing research including lack of focus on sexuality education for youngest pupils aged 6-12. The identified gaps justify a call for more research from diverse sociocultural, political and geographical contexts, more substantial use of social theory in conceptual research and more research focusing on sexuality education for younger pupils. The study also points to the need for conducting systematic reviews in the field that would include the gray literature, books, reference search and consulting the experts, which would allow for in-depth data extraction and nuanced synthesis, focusing on potentials and challenges, and on processes and outcomes of non-conservative approaches to sexuality education for youngest pupils in schools in diverse cultural and socio-political and educational contexts.

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School and emotional well-being: a transcultural analysis on youth in Southern Spain

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Verónica C.C. Cala
University of Almeria, Almeria, Spain

Abstract
Purpose – The purpose of this paper is to assess and compare school well-being (SW) and emotional well-being (EW) among Romanian, Moroccan and Spanish youth, to determine the degree of relation between EW and scholar well-being.

Design/methodology/approach – The paper employed cross-sectional research with cluster sampling in two primary schools and seven secondary schools. The questionnaire Kidscreen-27 was distributed to a sample of 1,840 Romanian, Moroccan and Spanish students aged between 10 and 19 years old. Data analysis was conducted with the software package SPSS, version 21.

Findings – EW shows significant gender (gender gap) and origin inequalities (lower performance for the Moroccan community). However, well-being in school shows positive results for the Moroccan students and women. Moreover, EW and well-being at school are presented as related and co-linear variables with a predictive power over one another.

Research limitations/implications – Understanding cultural expressions in heterogeneous cultures is a very complex task. Despite the cultural adaptation and validation of instruments, the applied surveys could not consider cultural differences.

Practical implications – The paper underlines that gender and origin remain decisive and determinant for adolescent health. However, the school can have positive effects on the well-being of immigrants. The reasons for well-being need to be explored, and it would be useful to develop educative strategies to implement transcultural EW and SW.

Originality/value – It is the first study about SW and EW of immigrants in Spain that explains a better SW in immigrants groups. It is also relevant for applied school intervention to predict the relationship between EW and SW.

Keywords Health education, Adolescents, Emotional well-being, School environment, Culture and health, Migrant health

Paper type Research paper

Background
Promoting positive social and emotional development during childhood and adolescence is increasingly seen as a fundamental objective for schools. The school is increasingly conceived as a place for the development of life skills, well-being and democracy (Cohen, 2006), as a place where values are acquired, for personal and social development (Bisquerra, 2003; Elias et al., 1999; Goleman, 1996) and as the site for dialogue, and critical and reflective thinking (Murphy et al., 2014).

All these approaches agree on a necessary re-formulation of the traditional and restrictive concept of schooling. To the extent that health, effective communication and well-being are considered as pillars of the educational model, newer approaches are no longer focused solely on scholastic performance and academic results (Fitz-Gibbon, 2006). However, there is paucity of studies on the analysis of welfare at school from an intercultural perspective. The expansion of the promotion of mental health in schools has been carried out with a considerable lack of information about how schools can best respond to multicultural populations (Habib, 2012), failing to explore the situation of migrants, or being sufficiently sensitive to the need for schools to respond to differences between the social groups they serve.
Sociocultural factors on the emotional health of a migrant population

Domnich et al. (2013) systematised three factors which can influence the well-being of an immigrant population in a school:

(1) Socio-structural factors such as age, gender, social class, race, socio-educational level and the power position of the social group from which the students come.

(2) Behavioural and lifestyle factors, influenced by the environmental relationship between migrants and the host community, including the acculturation of migrants (Tarnutzer and Bopp, 2012; Harker, 2001; Berry et al., 1987). Cultural phenomena can have harmful effects on human health, such as the westernisation of lifestyles (which refers to the adoption of negative health patterns associated with western culture such as worse dietary behaviours or less physical activity). The situation is not all negative, and positive cultural phenomena can contribute to better health. These include “the healthy Latin or migrant effect” (MacDonald and Kennedy, 2004) which suggests that there is a selection of healthy people who migrate, “the immigrant paradox” according to which the first generations are healthier than successive ones, and “cultural buffering” whereby the original cultures of migrants can help reduce stress and maintain healthier behaviours (Taylor and Sarathchan, 2016).

(3) Psychosocial factors that occur at a more individual and subjective level, including critical life events and chronic stressors, the need to learn a new language, poverty, discrimination and racism (Perreira and Ornelas, 2011). These stress factors affect the immigrant population disproportionately, and entail an increased risk for mental and emotional disorders (Sirin et al., 2013; Achetegui, 2002, 2004).

Studies on immigrants and ethnic minorities at school have identified lower levels of well-being and adaptation. Pantzer et al. (2006) carried out a study in Girona, and showed that young migrants in schools experienced worse health and a lower quality of life than the native population. Ethnographic research on health-related behaviours of the Afro-Caribbean population conducted in Britain by Ochieng (2010) identified several factors that undermine health in school, including discrimination and racism, the existence of an exclusively Eurocentric curriculum, gender differences and expulsion as a form of discipline.

Another major issue regarding school and well-being among the migrant population is gender inequality. The “gender gap” is a phenomenon associated with worse psycho-emotional health in women across all cultural groups (Wade et al., 2002), although the way in which gender gaps are expressed varies among cultural groups (Alves et al., 2011).

The association between school well-being (SW) and emotional well-being (EW)

The need to include psycho-educational health as a goal is gaining international importance and is influencing the development of education policies in countries across the world. There are several studies that relate the emotional development of children and young adults to the acquisition of healthy behaviours, better school performance and an improved school environment (Denny et al., 2011; Virtanen et al., 2009) and contribute to the prevention of bullying (Shaheen et al., 2014). There are also studies which suggest that adolescents who show lower levels of emotional health find it more difficult to adapt to school, have a lower academic performance, have more learning difficulties, greater relational and communicative difficulties, an increased prevalence of risky behaviours such as addictions (Bond et al., 2007), anorexia, and unwanted pregnancies and higher rates of psycho-emotional disorders, such as depression and anxiety (Bisquerra, 2000).

SW has been defined as an affective positive state, relatively persistent, characterised by the satisfaction, dedication, adherence and absorption in the school activities (Angel-Gonzalez et al., 2017). It includes the degree of comfort students feel at school, and
the value they attach to school. As Roffey (2013) and Noble and McGrath (2008) affirmed, the student’s level of well-being at school is indicated by satisfaction with life at school, engagement with learning and social-emotional behaviour. Optimal student well-being is characterised by positive feelings and attitudes, positive relationships at school, resilience, self-optimisation and a high level of satisfaction with learning experiences.

The urgency for multicultural schools that promote health
Schools in multicultural societies are potentially meeting points for different cultural groups in which an exchange of values and mutual enrichment takes place, and where “cultural shock” becomes an opportunity to learn and solve problems (Soriano, 2006). Multicultural schooling contexts can have positive effects on the psychosocial and identity development of minority groups and of all students, allowing for increased cultural empathy (Le et al., 2009). If schools wish to see themselves as health promoting, they cannot ignore the social and cultural health factors of their students, or underestimate the importance of the links between EW and health, cultural co-existence and academic success (Soriano and Franco, 2010; McLaughlin, 2008; Soriano, 2008). The school needs to be an inclusive space in which a health empowerment of all sociocultural groups can take place, paying special attention to those facing greater difficulties.

Aims of this study
The study aimed to assess and compare the educational and EW of adolescents aged between 10 and 18 of the three main nationalities residing in Southern Spain, namely Moroccan, Romanian and Spanish, and to establish how origin and gender have an impact on adolescents’ school life and well-being.

It also sought to explore whether the way in which students perceive the school environment in terms of its ability to promote their emotional well-being is predictive of their school welfare.

Methods
Sample
The sample consisted of 1,837 adolescents from two primary schools and nine secondary schools in Southern Spain in the province of Almeria. It was made up of 1,313 Spanish students, 367 Moroccan students and 157 Romanian students: 71.41 per cent considered themselves to be Spanish, 20 per cent Moroccan, and 8.59 per cent Romanian. With respect to gender distribution, 50.84 per cent of the participants in the questionnaire were females and 49.16 per cent were males (Table I).

Students ranged in age from 10 to 19 years old, with more than 95 per cent of the participants aged between 11 and 18 years old. In all, 87.2 per cent stated that they did not suffer from any diagnosed diseases, 6.2 per cent stated that they suffered from asthma or allergies, and the remaining 6.6 per cent stated that they suffered from other types of diseases.

<table>
<thead>
<tr>
<th>Gender</th>
<th>Spain</th>
<th>Morocco</th>
<th>Romania</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>658</td>
<td>181</td>
<td>92</td>
<td>931</td>
</tr>
<tr>
<td>Male</td>
<td>655</td>
<td>186</td>
<td>65</td>
<td>906</td>
</tr>
<tr>
<td>Total</td>
<td>1,313</td>
<td>367</td>
<td>157</td>
<td>1,837</td>
</tr>
</tbody>
</table>

Table I. Distribution according to gender and nationality (number and percentage)
**Procedure**

This study was a cross-sectional study (data collected from a representative subset of adolescent population in the South of Spain at a specific point in time) with random cluster sampling in schools. With the support of the Spanish Department of Education, a list of schools in the province with higher proportions of Romanian and Moroccan students was compiled. The schools where the questionnaire was conducted were selected randomly from this list.

**Instrument**

The research included the use of the Kidscreen-27 questionnaire. Kidscreen was the first transcultural instrument for measuring quality of life related to health. It was developed by European Commission, and 13 countries were involved in its design and drafting. Studies in many countries have validated the questionnaire from a transcultural perspective (Ravens-Sieberer *et al.*, 2007, 2008; Aymerich *et al.*, 2005).

Kidscreen-27 involves five dimensions to measure health and quality of life: (1) physical well-being (2), psychological well-being and EW (3), autonomy and parents (4), peers and social support (5), and SW. This study looks at dimensions (2) and (5).

The data were analysed using the statistical analysis software SPSS, version 21. In statistical hypothesis testing, it is considered that there is statistical significance when *p* values are inferior to 0.05, with a 95 per cent probability, and inferior to 0.01, with a 99 per cent probability.

**Results**

Table II shows the means obtained for each group on both EW and SW. In terms of EW, the group scores ranged from 25.68 (Moroccan girls) to 28.23 (Spanish boys) out of 35 points. Boys had higher scores than girls, and the native Spanish group for both genders reported higher levels of EW. All cultural groups showed significant differences by gender (*p* < 0.05).

In the case of SW, the mean scores ranged from 14.75 (the lowest scores were for Romanian boys) and 16.32 (the highest for Moroccan girls) out of a maximum possible score of 20 points. Girls had higher scores than boys in all groups. There were higher rates of SW in the case of the Moroccan group. Moroccan boys scored 0.98 points more than Spanish boys and 1.07 more than Romanian boys, while Moroccan girls scored 0.92 points more than Spanish and 1.23 than Romanian girls. The only statistically significant differences in SW by gender were observed in Spanish group (*p* = 0.002).

Table II shows gender differences between the cultural groups, with immigrants and native girls showing lower levels of EW than boys. Spanish girls showed 1.5 less than Spanish boys (*p* = 0.000), Moroccan girls showed 1.98 points less than boys (*p* = 0.001) and Romanian girls 2.04 points less than Romanian boys. Moroccan girls experienced a greater sense of SW than their Spanish and Romanian counterparts, but these differences are not statistically significant.

<table>
<thead>
<tr>
<th></th>
<th>Emotional well-being</th>
<th>School well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>M</em></td>
<td>SD</td>
</tr>
<tr>
<td>Spanish women</td>
<td>26.73</td>
<td>5.47</td>
</tr>
<tr>
<td>Moroccan women</td>
<td>25.68</td>
<td>5.74</td>
</tr>
<tr>
<td>Romanian women</td>
<td>25.99</td>
<td>5.42</td>
</tr>
<tr>
<td>Spanish men</td>
<td>28.23</td>
<td>4.89</td>
</tr>
<tr>
<td>Moroccan men</td>
<td>27.65</td>
<td>4.76</td>
</tr>
<tr>
<td>Romanian men</td>
<td>28.03</td>
<td>5.45</td>
</tr>
</tbody>
</table>

Notes: *p < 0.05; **p < 0.001
Table III shows the results of the application of the ANOVA test to determine whether EW showed statistically significant differences among the three cultural groups for both genders, and for boys and girls separately, i.e. if the differences are linked with the country of birth. There were statistically significant differences regarding overall EW between Spaniards and Moroccans ($p \leq 0.05$).

In terms of SW, place of origin has a better relationship with the school context, with clear differences between the Spanish and Moroccan group and Moroccans and Romanians. Therefore, a better perception of SW is associated with a Moroccan origin, whilst Spanish and Romanian students had less positive views regarding school than Moroccan students ($p < 0.01$), as shown in Table IV.

**The relationship between EW and SW**

In addition to analysing the differences between cultural groups, the association between EW and SW was also examined. A correlation between both constructs was established and a linear regression was then performed to define the possible predictive nature.

Table V shows the results obtained by applying the Pearson correlation. EW correlated with SW. A co-linear positive relationship was established, suggesting that both concepts influence each other in a positive manner. The existence of this correlation allowed us to analyse the predictive nature of one over the other.

**Table III.** ANOVA of emotional well-being

<table>
<thead>
<tr>
<th>Emotional well-being</th>
<th>Total</th>
<th>Sig.</th>
<th>Total</th>
<th>Sig.</th>
<th>Total</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Dif.</td>
<td>SE</td>
<td>Sig.</td>
<td>Mean Dif.</td>
<td>SE</td>
<td>Sig.</td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morocco</td>
<td>0.797</td>
<td>0.325</td>
<td>0.038*</td>
<td>0.579</td>
<td>0.421</td>
<td>0.355</td>
</tr>
<tr>
<td>Romania</td>
<td>0.655</td>
<td>0.45</td>
<td>0.312</td>
<td>0.201</td>
<td>0.646</td>
<td>0.948</td>
</tr>
<tr>
<td>Morocco</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>−0.7967</td>
<td>0.325</td>
<td>0.038*</td>
<td>−0.579</td>
<td>0.421</td>
<td>0.355</td>
</tr>
<tr>
<td>Romania</td>
<td>−0.141</td>
<td>0.514</td>
<td>0.959</td>
<td>−0.377</td>
<td>0.721</td>
<td>0.86</td>
</tr>
<tr>
<td>Romania</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Spain</td>
<td>−0.655</td>
<td>0.45</td>
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</tr>
<tr>
<td>Morocco</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>0.953</td>
<td>0.194</td>
<td>0.000*</td>
<td>0.983*</td>
<td>0.287</td>
<td>0.002*</td>
</tr>
<tr>
<td>Romania</td>
<td>0.177</td>
<td>0.275</td>
<td>0.795</td>
<td>0.092</td>
<td>0.442</td>
<td>0.977</td>
</tr>
<tr>
<td>Morocco</td>
<td>0.953</td>
<td>0.194</td>
<td>0.000*</td>
<td>0.983*</td>
<td>0.287</td>
<td>0.002*</td>
</tr>
<tr>
<td>Romania</td>
<td>1.130</td>
<td>0.311</td>
<td>0.001*</td>
<td>1.075</td>
<td>0.492</td>
<td>0.075</td>
</tr>
<tr>
<td>Romania</td>
<td>−0.177</td>
<td>0.275</td>
<td>0.795</td>
<td>−0.092</td>
<td>0.442</td>
<td>0.977</td>
</tr>
<tr>
<td>Morocco</td>
<td>−1.130</td>
<td>0.311</td>
<td>0.001*</td>
<td>−1.075</td>
<td>0.492</td>
<td>0.075</td>
</tr>
<tr>
<td>Romania</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** $*p = 0.05$; $**p = 0.001$

**Table IV.** ANOVA of school well-being

<table>
<thead>
<tr>
<th>School well-being</th>
<th>Total</th>
<th>Sig.</th>
<th>Total</th>
<th>Sig.</th>
<th>Total</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Mean Dif.</td>
<td>SE</td>
<td>Sig.</td>
<td>Mean Dif.</td>
<td>SE</td>
<td>Sig.</td>
</tr>
<tr>
<td>Spain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morocco</td>
<td>−0.953</td>
<td>0.194</td>
<td>0.000*</td>
<td>−0.983*</td>
<td>0.287</td>
<td>0.002*</td>
</tr>
<tr>
<td>Romania</td>
<td>0.177</td>
<td>0.275</td>
<td>0.795</td>
<td>0.092</td>
<td>0.442</td>
<td>0.977</td>
</tr>
<tr>
<td>Morocco</td>
<td>0.953</td>
<td>0.194</td>
<td>0.000*</td>
<td>0.983*</td>
<td>0.287</td>
<td>0.002*</td>
</tr>
<tr>
<td>Romania</td>
<td>1.130</td>
<td>0.311</td>
<td>0.001*</td>
<td>1.075</td>
<td>0.492</td>
<td>0.075</td>
</tr>
<tr>
<td>Romania</td>
<td>−0.177</td>
<td>0.275</td>
<td>0.795</td>
<td>−0.092</td>
<td>0.442</td>
<td>0.977</td>
</tr>
<tr>
<td>Morocco</td>
<td>−1.130</td>
<td>0.311</td>
<td>0.001*</td>
<td>−1.075</td>
<td>0.492</td>
<td>0.075</td>
</tr>
<tr>
<td>Romania</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Notes:** $*p = 0.05$; $**p = 0.001$
The analysis of the possible predictive capacity between EW and SW was conducted using a linear regression as they are continuous variables. Table VI shows a positive relationship between them. EW predicted to some extent well-being at school. Since the $\beta$ coefficient has a value close to 0.4 ($\beta = 0.394$), it would appear to have a moderate impact on the dependent variable, SW. Analysing the results by place of origin, EW remained a predictive factor for SW.

**Discussion and conclusions**

Our findings suggest that the sense of SW influences the educational experience of adolescents. They also indicate the persistence of socio-structural differences involving gender and place of origin on young adults’ well-being and health, and the strong link between the emotional state of the student and their sense of well-being at school.

With regard to the inequalities between the different sociocultural groups, the results show divergent trajectories for the western students – Spanish and Romanian – and those students from Southern countries – Moroccan. This coincides with previous studies with these three cultural groups (Soriano et al., 2014; Soriano and Cala, 2014a, b).

The Moroccan student population reported the worst results in terms of EW and the best in terms of SW. The EW differences between Moroccan and Spanish students were statistically significant ($p < 0.05$) which may therefore be attributable to their country of origin, similarly the higher scores for Moroccan students and lower in Romanian students ($p < 0.05$) also appear to be connected to origin. To provide a possible explanation of the phenomenon observed in the Moroccan student population, we can refer to the influence of socio-structural factors such as the socio-economic conditions of Moroccan families living in the territory, behavioural factors influenced by acculturation processes (maintenance of own lifestyles and the adoption of western styles) and psychosocial factors, such as acculturation stress.

The results suggest poorer mental, psychological and emotional health conditions among the young immigrant population (Alves et al., 2011; Bhugra and Becker, 2005). The results are not consistent with the “ethnic density hypothesis” (Gieling et al., 2010)

### Table V.
Correlation emotional well-being school well-being

<table>
<thead>
<tr>
<th></th>
<th>Emotional well-being</th>
<th>School well-being</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson correlation</td>
<td>1</td>
<td>0.382**</td>
</tr>
<tr>
<td>Sig.</td>
<td></td>
<td>0.000</td>
</tr>
</tbody>
</table>

### Table VI.
Linear regression between emotional and educational well-being with the total sample and according to place of origin

<table>
<thead>
<tr>
<th></th>
<th>$R^2$</th>
<th>$\beta$</th>
<th>$t$</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional well-being</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>0.155</td>
<td>0.394</td>
<td>17.642</td>
<td>0.000**</td>
</tr>
<tr>
<td>By origin</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spain</td>
<td>0.171</td>
<td>0.413</td>
<td>15.936</td>
<td>0.000**</td>
</tr>
<tr>
<td>Morocco</td>
<td>0.180</td>
<td>0.424</td>
<td>8.238</td>
<td>0.000**</td>
</tr>
<tr>
<td>Romania</td>
<td>0.084</td>
<td>0.290</td>
<td>3.671</td>
<td>0.000**</td>
</tr>
</tbody>
</table>

**Notes:** Dependent variable: school well-being; predictive variables: (Constant). emotional well-being. $*p < 0.05; **p < 0.001$
which suggests that the greater the density of an ethnic group within a class, the lower the chances of presenting psycho-emotional problems.

Moreover, the higher levels of SW may suggest that young Moroccans place a higher value on the school. The positive perception of the school in Moroccan students is consistent with the “immigrant paradox” (Abraido-Lanza et al., 1999) and the hypothesis of “cultural buffering” which suggests that immigrants’ original cultures may function to promote healthy behaviours and lifestyles because of the protective cultural strength of family and social networks (Taylor and Sarathchan, 2016). In this case, North African cultures show high degrees of respect for school as the main educational institution. To support this, a study on educational support by Vedder et al. (2005) found that German students felt they received greater educational support from their families whilst Moroccan and Turkish students were more likely to see the support as coming from their teachers.

The fact that the young Romanian population shows no significant differences either in terms of EW or SW in relation to the Spanish population may suggest that there are certain cultural similarities, as they are both western cultures. It may be because there is an acculturation process that is more pronounced than in the case of the Moroccan student population. The behavioural similarity between Spanish and Romanian students coincides with the findings of a qualitative study by Soriano and Cala (2014a, b) in which Romanian and Spanish students also showed a very similar health situation, perhaps due to cultural assimilation, but interviews with Romanian student identified greater school dissatisfaction, more loneliness and more oppressive family ties.

Our data confirm the persistence of an EW “gender gap” in all cultural groups, which has been suggested by other research (Soriano et al., 2014; Soriano and Cala, 2014a, b). The lower levels of EW experienced by girls have been linked with more time-stress, more task overload and the pressure of gender norms (Senik, 2015). However, girls tend to show higher levels of SW (Løhre et al., 2014). The reasons for this could be further analysed in future investigations.

There was a clear correlation between SW and EW, over and above any differences between cultural groups. It would appear that school relationships and school dynamics influence mood in both positive and negative directions. This is in line with the findings of Reschly et al. (2008) who concluded that positive emotions support students’ engagement at school and their academic learning. This suggests the importance of encouraging cross-cultural development programmes and emotional care. Similarly, nurturing a good school environment and promoting a satisfactory atmosphere can influence positively the emotional state of the students (Saab and Klinger, 2010). Our findings suggest an urgent need for intercultural health promoting schools that recognise alleviate sociocultural health inequalities faced by young adults, by incorporating intercultural psycho-emotional programmes, which include a gender perspective.

Implications

If the school is to be effective as a health socializing institution for all groups, including immigrant groups (in the case of Southern Spain – Romanian, and more especially Moroccan groups), there is a need to develop inclusive educative programmes. An inclusive and transcultural framework can contribute to understanding cultural diversity as a source of personal and social enrichment among the school community, whilst attempting to overcome inequalities.

An inclusive and intercultural atmosphere in classrooms needs to be multidimensional. It should consider the needs of disadvantaged and vulnerable groups, as for example in the case of Southern Spain, valuing immigrants’ relationships with the school. At the same time, special attention needs to be paid to meeting the health challenges of different cultural groups. In case of immigrant youth, special psychological assistance must be given. This is a challenge as Spain has few school nurses or psychologists (they are recommended but not compulsory) who might be trained to support children and youth, and show sensitivity to transcultural issues.
Conclusions

Contemporary societies have undergone changes that oblige school to readapt to the challenges of becoming a truly common area for EW and SW promotion and responding to the expression of the cultural diversity in the multicultural context. Our research shows that neither origin nor gender offers a straightforward linear pattern of response in the different health dimensions. It is therefore necessary to integrate the transcultural and gender perspective in the study of adolescent well-being, to identify the positive aspects of each cultural and social group and strengthen them.

Note

1. All versions of the Kidscreen Instrument can be found at www.kidscreen.org/

References


School and emotional well-being


Further reading

About the authors
Encarnación Soriano is a Professor of Research Methods in Education at the University of Almería (Spain) and the Director of the research group “Research and Evaluation in Intercultural Education”. She is an author and editor of numerous books and articles on issues of intercultural education, cultural identity, intercultural citizenship, and interculturality and gender.

Verónica C.C. Cala is a Lecturer in Research Methods at the University of Almería (Spain) and Member of the “Research and Evaluation in Intercultural Education”. Cala has PhD in Health Education with Migrant Adolescents and is licensed in Medicine and Surgery at the Complutense University of Madrid. Her research areas are focused on transcultural health education, migrant adolescent health, intercultural education and research methods in health education. Verónica C.C. Cala is the corresponding author and can be contacted at: vcc284@ual.es
Subjective health literacy among school-aged children

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"Faculty of Sport and Health Sciences, University of Jyväskylä, Jyväskylä, Finland"

Minna Torppa  
"Faculty of Education, University of Jyväskylä, Jyväskylä, Finland, and"

Jari Villberg, Lasse Kannas and Leena Paakkari  
"Faculty of Sport and Health Sciences, University of Jyväskylä, Jyväskylä, Finland"

Abstract

Purpose – The purpose of this paper is to explore Finnish adolescents’ subjective health literacy (HL) in association to school achievement, learning difficulties, educational aspirations, and family affluence.

Design/methodology/approach – Nationally representative data were collected in Finland as a part of the international Health Behaviour in School-aged Children study. The respondents consisted in total of 3,833 adolescents (7th and 9th graders) from 359 schools. The Health Literacy for School-aged Children instrument was applied to measure adolescents’ subjective HL, while the Family Affluence Scale was used to measure adolescents’ socioeconomic status. Information was gathered on school achievement, learning difficulties, and educational aspirations.

Findings – Approximately one-third of the adolescents manifested a high level of HL, around 60 per cent had a moderate level of HL, and about one-tenth had low HL. The HL level was lower for boys than for girls, and lower for 7th graders than for 9th graders. In the total sample, the strongest explanatory variables for HL were school achievement in the first language, and educational aspirations.

Originality/value – This study provides the first nationally representative examination of adolescents’ subjective HL levels, and how these vary across age and gender groups. In drawing conclusions and presenting suggestions for HL interventions, it is important to verify the nature of the HL examined in any given study, and how it was researched.

Keywords Health education, Learning difficulties, School health promotion, Adolescence

Paper type Research paper

Introduction

In the field of public health and health promotion, there has been increasing interest in the health literacy (HL) of various age groups. HL as “the degree to which individuals have the capacity to obtain, process and understand basic health information and the services needed to make appropriate health decisions” (Ratzan and Parker, 2000, p. vi) has been reported to be a clear risk factor for poor health (Volandes and Paasche-Orlow, 2007). The development of HL among the population can be seen as an important means to decrease health disparities (Kickbusch et al., 2006). The advancement of HL among the broader population requires a focus on HL, with age-appropriate measurements, across various age groups and settings (Kickbusch et al., 2013). Children within schools comprise one such target.

School comprises a valuable setting for supporting HL, since the school reaches most of the population within a certain age demographic. The foundation for HL, health behaviour, and health and well-being in general is laid during childhood and the school years. Adolescence is generally understood to be a significant period of life in many respects, including that of independent decision making (Ghanbari et al., 2016). Health inequalities among the adult population can be partly explained via health behaviours adopted in adolescence, and with reference to early life circumstances (Inchley et al., 2016, p. 5).

This study is funded by National Institute for Health and Welfare, Finland and Academy of Finland (No. 276239).
One of the main purposes of the school is to reduce inequalities, including those that are already present in adolescence (UNESCO, 2014a). Education contributes to the health and well-being of pupils in a general sense (UNESCO, 2014b); however, when health-related competences (i.e. HL) are given specific attention when formulating and putting into practise school health education learning objectives and standards, health disparities are likely to further decrease (see Parker et al., 2003). As Perry (2014, p. 217) has aptly noted, “the task of improving HL amongst millions of adolescents is daunting; but, ultimately, improving HL in adolescents is imperative for achieving better health outcomes”. There is a clear and increasing gap between the demands to take care of one’s health and the actual skills that people possess (Kickbusch et al., 2013; Gazmararian et al., 2005; Parker et al., 2003). From this perspective, the development of HL among schoolchildren is not merely desirable, but could be regarded as a moral act.

The level of school-aged children’s HL – what have we learned so far?
Over the years, most studies on HL have been conducted on patients in a health care context, with a research focus on the basic skills of reading, writing, and numeracy. These are often referred to collectively as functional HL, as defined by Parker et al. (1995). Research on these domains continues, and the importance of functional HL skills on a person’s health remains widely recognised. Nevertheless, there has been an increasing willingness to move beyond these skills and to monitor a broader construct of HL, one that would encompass the HL competences (e.g. critical thinking, problem solving and advocacy skills) that are nowadays needed if individuals are to take care of and sustain their own and community health in modern society (Nutbeam, 1998; Sørensen et al., 2012).

There has only been limited monitoring and reporting of HL of any kind among school-aged children overall (Ghanbari et al., 2016; Ormshaw et al., 2013), with studies focusing primarily on the functional HL of adolescents. Moreover, there have not been many cross-national comparative studies on adolescents’ HL levels, although some information has been obtained from countries or regions in various parts of the world, including Asia (Taiwan, China) and the USA. Studies focusing on functional HL have shown that up to 90 per cent of children in Taiwan and China have a moderate or high level of HL, while 10 per cent have low HL (Chang, 2010; Lam and Yang, 2014). In the USA, the proportion of young people with “below basic” HL has been the same as in Taiwan and China (Kutner et al., 2006; see also Ghaddar et al., 2012). The findings reflect a good general literacy level among young people in those areas (UNESCO, 2014c). Interestingly, when another study in the same area of Asia assessed HL – via an instrument which addressed the broader construct of HL – the proportion of children with low HL was higher, at over 25 per cent (Shih et al., 2016). This is consistent with the view that functional HL tools such as Test of Functional Health Literacy in Adults (Parker et al., 1995) and Rapid Estimate of Adult Literacy in Medicine (Davis et al., 1991) focus on phenomena (e.g. reading ability; DeWalt and Pignone, 2005) that are narrower in scope than the HL domains addressed in the fields of public health and health promotion.

In Europe, HL has been measured mainly in adult populations via the European Health Literacy Survey. This has been conducted within eight European countries, and it has also included adolescents and young adults (15 years and older) (Sørensen et al., 2015). However, since age-specific findings have not been reported, there is no information on HL among the young people represented in that sample.

In Finland, HL among school-aged children has been studied as part of the national assessment of learning applied to health education as a distinct school subject. Using an objective measure (a pen and paper exam) based on a broad construction of HL, a nationally representative sample of 9th graders gave responses in various tasks (Summanen, 2014). The pupils showed only a satisfactory level of competence. However, it should be noted that...
the assessment was first and foremost an evaluation of how well pupils had met the learning criteria identified in the national curriculum. Hence, the main starting point for the development of the exam was the curriculum, not the concept of HL, even if the findings do indeed reflect HL.

According to a review by Perry (2014, p. 215), the majority of studies on the current HL status of adolescents has used “health literacy instruments that have not been validated for use in adolescents”, hence caution is seen as necessary in interpreting the findings. Moreover, most of the studies have focused on functional literacy, with a concomitant lack of studies addressing the broader construct of HL, plus related factors. It is only recently that efforts have been made to develop adolescent-specific instruments that go beyond the evaluation of basic literacy skills (Ghanbari et al., 2016; Paakkari et al., 2016; Shih et al., 2016). One of such instruments is the Health Literacy for School-aged Children (HLSAC) instrument (Paakkari et al., 2016). It was developed based on a broader construct of HL and for the purpose of measuring HL of the adolescents.

The aim of this study was to investigate the level of subjective HL among adolescents (boys and girls, 7th and 9th grade, ages 13 and 15) in Finland, on the basis of the HLSAC instrument. In addition, the study sought to determine the associations between HL, school achievement, learning difficulties, educational aspirations, and family affluence.

Methods

Participants and data collection

The empirical data for the study were collected in Finland in 2014, as part of the cross-national collaborative study entitled Health Behaviour in School-aged Children (HBSC). The general objective of the HBSC research is to gain a better understanding of lifestyles, health behaviours, and the surrounding context, insofar as they affect children and adolescents (Currie et al., 2009). The research thus covers various aspects of adolescence, including demographic factors, health behaviours, perceived health, HL, learning, lifestyles, and life circumstances. All the measures are based on self-reports.

The data for the present study were nationally representative, being obtained from a total of 3,833 adolescents (boys 7th grade $n = 880$, boys 9th grade $n = 882$, girls 7th grade $n = 894$, girls 9th grade $n = 963$) in 359 schools. The schools were chosen from the Finnish school register using a cluster sampling method. Sampling was adjusted to take into account the province within Finland, the type of municipality (urban, semi-urban, rural), and the size of the school. Within each school the participating class was randomly selected.

The data collection followed the general guidelines of responsible conduct of research (Finnish Advisory Board on Research Integrity, 2012), and the research protocol of the international HBSC study (Currie et al., 2014): 13- and 15-year-old participants responded voluntarily and anonymously to a standardized paper-and-pen questionnaire, administered in the course of one lesson. The pupils were informed of the confidentiality of the data, and of the fact that only group-level results would be reported.

The response rate of the pupils was 85 per cent, while the response rate for the schools was 68 per cent.

Measures

HL instrument. A brief HLSAC instrument (Paakkari et al., 2016) was used to measure the adolescents’ subjective (self-reported, perceived) HL. The validated ten-item instrument (Table I) contains two items from each of the five core components (theoretical knowledge, practical knowledge, critical thinking, self-awareness, citizenship). The HLSAC instrument has been found to have high internal consistency (overall Cronbach’s $\alpha = 0.93$, Table II).
All the items took the form “I am confident that […]”, and the Likert-type response scale included four options: “not at all true”, “barely true”, “somewhat true”, and “absolutely true”. For the analysis of the HL levels the response options “not at all true” and “barely true” were combined to describe “low” HL.

### Table I. Percentage distributions of the items in the HLSAC instrument, divided by gender

<table>
<thead>
<tr>
<th></th>
<th>Boys ($n = 1,820$)</th>
<th>Girls ($n = 1,912$)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not at all true</td>
<td>Absolutely true</td>
</tr>
<tr>
<td></td>
<td>Barely true</td>
<td>Somewhat true</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Theoretical knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having good information regarding health</td>
<td>2.6 9.3 44.6 43.5</td>
<td>0.5 7.5 45.4 46.6</td>
</tr>
<tr>
<td>Ability to give examples of things that promote health</td>
<td>2.3 13.6 49.9 34.1</td>
<td>0.9 12.2 49.9 37.0</td>
</tr>
<tr>
<td><strong>Practical knowledge</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to find health-related information that is easy to understand</td>
<td>2.1 9.3 44.3 44.3</td>
<td>0.6 6.3 42.5 50.7</td>
</tr>
<tr>
<td>Ability to follow the instructions given by doctors and nurses</td>
<td>2.3 9.6 43.9 44.3</td>
<td>0.7 5.7 35.3 58.2</td>
</tr>
<tr>
<td><strong>Critical thinking</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to decide if health-related information is right or wrong</td>
<td>2.3 12.7 49.7 35.4</td>
<td>1.5 12.9 51.9 33.7</td>
</tr>
<tr>
<td>Ability to compare health-related information from different sources</td>
<td>2.8 13.8 48.5 34.9</td>
<td>1.9 13.8 51.7 32.6</td>
</tr>
<tr>
<td><strong>Self-awareness</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to justify one’s own choices regarding health</td>
<td>2.5 12.2 48.7 36.6</td>
<td>0.9 9.3 49.7 40.2</td>
</tr>
<tr>
<td>Ability to judge how one’s own behaviour affects one’s health</td>
<td>3.2 12.0 45.3 39.5</td>
<td>1.1 9.0 48.8 41.1</td>
</tr>
<tr>
<td><strong>Citizenship</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ability to judge how one’s own actions affect the surrounding natural environment</td>
<td>2.5 10.6 49.4 37.5</td>
<td>0.9 8.8 48.2 42.1</td>
</tr>
<tr>
<td>Ability to give ideas on how to improve health in one’s immediate surroundings</td>
<td>3.5 16.5 51.8 28.2</td>
<td>2.4 16.3 52.4 28.9</td>
</tr>
</tbody>
</table>

### Table II. Descriptive statistics and the Cronbach’s $\alpha$ for health literacy (HLSAC)

<table>
<thead>
<tr>
<th></th>
<th>n</th>
<th>Min.</th>
<th>Max.</th>
<th>Mean</th>
<th>SE</th>
<th>SD</th>
<th>Skewness</th>
<th>SE</th>
<th>Kurtosis</th>
<th>SE</th>
<th>$\alpha$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boys 7th grade</td>
<td>880</td>
<td>10</td>
<td>40</td>
<td>31.90</td>
<td>0.20</td>
<td>5.91</td>
<td>$-0.65$</td>
<td>0.08</td>
<td>0.52</td>
<td>0.17</td>
<td>0.94</td>
</tr>
<tr>
<td>Boys 9th grade</td>
<td>882</td>
<td>10</td>
<td>40</td>
<td>32.39</td>
<td>0.20</td>
<td>6.06</td>
<td>$-0.96$</td>
<td>0.08</td>
<td>1.42</td>
<td>0.16</td>
<td>0.95</td>
</tr>
<tr>
<td>Girls 7th grade</td>
<td>894</td>
<td>10</td>
<td>40</td>
<td>32.51</td>
<td>0.17</td>
<td>5.13</td>
<td>$-0.54$</td>
<td>0.08</td>
<td>0.25</td>
<td>0.16</td>
<td>0.91</td>
</tr>
<tr>
<td>Girls 9th grade</td>
<td>963</td>
<td>10</td>
<td>40</td>
<td>33.32</td>
<td>0.16</td>
<td>4.88</td>
<td>$-0.61$</td>
<td>0.08</td>
<td>0.38</td>
<td>0.16</td>
<td>0.91</td>
</tr>
<tr>
<td>Total</td>
<td>3,619</td>
<td>10</td>
<td>40</td>
<td>32.55</td>
<td>0.09</td>
<td>5.53</td>
<td>$-0.76$</td>
<td>0.04</td>
<td>0.93</td>
<td>0.08</td>
<td>0.93</td>
</tr>
</tbody>
</table>

All the items took the form “I am confident that […]”, and the Likert-type response scale included four options: “not at all true”, “barely true”, “somewhat true”, and “absolutely true”. For the analysis of the HL levels the response options “not at all true” and “barely true” were combined to describe “low” HL.
The levels of HL were classified in such a way as to fall into three groups. The thresholds were set by an expert group (consisting of researchers and teachers in the field of health promotion, education, and psychology) who determined the HL scores required to reach a given level. Following consideration of the contents of the items, and inspection of the response distribution, the resulting HL levels consisted of “low” (score 10-25), “moderate” (score 26-35), and “high” (score 36-40).

**School achievement.** Participants were asked to indicate their school achievement in their first language and in mathematics via the following question: “In my latest school report the mark was […]”. The response scale (marks) ranged from 4 (fail) to 10 (excellent). The marks thus obtained were regrouped to form three categories (marks 4-6, marks 7-8, and marks 9-10).

**Learning difficulties.** Respondents were asked to indicate whether they had learning difficulties in two areas, namely reading or spelling, and mathematics. The response options for both questions were no, some, and yes.

**Educational aspirations.** To assess educational aspirations, the adolescents were asked what they would do when they finished comprehensive school (at age 15). The response options were: “upper secondary school (age 16-19)”, “vocational school or other vocational training”, “an apprenticeship, double examination (upper secondary school and vocational school)”, “get a job”, “be unemployed”, or “don’t know”. Only the options “upper secondary school” and “vocational school or other” were included in the statistical analysis (dummy variable), because of very low frequencies for the other responses. The upper secondary school in Finland mainly represents an academic orientation, while the vocational school or vocational training can be seen as having a practical orientation.

**Family affluence.** The Family Affluence Scale (Torsheim et al., 2015) included six items that are associated with parental income and hence function as measures of adolescents’ socioeconomic status. The questions encompassed the material conditions of the household, covering: occupancy of bedrooms; number of bathrooms; number of computers and dishwasher ownership; ownership of a car; and holidays abroad. The response options for the questions on the dishwasher and on having own bedroom were “no” and “yes”. For the other questions the response scale was “none”, “one”, “two”, and “more than two”. The respondents were divided into three affluence groups according to the HBSC protocol (Currie et al., 2016): low affluence (lowest 20 per cent), medium affluence (middle 60 per cent), and high affluence (highest 20 per cent).

**Statistical analysis**
All the statistical analyses were conducted for the total sample, separately for boys and girls, and for 7th and 9th graders. The descriptive statistics for HL included means, standard errors, standard deviations, distributions of skewness and kurtosis, and percentage distributions of the HL levels. The differences between the group means (for gender and grade), gender and grade interaction effect on the HL were tested via a two-way analysis of variance (ANOVA).

The analyses were conducted using SPSS (version 22). The relationships between subjective HL and school achievement, learning difficulties, educational aspirations, and family affluence were tested via a mixed-effects multilevel regression analysis, because the data had a hierarchical structure (pupils nested in classrooms). The analyses in this case were conducted using Stata (version 14).

**Results**

**Level of subjective HL**
The HLSAC instrument used contains ten items (Table I).

Respondents indicated that their theoretical and practical knowledge was, generally speaking, at the “good” level. Around 90 per cent reported having a good knowledge of...
health; they felt that they could easily find understandable health information and could follow the instructions of doctors or nurses (response options: “somewhat true” or “absolutely true”).

More difficulties were indicated regarding critical thinking and citizenship. About 15 per cent reported difficulties in the ability to compare the information from different sources, or in the ability to decide if information is right or wrong. Approximately one in five indicated problems in terms of being able to give ideas on how to improve health in their environment.

Gender comparison showed that the boys reported more difficulties (response options “not at all true” or “barely true”) than the girls on almost every HL item. Similarly, more girls than boys reported having good competence in the cases that were asked, that is, they chose the response option “absolutely true” more often than the boys in most of the HL items.

Table II reports the descriptive HL statistics for girls and boys in the 7th and 9th grades, separately. The HL distributions were approximately normal. In every group, the minimum score was 10 and the maximum 40. The overall mean HL score was 32.55. The lowest subjective HL was found among 7th grade boys (mean score 31.90), and the 9th grade girls reported highest subjective HL (mean score 33.32). The girls HL mean score was higher than boys, and according a two-way ANOVA the difference was statistically significant \( F(df1) = 8.214, p = 0.004 \). The mean score of the HL was higher among the 9th graders than among 7th graders, and this difference was also statistically significant \( F(df1) = 10.555, p = 0.001 \).

Thereafter, we categorised HL into three levels (low = score 10-25, moderate = score 26-35, high = score 36-40). We observed that around one-tenth of the participants had low HL, 57 per cent had moderate HL, and approximately one-third achieved a high level of HL (Figure 1). In both age groups, there were more boys than girls with low HL. In both genders, the proportion of pupils who had a high level of HL increased towards the 9th grade.

**HL associations with school achievement, learning difficulties, educational aspirations, and family affluence**

The descriptive statistics for the predictors (Table III) showed that poorer results were more common among boys, and in general more frequent for mathematics than for the first language. Adolescents reported more difficulties in mathematics than in reading or spelling. About four out of five respondents reported that they had no difficulties in

![Figure 1. Levels of subjective HL by gender and grade, and for the total sample (percentage distribution)](image-url)
In mathematics, on average half of the participants reported difficulties, with girls reporting more difficulties than the boys. The majority of the participants intended to apply to upper secondary school, or to vocational school, or other vocational training. Among boys the intention to go vocational school or vocational training was higher than for the girls, most of whom reported that they intended to go to upper secondary school.

In the total sample, the strongest correlations between HL and the other variables were for school achievement in the first language, and for educational aspirations ($r = 0.22$) (Table IV). The correlations for the other variables (difficulties in reading, spelling or mathematics, family affluence) varied between 0.12 and 0.14. Better performance in the first language or mathematics, family affluence, and higher educational aspirations predicted higher HL, whereas lower HL was associated with difficulties in reading, spelling, or mathematics. Overall, the correlations were somewhat higher among the 9th grade pupils than among the 7th grade pupils.

In the total sample, the predictive variables for HL were school achievement in the first language, educational aspirations, difficulties in reading or spelling, difficulties in mathematics, and family affluence. Among the respondents who were planning to go to upper secondary school after finishing the comprehensive school, the HL score was 1.3 points higher than among those who were planning to enter vocational school or other vocational training.

The HL predictors varied between class and gender groups. For the girls (7th and 9th graders) the strongest predictive variable for HL was school achievement in the first language, and for the boys difficulties in mathematics. The multilevel effect of the school was significant only for the total sample and for 9th grade girls.

Discussion
To recap, the first aim of the study was to ascertain the level of school-aged children’s subjective HL, and the associations of HL with school achievement, learning difficulties, educational aspirations, and family affluence.

Subjective HL
The adolescents’ subjective HL level proved to be fairly high according to the HLSAC-scale: about 60 per cent had moderate HL, around one-third reported a high level of HL, and no
more than about one-tenth had low HL. The girls’ HL level was higher than that of the boys, and HL was higher among the 9th graders than the 7th graders. According to the regression analysis, the strongest predictive variables for HL in the total sample were school achievement in the first language and educational aspirations. For the boys, the most important predictor of HL was difficulties in mathematics, and for the girls, school achievement in the first language. A regression model across gender and grade level explained 8 per cent of the HL variance. The model predicted more of the HL variance for the 9th grade than for the 7th grade.

The fact that, in general, most of the pupils reported a fairly high level of HL may be because in the Finnish school system health issues are taught within health education as a school subject, which is a statutory independent subject both at primary school (grades 1-6, ages 7-13) and at secondary school (grades 7-9, ages 13-15). Schools have to follow the national curriculum and the objectives for the subject. Moreover, every school has to offer the same amount of HE teaching to every pupil. Nevertheless, pupils gain health knowledge in other contexts as well, such as within media, guardians, and peers or other school subjects. It suggests that general health promotion work in the school community (involving e.g. health-promoting schools/whole-school approach) can advance HL among adolescents. Since the 9th graders have received more teaching than the 7th graders, this may partly explain the finding that the older pupils had better HL than the younger ones. On the other hand, we do not as yet have cross-national research results on the levels of HL in countries where there is no systematic teaching of HE. Hence, we do not know how having HE as a school subject affects the level of HL.

<table>
<thead>
<tr>
<th>Total sample</th>
<th>Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>95% confidence interval</th>
<th>Pearson correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>School achievement in the first language</td>
<td>0.56</td>
<td>5.54</td>
<td>0.000</td>
<td>0.36 0.76</td>
<td>0.22</td>
</tr>
<tr>
<td>Educational aspirations (upper secondary school)</td>
<td>1.25</td>
<td>5.24</td>
<td>0.000</td>
<td>0.78 1.71</td>
<td>0.22</td>
</tr>
<tr>
<td>Difficulties in reading or spelling</td>
<td>−0.76</td>
<td>−3.83</td>
<td>0.000</td>
<td>−1.15 −0.37</td>
<td>−0.14</td>
</tr>
<tr>
<td>Family affluence</td>
<td>0.22</td>
<td>4.26</td>
<td>0.000</td>
<td>0.12 0.32</td>
<td>0.12</td>
</tr>
<tr>
<td>Difficulties in mathematics</td>
<td>−0.45</td>
<td>−3.02</td>
<td>0.003</td>
<td>−0.74 −0.16</td>
<td>−0.14</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Boys 7th graders</th>
<th>Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>95% confidence interval</th>
<th>Pearson correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational aspirations (upper secondary school)</td>
<td>0.95</td>
<td>2.08</td>
<td>0.038</td>
<td>0.05 1.85</td>
<td>0.13</td>
</tr>
<tr>
<td>Difficulties in mathematics</td>
<td>−0.98</td>
<td>−2.55</td>
<td>0.011</td>
<td>−1.73 −0.22</td>
<td>−0.13</td>
</tr>
<tr>
<td>Family affluence</td>
<td>0.30</td>
<td>2.50</td>
<td>0.013</td>
<td>0.06 0.54</td>
<td>0.12</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Boys 9th graders</th>
<th>Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>95% confidence interval</th>
<th>Pearson correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational aspirations (upper secondary school)</td>
<td>1.41</td>
<td>2.93</td>
<td>0.003</td>
<td>0.47 2.36</td>
<td>0.25</td>
</tr>
<tr>
<td>Difficulties in mathematics</td>
<td>−1.05</td>
<td>−3.23</td>
<td>0.001</td>
<td>−1.69 −0.41</td>
<td>−0.23</td>
</tr>
<tr>
<td>Difficulties in reading or spelling</td>
<td>−1.12</td>
<td>−2.62</td>
<td>0.009</td>
<td>−1.95 −0.28</td>
<td>−0.19</td>
</tr>
<tr>
<td>Family affluence</td>
<td>0.33</td>
<td>2.98</td>
<td>0.003</td>
<td>0.11 0.54</td>
<td>0.15</td>
</tr>
<tr>
<td>School achievement in the first language</td>
<td>0.53</td>
<td>2.53</td>
<td>0.012</td>
<td>0.12 0.95</td>
<td>0.24</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Girls 7th graders</th>
<th>Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>95% confidence interval</th>
<th>Pearson correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational aspirations (upper secondary school)</td>
<td>1.22</td>
<td>2.57</td>
<td>0.010</td>
<td>0.29 2.15</td>
<td>0.17</td>
</tr>
<tr>
<td>School achievement in the first language</td>
<td>0.62</td>
<td>2.79</td>
<td>0.005</td>
<td>0.19 1.06</td>
<td>0.17</td>
</tr>
<tr>
<td>Family affluence</td>
<td>0.27</td>
<td>2.70</td>
<td>0.007</td>
<td>0.07 0.47</td>
<td>0.13</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Girls 9th graders</th>
<th>Coefficient</th>
<th>t</th>
<th>Sig.</th>
<th>95% confidence interval</th>
<th>Pearson correlation</th>
</tr>
</thead>
<tbody>
<tr>
<td>School achievement in the first language</td>
<td>0.89</td>
<td>4.97</td>
<td>0.000</td>
<td>0.54 1.24</td>
<td>0.30</td>
</tr>
<tr>
<td>Educational aspirations (upper secondary school)</td>
<td>1.80</td>
<td>4.43</td>
<td>0.000</td>
<td>1.00 2.60</td>
<td>0.29</td>
</tr>
<tr>
<td>Difficulties in reading or spelling</td>
<td>−0.76</td>
<td>−2.65</td>
<td>0.008</td>
<td>−1.33 −0.20</td>
<td>−0.17</td>
</tr>
</tbody>
</table>

Table IV. The mixed-effects multilevel regression model for HL (dependent variable)
Overall, girls showed a higher level of HL than boys. The result was consistent with the national HE examination, which showed a large gender difference (Summanen, 2014). Similar gender differences have been found among adults (Sørensen et al., 2015), but the comparison of the results is problematic because of different age groups and instruments. There is ongoing debate on the size of the gender gap and the explanations for it (Hyde, 2014; Voyer and Voyer, 2014). From a wider perspective, potential reasons for gender differences could relate to aspects of society, the culture, the school environment, and pedagogy that may favour girls (Stoet and Geary, 2013). The results of the PISA study indicate consistent differences between boys and girls in reading, doing homework, and investing effort at school (OECD, 2015), and in attitudes to learning and school (OECD, 2015; Summanen, 2014). In Finland, girls tend to be more interested than boys in the health issues discussed in HE lessons (Aira et al., 2014).

Pupils with a higher level of self-regulation (i.e. the ability to control, direct, and plan their thinking, emotions, and behaviours, Schunk and Zimmerman, 1997) generally perform better than students with lower levels of self-regulation (OECD, 2015). Girls tend to be more self-regulated and disciplined than boys, and have better ability to set goals, plan ahead, and deal with setbacks and frustrations (Duckworth and Seligman, 2006; Kenney-Benson et al., 2006). All these reasons could partly explain the higher HL levels among the girls in our study. However, it is important to remember that boys and girls are not homogenous groups: both boys and girls include pupils who do not cope with school, and others who manage education well.

**Associations between HL and other variables**

The second aim of this study was to explore the association of HL with school achievement, learning difficulties, educational aspirations, and family affluence.

There were statistically significant associations between HL and the variables in question. School achievement in the first language was the strongest predictive variable both in the total sample and for girls; however, for boys the best predictor was difficulties in mathematics. This finding was consistent with the study of the Finnish National Board of Education, in which school achievement in mathematics explained 21 per cent of the success in the HE national exam, while the first language explained as much as 31 per cent (Summanen, 2014). School achievement in general is linked to perceived competence in health issues; thus, the finding is unsurprising, given the nature of HLSAC, which is based on beliefs in one’s own competences (i.e. self-efficacy).

In this study, difficulties in reading, spelling, or mathematics, and also low educational aspirations, predicted a lower level of HL. Learning difficulties have been found to be associated with adolescents’ academic achievement, and this also predicts their educational aspirations (Rimkute et al., 2013). Adolescents with higher educational aspirations are more willing than others to seek an academic professional career in the future (Jodl et al., 2001). The study by Summanen (2014) indicated that pupils who were planning to continue to upper secondary school succeeded better in assessments of learning within HE (i.e. the school subject) than those who were planning otherwise. In particular, pupils who were thinking of taking a break for a year, or going directly to a job, succeeded poorly in the examination (Summanen, 2014).

Studies have shown that, compared to students who move on to upper secondary school after comprehensive school, unhealthy behaviours are more common among adolescents who go on to vocational school or training (Grotvedt et al., 2008; Luopa et al., 2014; Vereecken et al., 2004). In Finland, among those adolescents who study at upper secondary school, 8 per cent smoke daily, while for young people studying in vocational school the proportion is 36 per cent. A similar picture emerges with regard to other unhealthy behaviours such as alcohol consumption, having less sleep, physical inactivity, and
experimentation with drugs (Luopa et al., 2014). The aspiration to study in a vocational school indicated a lower level of HL overall. Thus, a non-academic educational path, in conjunction with low HL (which is a risk factor per se), can reinforce health inequalities among children and adolescents.

In this study, family affluence predicted a higher level of HL. It has been suggested that low socio-economic status is a risk factor for academic performance (Frederickson and Petrides, 2008). According the PISA study (OECD, 2015), there are differences in academic achievement (reading, mathematics, science, problem-solving) which are associated with parents’ education, occupation, and family wealth, or household possession. Boys, in particular, are in a disadvantaged position when their parents’ socio-economic status is low (OECD, 2015). Parents’ education was also linked to HE learning outcomes in a study conducted for the Finnish National Board of Education (Summanen, 2014). There are multiple reasons for the correlation between family affluence and adolescent HL. Highly affluent families may possess forms of capital that are conducive to HL. These include general knowledge of health issues, and a high value given to health in general, in addition to the higher school achievement and the higher income of the families (Reardon, 2011).

The amount of explained variance remained low in the regression model with school success, educational aspirations, family affluence, and learning difficulties explaining HL. This has been noticed also in previous studies. The comparative study on HL in EU (HLS-EU Consortium, 2012) showed that age, gender, education, financial deprivation, and social status explained about 10 per cent of variance in HL in countries like Austria, Germany, or the Netherlands. However, in other countries, e.g. Poland, Greece, and Bulgaria, the coefficient of determination was higher, over 20 per cent. It seems that the socio-economic indicators influence to HL more in certain countries than in others (HLS-EU Consortium, 2012).

Limitations of the study
This study had certain limitations. In the best case, the same instrument will contain both subjective and objective measurements of HL. It then becomes possible to compare results for the same respondents. Because the respondents may give so-called “socially expected answers”, the self-reported questionnaires could give higher scores than objective measurements. The measurement of educational difficulties was here based on the adolescents’ report of their experience, and the report could be different from what would be revealed by actual tests in reading, mathematics, or problem solving. Moreover, the marks in the first language and in mathematics were reported by the pupils themselves, and there could have been some problems with retention of the information.

The research design was cross-sectional, meaning that the results do not address change across time, instead describing differences between two (separate) samples of 7th and 9th graders. A longitudinal study could provide more detailed information on the development of each participant’s HL during the last years of secondary school.

Comparison of the findings between different studies using different instruments (e.g. Chang, 2010; Ghaddar et al., 2012; Lam and Yang, 2014; Shih et al., 2016; Sørensen et al., 2015) is difficult, since the studies in question may be measuring various constructs of HL. Previous research has shown that the tool used to measure HL has an influence on the level of HL identified (Barber et al., 2009).

Conclusions
This paper provides the first results on the level of adolescents’ subjective HL in Finland, measured by the instrument specifically developed for the target group. It is based on nationally representative data, and it offers important insights into how HL levels vary between different class and gender groups. The study of subjective HL is clearly important, since one’s perceived competence – i.e. self-efficacy – has been found to be a clear and independent factor explaining...
various health-related behaviours (Bandura, 2004; Conner and Norman, 2005). The overall findings of this study are somewhat different from those of Finnish National Board of Education (Summanen, 2014); when measured objectively adolescents’ HL was at the satisfactory level (Summanen, 2014), whereas this study using a subjective measure showed a good level of HL among the target group. This indicates that both objective and subjective measures are needed in order to construct strong policy recommendations.

It is likely that reducing school achievement gaps could contribute to a reduction in HL disparities among school-aged children. If this is so, it confirms the important role of education and of schools in tackling health disparities. The establishment of school-based learning standards for HL could assist in tackling health disparities overall (Parker et al., 2003).

In drawing conclusions and making suggestions for HL interventions, there is a clear need for researchers and politicians to be clear about the different kinds of HL covered in various studies, and the methods and measures applied. Caution is needed, insofar as general discussion of HL—divorced from careful consideration of what is actually focused on—could lead to impractical conclusions, false generalisations, and unhelpful concrete practices. Future avenues could include monitoring children’s HL across various settings, using the same instrument to check the influence of the context. It may be possible to utilise the findings of this study within cross-national research, for example as a part of the international HBSC study.

References


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