

# From teaching young people to be healthy to learning health

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In this article we make a case for a shift in health education practice away from teaching young people to be healthy to an understanding of the ways young people learn health. Initially, we illustrate ways in which health education curricula have developed in Sweden and New Zealand, two countries ostensibly leaning towards a process related health concept in contemporary school curriculum. With a point of departure in socio-cultural learning theory, we then critique the individualistic approach to health education, which characterizes much health policy today, and instead argue for an approach to health education that takes as its starting point the learning that occurs in the lives of young people. Finally, we outline some implications of this approach for health education research and practice.

Keywords: health education, learning, individualism, instrumentalism.

## Introduction

During the last twenty years there has been a worldwide reappearance of interest in questions about the health of young people from politicians as well as from educators. In the light of an expanding population of aged people in the western world and growing concern about obesity, adolescent sexual health and drug abuse (Barton & Whitehead 2008, Flodmark, Marcus & Britton 2006, Hanson & Chen 2007), education has understandably been foregrounded as a tool for creating healthy citizens, affording ready-made lifestyles and a menu of healthy

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behaviours from which young people can choose (Simovska 2007). Health education, in particular has been positioned as a corner stone of educational initiatives, with programmes such as Health Promoting Schools being taken up in many schools across the UK, Europe, North America and Australasia (St Leger & Nutbeam 2000).

While we do not wish to downplay the significance of health education, we, in line with other scholars (e.g. Nutbeam 2008, Rich & Evans 2005, Simovska 2007, Wright & Burrows 2004), would argue that health education, as it has been conceived, represents no more than a partial response to these alleged health problems. Indeed, we are not necessarily convinced that health education *should* be regarded as a vehicle for solving these health problems.

Inspired by previous works of Rich and Evans (2005), Nutbeam (2008) and Wright and Harwood (2008), we, much in the same way as Biesta and Lawy (2006) discuss citizenship education, argue that there needs to be a shift in focus for health education practice from teaching young people to be healthy towards the different ways in which young people 'do' health, to how they learn to make sense of themselves as healthy (or not) in the local and global contexts within which they live.

In the article, we initially, as a background, illustrate ways in which health and physical education curricula have developed in Sweden and New Zealand, two countries now ostensibly leaning towards a process related health concept in contemporary school curriculum. In the second part of the article, we problematise an individualistic approach to health education, which characterizes much health policy today, and instead argue for an approach to health education that takes as its starting point the learning that occurs in the lives of young people. Finally, we outline some implications of this approach for health education practice.

## A Historical Overview of Health Education in Sweden and New Zealand

The health of the populace has always been regarded as an important societal concern. Since the instantiation of compulsory schooling, schools have invariably been drawn into public health efforts, albeit in different ways. We begin by illustrating how health and health education have been represented in national curriculum documents across Sweden and New Zealand throughout the last century. We regard these two contexts as interesting exemplars in relation to our argument because both have recently moved to embrace a more holistic, process-related notion of health in their respective curricula.

Our approach in the historical overview is to regard curriculum documents as political statements, espousing the norms, knowledge, values and direction of the political will of government regarding education (Englund 1986). We do not regard the descriptions of health portrayed in curriculum documents as reflective of health education as it is practiced, but rather as indications of what expectations about health education have gained political legitimacy at different times (Goodson 1990, Kirk 1990, Popkewitz 1997). As O'Neill (2004) suggests this approach permits a "grouping of some of its *continuities* as well as its *disjunctures* with the past" (p. 28).

### The First Wave: from Moral to Medical Health Education

In Sweden, the turn to the 20th century is characterized by questions of health and hygiene in society. In schools, as in society at large, a shift from regarding health as primarily an issue of religion and morality to a reliance on physiology and medical science can readily be apprehended. This can also be understood as a shift from a value based conception of education to a scientific rational conception of education where schooling is to be premised on objective foundations (Englund 1986). In other words, tradition and faith is replaced by science and rationality.

In schools, this move toward science as an arbiter of health result in a heightened presence of medical doctors and/or inspectors in schools. These 'professionals' not only conduct routine medical examinations of school children but also, on account of their presumed expertise and authority, they increasingly exert an influence over many other matters of schooling. Doctors, for example, influence curriculum content, teaching practices, the interior and exterior design of school buildings and the kinds of environments children are schooled in (Hammarberg 2001). This emphasis is clearly reflected in the 1919 Swedish curriculum, where health is routinely described as general hygiene, body and mouth hygiene, clothes, bright schools, fresh air, physical activity, posture, rest, sleep, housing, contagious diseases (especially tuberculosis), protection against infection, dangers of stimulants (like tobacco, alcohol or coffee) and First Aid. In both its content and pedagogical aims, this curriculum is informed by rationalist and scientific assumptions, requiring (or at least desiring) students to demonstrate the character and self-discipline needed to abide by the rules of 'natural' science' That is, being clean, avoiding disease, resting and acquiring enough health-related physical activity is represented as both a personal and civic duty.

In the 1955 curriculum health education is also integrated in general citizenship education including leisure, hobbies, sexuality, social health care, outdoor life etc. Health education, however, is still very prescriptive, behaviouristic and founded on health as a medical matter focusing chiefly on inculcating good habits regarding food, exercise, sleep and drugs.

Early to mid 20th century New Zealand curriculum shares much of the Swedish emphases regarding health. Using the British syllabi of 1909, 1919 and 1933 as teaching resources through until the 1940s, posture, hygiene, nutrition, ventilation and precision of movement is foregrounded in New Zealand with an early focus on preparing fit soldiers for war and strong women to produce them (Burrows 1999, 2002, Stothart 1974, 1991). The Aristotlean notion that a healthy body breeds a healthy mind is also thoroughly instantiated in curriculum throughout these decades together with discourses of 'efficiency' and the 'national good'. That is, the promotion of health, intelligence and sound character are widely regarded as essential pre-requisites for a strong nation (Syllabus of Physical Training for Schools 1919).

As was the case in Sweden, medical officers play a pivotal role in schooling at the time, examining children's bodies, sifting and sorting those with postural or physiological defects from those with 'normal' attributes and profoundly influencing the shape and substance of health education throughout the first half of the century. Health as absence of disease is the predominating philosophy fuelling school policies. Physiological principles deriving from biomedical science undergirded curriculum suggestions and although the importance of environment was recognised in some 1940s documentation, a largely medicalised view of health remain centre-stage.

## The Second Wave: from Biomedical Health Education to Healthy Lifestyles

Following the peak of medico-health education in the Swedish 1962 and 1969 curricula, the concept of a healthy lifestyle is introduced, becoming especially dominant during the 1970s. In health education, this emphasis is evidenced in an increasing concern with alleviating students' supposed risky lifestyles through working on their values and behaviours (Palmlblad & Eriksson 1995). An abundance of health 'information' is proffered to students during this period with instructions like 'avoid fat food' and 'move more' readily offered as health-enhancing tools. What Colquhoun and Kirk (1987) have referred to as an ideology of 'healthism' thoroughly imbues this curriculum. That is, it is presumed that information will generate changed attitudes and in turn changed behaviours.

In the 1980 curriculum health education avowedly includes students' lifestyles, the physical environment, psychosocial factors, drugs, social life and well-being. However, the practice of health education is to a great extent concentrated to a few theme based health education days during the school year. Health education, under the 1980 curriculum, also becomes a relational matter where friends, activities, discussions, critical reflection and personal positioning in health matters are discussed. However, Palmblad and Eriksson (1995) argue that only specific behaviours are still regarded as eligible, so that health education becomes a matter of "guess what's in my head?" with pre-prescribed answers to students discussion envisaged.

This trend toward promoting healthy 'lifestyles' is also clearly embedded in New Zealand's health education policy and curriculum from the late 1950s through until the 1980s where shifts toward a less medicalised, ostensibly more holistic notion of what health might entail can be discerned. The emergence of egalitarian educational ideas, emphasizing 'creativity', 'spontaneous movement' and 'free play' coupled with a vision of New Zealand children as 'naturally healthy' due to their location in a climactic and geographical context which afforded much opportunity for 'outdoors activity', inspired a more progressive approach to the health of children. While nutrition, hygiene and exercise still are privileged in official policy documents, the health of the 'whole child' is envisaged as something that encompassed environmental, social and mental attributes as well as the body. Through the 1970s and early 1980s this understanding that the health of a child was more than a bodily matter developed further with the release in 1985 of a dedicated *Health Education Syllabus*.

The wider, more multi dimensional notion of health this syllabus embraced was somewhat tempered by its focus on the individual child as receptacle of health knowledge and ultimately responsible for achieving specified learning outcomes and health behaviours. As was the case in Sweden, throughout the late 1970s and 1980s, heightened concern about cardiovascular disease and an attendant identification of 'risk factors' associated with these (e.g. smoking, eating 'bad' food, lack of exercise) resulted in health education being widely regarded as the promotion and eventual adoption of particular health behaviours for the purposes of preventive health care (Burrows 2002). This instrumental and individualistic conception of health fail to adequately acknowledge "the complex interplay of economic, socio-political, cultural and environmental factors which impact an individuals health status" (Tasker 2004, p. 204) and also assume a homogeneity of experience and capacity to enact health imperatives across social classes.

## The Third Wave: ... Towards Physical, Psychological and Social Well-Being?

In New Zealand, the third wave, while mildly evident in the 1970s, is clearly articulated in the policies emerging in the 1990s. The 1999 Health and Physical Education in the New Zealand Curriculum herald a substantial shift from the individualism characterizing prior syllabi to a “holistic conceptualization of wellness emphasizing the inter-relatedness of physical, social, mental and emotional, and spiritual dimensions of health (hauora) (Tasker 2006, p. 2). In this view of health, a balance and integration between the individual and societal considerations was sought, together with the promotion amongst students of a self-reflective and critical thinking approach to considering their own and others’ health. Also socio-ecological aspects are more clearly emphasized in the New Zealand curriculum, where the students also should learn to: “...contribute to the well-being of those around them, of their communities, of their environments (including natural environments), and of the wider society” (2007, p. 22).

In Sweden as well, the introduction of a 1994 curriculum signals a break, especially in the context of Physical Education and Health, from health being regarded as a purely physiological/medical matter to a view of health as a holistic concept, related to psychological and social as well as bodily components of well-being (Skolverket 1994). Health is defined as: “... physical and mental health, as well as social well-being” (Skolverket 1994, p. 2). These emphases are not only directed at individuals but also to student capacity to influence the development in society, public health and the environment. Physical education is also supposed to provide the prerequisites for students to take responsibility for their health by choosing and reflecting on different activities implications for health “in a natural context” (Skolverket 1994, p. 2).

Much is however open for local interpretation since the general Swedish curriculum specifies several broad goals yet contains few detailed regulations. Indeed, in the general curriculum the only thing mentioned about health is that students after year nine should: have basic knowledge about the prerequisites for good health and an understanding about the importance of personal lifestyles (Skolverket 1994).

Together the 1994 Swedish Curriculum and New Zealand’s 1999 Health and Physical Education in the New Zealand Curriculum comprise a shift in conceptualization of health to a version clearly aligned with the global shift fuelled by the Ottawa charter on health promotion (WHO 1986). This re-working of health in more holistic, encompassing and process-orientated ways theoretically opens up spaces of freedom for schools and teachers to think about and do health

differently. In particular, we suggest that the possibilities of creating a form of health education informed by genuine participation (Simovska 2007), democracy (Jensen 1997) or health literacy (Manganello 2008, Nutbeam 2008) both in school as a whole and in different subjects is potentially both possible and legitimate.

In the following section we explore these spaces of freedom, suggesting that despite the promise this move to a wider and less prescriptive notion of health education policy in both countries yields, the relatively recent emergence of extreme concern about childhood obesity threatens to fill the spaces of freedom ostensibly created.

## The Idea of Health Education, from an Individual to a Contextual Approach

The instrumental and individually focused health education visible in the first and second wave health education is now challenged in the third wave proposed in the curricula in New Zealand and Sweden. However, studies from both countries (Burrows 2009, Quennerstedt 2008, Webb, Quennerstedt, & Öhman 2008) as well as from Australia (Wright & Dean 2007) indicate that, in many instances, discourses of fitness and obesity are clearly manifesting themselves in schools, school texts and school subjects. As Gillespie and Burrows (2006) suggest, just at the point when new curricula have generated genuine opportunities for re-envisioning health and physical education, obesity concerns appear to be prompting a return to the notion of health as a matter of eating the 'right' foods and exercising regularly. The promise of Swedish and New Zealand curricula grounded in a contextual approach to health education gives way, in this scenario, to what we argue to be an individualistic, instrumental, biomedical and morally normative health education, *again* directed towards behavioural change, disease prevention and individual lifestyle choices. In other words, the opportunities the new curricula afford for learning health are traded for the notion that teaching young people *how* to be healthy should be the penultimate goal of health education.

### Learning Health in Context

We wish to suggest that *one* way of overcoming the problems with individualism and instrumentalism in health education, that would honour the tenor of curriculum documents in Sweden and New Zealand as well as WHO central documents on health promotion, is to discuss health education in terms of *learning health*. In this way we share many



of the objectives of Simovska's (2007) notion of genuine participation and Jensen's (1997) concept of democratic health education.

Learning can be understood in several different ways (Sfard 1998), often as a change that constitutes some sort of difference, for example, as concept development, more possibilities, new ways to act, new relations, increased complexity or in a changed participation in knowledge and a valuing of communities of practice (e.g. Biesta & Burbules 2003, Carr & Claxton 2004, Dewey & Bentley 1949, Hodgkinson, Biesta, & James 2007).

In this article we ground our arguments in a socio-cultural perspective of learning. Learning, informed by a socio-cultural perspective, can be described as the process in which human beings appropriate ways of acting that enable them to participate in different practices (Chaiklin & Lave 1996, Lave & Wenger 1991, Sfard 1998). Even though there are differences between the theoretical traditions in this perspective they share the assumption of the social nature of thinking and learning (see Wertsch, Del Rio & Alvarez 1995). As Wertsch (1998) argues: "The task of a sociocultural approach is to explicate the relationships between human *action*, on the one hand, and the cultural, institutional, and historical contexts in which this action occurs, on the other" (p. 24).

Adopting a socio-cultural perspective requires moving beyond the distinction often made in psychological studies between the individual and society (Dewey & Bentley 1949, Hodgkinson, Biesta & James 2007). Learning is consequently not regarded as possessing or acquiring something external, but as a process of becoming a participant. Learning is always regarded as situated, occurring in a particular context. In other words, learning is a social process, something that cannot be divorced from relations between individuals and others, nor from the situation within which it takes place. Learning (health) is regarded as becoming a member of a certain community and includes the ability to communicate in that community together with the capacity to act within its norms (Sfard 1998).

## Problems with the Idea of Health Education as Saving Young People from Obesity

In international debates, several scholars call attention to the perils of embracing discourses of weight, obesity and body ideals (Evans, et al. 2008, Halse 2008, Johns & Tinning 2006, Wright & Harwood 2008) in school-based health education. These scholars each take issue with the normative nature of healthist and moralistic perspectives that tend



to individualize all questions of health. As Gard and Wright (2001) argue, harnessing education to obesity reduction goals inevitably leads to the classification of students as ‘normal’ or ‘abnormal’, constructs them as ‘good’ or ‘bad’ citizens and construes students as ‘at risk’ and thus in need of governmental intervention. McCuaig and Tinning (2010) further argue that health education has, in essence, become a moral enterprise whereby students are impelled to meet fitness and weight-reduction objectives to avoid the risks of obesity that experts in the media together with neo-liberal market forces impute upon them.

The deleterious consequences of such thinking are presently revealing themselves in schools where overweight children are running ‘fat laps’ (Australia), special Physical Education programmes for overweight students have been designed (Sweden) and children are subjected to governmental health surveillance through the widespread use of Body Mass Index testing (USA, UK). In Australia and the UK, debates about the ethics of removing obese children from their parents rage and in Canada, ‘exergaming’ technologies like Wii fit are being used in school-based Physical Education settings. In New Zealand and elsewhere, daily dosages of physical activity are prescribed for children in schools, with energy in/energy out constituting the central rationale for daily walks and/or runs (Kirk 2006). In this context, we wonder whether such activities signal the rise of a *fourth wave* health education, a wave focused on saving young people from obesity?

From a socio-cultural learning perspective, we, in line with above mentioned scholars, suggest that there are (at least) two key problems with this potential fourth wave in health education. The first problem is that fourth wave (obesity guided) health education is aimed at the *individual* student, holding each accountable for their body weight and body shape and consequently their health. We suggest that this responsabilisation of the individual, this representation of individuals as entrepreneurs of their own lives (Higgins & Nairn 2000, Kenway & Bullen 1999) disregards the social, cultural and societal aspects of both health and education. Students, under fourth wave health education, are valued for their changed body weight rather than for their developing knowledge and understanding in contexts that are meaningful to them (Evans 2003, Evans et al. 2008). California’s State fitness testing requirements provide a startling example of the effects this kind of thinking can have on school-based pedagogies. From 2009, Body Mass Index, together with capacity to perform exercises like curl ups, push ups and trunk lifts constitute assessment standards for required enrolment in 10th to 12th grade Physical Education. Students who fail the tests will achieve a fail grade for the subject, and consequently

potentially fail to graduate from high school with passed grades in all subjects (cf. Webb & Quennerstedt 2010).

The second problem relates to the *instrumental* view of education implied, and the idea that student health is regarded as an outcome of health interventions and health education in terms of not being inactive, overweight or obese, measured by energy in/out or by Body Mass Index. As Biesta and Lawy (2006) argue, an instrumental orientation concentrates on finding “[...] the ‘best’ and most ‘appropriate’ methods and approaches of teaching [...] what is regarded to be a common goal they can aspire to” (p. 72). Rather than, as the World Health Organization acknowledges, viewing health as something always in the process of becoming, developed in the sociocultural and economic contexts of individual lives (WHO 1986), an instrumental view assumes a shared and achievable goal for all – the trim, active and dietary conscious youngster.

If we are to discuss health education from a socio-cultural learning theoretical position in terms of learning health, then, health education has to be grounded in how young people are participating in processes of knowing. Drawing on this perspective, learning health would be something you continuously do, and health conceived of as a practice and not as an outcome of health education. Health education would, informed by this perspective, focus on students’ knowledge, skills and the values they develop as well as the contexts within which they live and act. It would also address questions about *how* students learn about the idea of health and the ways health is practiced in diverse settings. Multiple perspectives on what comprises healthy living would be embraced rather than requiring all students to subscribe to a universalized, inevitably ethnocentric view of what health entails. The wider context then provides opportunities to *be* healthy and to *learn* healthy lives and in consequence health also becomes a societal responsibility and not solely the responsibility of the individual. Finally, regarding health in context rather than as an individual responsibility leads us towards a notion of education as health promoting rather than education as a vehicle for the achievement of some monolithic version of ‘health’ (cf. Nutbeam 2008).

In this scenario, questions about how young people come to acquire skills to participate in so-called healthy practices, how they come to form positive or negative dispositions towards themselves and their own bodies and questions about the ways health can be practiced in diverse settings and situations are prioritized. Rather than confining health and health education to the prevention of premature death and disease, this approach conceives of health as a set of resources, as a dynamic process rather than an end product. Health “[...] is not a

fixed end-point, a "product" we can acquire, but rather something ever changing, always in the process of becoming" (Haglund, et al 1991, p. 3). Health education is then conceived as a practice – 'healthying' – and not a fixed, static outcome set up by research and public health policies as something to achieve in education. Instead it is about the learning that occurs in the lives of young people.

In this way, by discussing health education in terms of learning health, both the problems of individualism and instrumentalism can potentially be overcome through the shift from teaching to learning, and the shift from viewing health as an individual matter to viewing health as a socio-cultural process.

## From Teaching Young People to be Healthy to Learning Health

Today, both New Zealand and Sweden have school curriculums that encourage schools, teachers and health education to incorporate a process related perspective on health, drawing on notions of health literacy (Nutbeam 2008), genuine participation (Simovska 2007) and/or democratic health education (Jensen 1997). However, the openness and spaces for interpretation of both curricula also renders health education practice vulnerable to market and governmental values prioritizing ideal body weight and shape. Fuelled by the political and public concerns of the declining health status of children and adolescents, a scientifically normative health education primarily concerned with addressing inactivity and obesity concerns goes hand in hand with a market driven society where young people are urged to choose healthy lifestyles over any other in the marketplace (Quennerstedt 2008, Macdonald, Hay & Williams 2008). This individualistic approach, (Evans et al. 2008, Gard & Wright 2005, Kirk 2006, Wright & Harwood 2008), readily turns, as Apple (2004) argues, to "possessive individualism where citizenship is reduced to simply consumption practices" (p.13). Another consequence of an excessive focus on obesity alleviation is that health education becomes regarded as a vehicle for the creation of so-called healthy citizens via the inculcation of ready-made knowledge, behaviours and lifestyles. In this scenario health education is objectified, decontextualised and the responsibility for health in general and obesity in particular willingly delivered to the individual student as a moral enterprise.

As suggested in the article, an alternative to conceiving good health as something that can be defined by politicians, researchers, public health policies, sport federations and the media, set up as an

aim for young people to achieve, is instead to conceive of health as a learning process that takes place in the context where young people live, learn, love and flourish (cf. WHO 1986). Learning health, then, is something one continuously does, a practice situated in one's life rather than an outcome of any health educative practice. Drawing on this perspective, health education would also attend to the ways in which young people learn *not* to be involved in, for example, physical activities or other health-related practices. Understanding why engagement in deliberate physical exercise or healthy eating may *not* be in the interests of a child's health would be perceived as just as important as understanding why one would desire to adhere to the orthodox ideas of healthy living prescribed in fourth wave health education.

In conclusion, to overcome individualism and instrumentalism in health education we need to move away from a notion of teaching young people how to be healthy through the deployment of ready made educational packages (Kirk 1990), and instead discuss learning as a process situated in young peoples lives as well as in wider social, cultural, political contexts. Health needs to be regarded as a societal responsibility whereby it is acknowledged that sociocultural and economic contexts afford diverse opportunities to *be* healthy and to *learn* healthy lives, however these are construed.

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