Critical health promotion and education—a new research challenge

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Abstract

In relation to health promotion and education, the use of post-positivist and constructivist approaches has been gathering strength in recent years. Despite this emerging tradition, little has been done to explore what this sort of approach actually represents, particularly in terms of health promotion in schools, professional organizations and wider society. Acknowledging this, it is suggested that more researchers in this area should be adopting qualitative approaches—including semi-structured interviews, focus groups, story/dialogue workshops and developmental schemes of health education—in order to uncover the hidden meaning of ‘health promotion’, particularly in the school context. This paper therefore attempts to challenge the idea that traditionalist paradigms of positivist research are capable of appropriately representing the nature and complexity of the health promotion issues. In this paper, methodological and theoretical frameworks that can enable researchers to understand health promotion from the perspective of students, teachers and school ‘stakeholders’ are suggested. Particular attention is given to a discussion of the potential value of designing and implementing programmes of health education or promotion using a critical pedagogical approach within schools in the UK. It is argued that programmes using a critical pedagogical and reflective approach, and which are aimed at social transformation, would be of enormous benefit to both researchers and educational/health professionals who are seeking to understand the complexity of health promotion issues from the perspective of children and adolescents.

Introduction

In relation to health promotion and education, the use of post-positivist and constructivist approaches has been gathering strength in recent years. Despite this emerging tradition, little has been done to explore what this sort of approach actually represents, particularly in terms of health promotion in schools, professional organizations and wider society. Acknowledging this, it is suggested that more researchers in this area should be adopting qualitative approaches, including semi-structured interviews, focus groups, story/dialogue workshops and developmental schemes of health education, in order to uncover the hidden meaning of ‘health promotion’, particularly in the school context. This paper, therefore, attempts to challenge the idea that traditionalist paradigms of positivist research are capable of appropriately representing the nature and complexity of the health promotion issues. In this paper, methodological and theoretical frameworks that can enable researchers to understand health promotion from the perspective of students, teachers and school ‘stakeholders’ are suggested. Particular attention is given to a discussion of the potential value of designing and implementing programmes of health education or promotion using a critical pedagogical approach within schools in the UK.

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**Aim**

This paper attempts to challenge the idea that traditionalist paradigms of positivist research are capable of appropriately representing the nature and complexity of health promotion issues. The paper argues for the use of qualitative methodological strategies with particular emphasis on programmes of health promotion that use critical pedagogy, in primary and post-primary schools in the UK, that can facilitate informed critical debate and discussion aimed at social transformation.

**Background**

Invariably, schools have become the focus of those charged with positively altering the health culture in the UK. It is hoped by policy makers at both the micro and macro level that a strong process of socialization in regard to healthy eating habits and positive health-related behaviours will result in the production of a generation dedicated to maintaining the general well-being of their society (Department for Education and Employment, 1997). Whilst this might be an ostensibly laudable aim, it is a naive and narrow approach that fails to negotiate the gap between policy and practice, and the chasm between normative claims to knowledge and genuine understanding. Many educationalists now readily accept that the critical pedagogical approach of Freire (Freire, 1970), Bruner (Bruner, 1996) and Gardner (Gardner, 1999) is the key to unlocking the potential of school students. Bruner (Bruner, 1996) has been pragmatic in accepting that despite all of the innovation in teaching methodology in recent years, the traditionalist paradigm of pedagogy has retained a place in Western educational culture. The introduction of imaginative approaches to teaching, he argued, necessarily involves changing the ‘folk’ pedagogical and psychological theories of teachers. That some teachers have chosen to cling to what they perceive to be the ‘safety’ of the traditionalist didactic methodology is perhaps a reflection of the pressures of examinations and performance tables based on examination results that deny teachers the opportunity to educate students about issues like health promotion. That teachers are judged according to the examination performance of their students is also a cause for regret. It encourages teachers to be unduly cautious in their preparation and delivery of the curriculum, ensuring that they are reluctant to dispose of outdated methods of instruction. The ‘folk pedagogy’ of didacticism, therefore, is arguably a utilitarian creation better suited to a bygone age, and is now rightly criticized as an ineffectual way of encouraging and developing positive learning and understanding. In addition, the Department for Education and Skills has not included health promotion as one of its educational or research priorities (Department for Education and Skills, 2003).

However, the inclusion of health promotion as a cross-curricular theme for all school children in the UK indicates that the government has implicitly acknowledged that it is a key area of education that should be addressed within the context of everyday school ‘lessons’. The current ambiguity regarding the treatment of cross-curricular themes and how they should be ‘taught’ should not deflect from this. Schools are tasked with ensuring that children are given access to the health promotion debate, yet even at the latter stages of post-primary education this topic is being dealt with in an ineffective way. The pressurized school culture in the UK, reflected in examination league tables and negative media attention towards the teaching profession in general, means that students are not given the room in which to analyse critically the key issues within the health promotion debate. This
is because a large amount of emphasis is placed on ‘core’ curricular subjects and cross-curricular themes are neglected. This results in a largely apathetic approach to health education (as one of the cross-curricular themes) and makes an investigation of the cultural context in which the health promotion debate is embedded extremely difficult.

In an educative context, there seems to be little awareness in the UK of how effectively schools (at both primary and post-primary level) are addressing the core objectives of health promotion, either through direct curricular application or through the ‘hidden’ curriculum of the school ethos and approach to education. Although models of ‘experiential learning’ (Kolb, 1984) and ‘reflective practice’ (Schön, 1983) have attained mainstream status and legitimacy, at least in terms of Initial Teacher Education, there seems to be little room for adherence to theoretical paradigms of reflective action within schools. It seems that curricular and examination-related pressures dominate them instead. It is the task of research to identify potential mechanisms by which critically oriented programmes of health education can achieve credibility within schools.

The National Healthy School Standard was proposed in the UK Government Green Paper *Our Healthier Nation* in 1998 (Department for Health, 1998). In this paper, the government identified the school as a setting to improve the health of children, and outlined its view that healthy schools are in a key position to improve the health and educational achievement of children and young people. In 1998, the government commissioned eight pilot initiatives in health promotion and education. The initiatives—in Cornwall, Doncaster, Durham and Darlington, Hounslow, Manchester, Norfolk, Staffordshire and City of Stoke on Trent and West Sussex—were limited both in scope and geography. They were envisaged as a means of developing leadership and management skills in Personal, Social and Health Education (PSHE), improving teaching in this area and tackling social exclusion issues. The pilot projects were evaluated externally by the Institute of Education, University of London, using a case study approach. This evaluation process involved interviews with key workers in the pilot sites, education and health professionals, school staff and governors, young people, parents, and those providing support services to schools. The evaluations found that the importance of celebrating achievements in the context of on-going whole school improvement was crucial to improving the status and credibility of school-based health promotion initiatives. The evaluations also showed the importance of involving young people at all levels, including those from minority ethnic groups, within health promotion schemes.

A clear role for the national healthy schools team in disseminating best practice and encouraging networking was suggested, in addition to the creation of a national standard that would be adaptable enough to reflect local best practice and meet local needs. Despite the obvious forum for the implementation of these ideas that PSHE provides, little has been done since then to strengthen the position or status of PSHE in the national curriculum or, indeed, to further develop more pilot health promotion projects for implementation throughout the regions of the UK.

The current offering of PSHE in schools has, therefore, done little to reassure health or education professionals that school students are being offered scope for informed discussion of issues central to their development. The fact that statutory provision of PSHE stops for students at the age of 16 emphasizes a lack of government activity in relation to ensuring that those in the post-compulsory sector are offered opportunities to analyse the personal social and civic components of health promotion. In many ways, there is undoubted crossover (and value) between health promotion and citizenship education for students in the post-16 sector. Citizenship, despite the recommendations of a government Advisory Group in 2000, remains a neglected feature of the education system for post-16 students. It may be that the establishment of a critically informed programme of citizenship education provides an ideal opportunity for the exploration of health issues. This would constitute an implicit recognition that the
health message is no longer simply specialized technical knowledge, but that it represents a core aspect of cultural, social and political debates. There is a need for qualitative research within schools that seeks to uncover perspectives of health education and promotion that are rooted in the culture and experience of schoolchildren, older school students, parents, teachers and community leaders. Piloting schemes of health education using critical pedagogical methods could serve to provide examples of how such approaches might both raise awareness of the health promotion message and empower disenfranchised sections of the community.

**Health promotion, schools and qualitative research**

The interpretivist tradition has gathered strength in educational research within the last three decades. Interpretivist educational research has stressed the need to put analyses in context, presenting the interpretations of many, sometimes competing, groups interested in the outcomes of instruction or particular educational programmes, such as health education/promotion. The constructivist aspect of this qualitative research tradition reflects the belief that school students individually and collectively construct reality (Denzin and Lincoln, 1994; Bruner, 1996). Proponents of the interpretivist/constructivist paradigm have sharply divergent views about the nature of reality from proponents of the quantitative paradigm. For qualitative researchers ‘truth is a matter of consensus among informed and sophisticated constructors, not correspondence with an objective reality’ (Lincoln and Guba, 1989), p. 44]. Unlike the technical, rational approach of previous positivist perspectives that dominated educational research, the interpretivist approach has been chiefly involved in helping to understand and evaluate change. Despite this movement, the positivist tradition arguably still enjoys strong support in many areas of social and educational research. Indeed, Smeyers and Verhesschen (Smeyers and Verhesschen, 2001) have argued that despite the increasing credibility of qualitative methods in social research circles, the debate between quantitative and qualitative research methods is still very much apparent. They note [(Smeyers and Verhesschen, 2001), p. 75] ‘the suspicion is that in some way what is offered by educational or more generally social science research, cannot adequately satisfy the need for solid knowledge’. However, Green and Tones [(Green and Tones, 1999), p. 133] have challenged the relevance of positivist research in the context of health promotion and have argued instead for a broader approach to assembling evidence about the effectiveness of health education programmes. Green and Tones (Green and Tones, 1999) have suggested that this broader approach will contribute to the move towards evidence-based practice within health promotion and education.

It is possible to suggest, however, that the quest for ‘solid knowledge’, in the form of tangible numerical outcomes like school league tables (which the government in the UK has encouraged), has served a dual purpose: (1) it has solidified the position and respectability of positivist research paradigms, and (2) it has ensured that schools have been forced to devote an unprecedented level of energy to curriculum ‘coverage’. This coverage and examination-related pressure means that teachers have less and less opportunity to engage their students in cross-curricular health education or meaningful health promoting activities, let alone find the space within a crowded timetable to offer discrete health education classes that employ a critical pedagogical approach.

There is a need to support interpretive qualitative research methodologies, in particular the use of critical pedagogy-oriented programmes of health promotion, within the UK education system. The interpretive aspects of qualitative research attempt to understand the phenomena of health promotion through the meanings that people (teachers, students, parents, health professionals, community members) assign to them. No matter how firm the empirical basis of positivist methodological approaches that seek to lay claim to
‘objective’ truths, such strategies arguably neglect the potential to explore the competing narratives within health-promoting schools. Rather, they tend to concentrate on making a series of ‘normative’ claims (Labonte and Robertson, 1996). Interpretive methods should not be discussed using the criteria of positivist research paradigms that have arguably developed out of positivist epistemological ideas. The advantage of interpretive research is its emphasis on the philosophical grounding of methods. From an interpretive perspective, researchers can draw the most valid conclusions by attaining the deepest understanding of the problem in its context.

There is a need for health promotion educative research projects that focus on encouraging high levels of participation and empowerment amongst schools, students, teachers and parents. These types of projects would use critical pedagogy as an intrinsic part of effectively communicating the health promotion message, supporting the objective of creating a teaching and learning environment that fosters cooperative, participative student learning. Discussion-based programmes of health education would attempt to reconfigure classroom practice in order to place a greater emphasis on student learning and provide a means by which health education could assume a central role in the establishment of school curricula aimed at achieving meaningful understanding of health issues. From a research perspective, researchers could be involved in the design and delivery of such courses—collaborating in the construction of frameworks for the course, evaluating the project by way of non-participant observation or as participant observers. Concurrent individual and group interviews, combined with other qualitative strategies such as student learning diaries, would further strengthen the rigour of this approach.

The development of the concept of empowerment in health promotion began with the emergence of the community health movement during the 1970s and 1980s. This movement attempted to stem the increasingly powerful flow of authoritarianism and individualism that had begun to dominate the social and political agenda in the UK (Beattie, 1991). Empowerment was identified as a possible solution—encouraging people to educate themselves, and calling for the government to support community groups, both structurally and financially, in their attempts to create change and address health inequalities. The WHO (WHO, 1986) emphasized this idea by acknowledging that health developments in communities should be made not only for the people, but also by the people. Effective learning and the consequent permanent alteration of social behaviour patterns require people to engage in a process of discovery and transformation (Daloz, 1986; Bevis and Watson, 1989). As noted by Tones and Tilford (Tones and Tilford, 1994), there has been a development of a more sophisticated approach in relation to educational models within health promotion, which have begun to take account of the importance of the concept of empowerment. These developments have been greatly influenced by child-centred progressive educational methods.

Currently, however, the UK educational system does not offer students or teachers the opportunity to engage in critical programmes of health education that are oriented towards empowerment. Health promotion has not been afforded discrete curricular status—currently forming only part of a wider PSHE programme. That this PSHE programme itself suffers from a relative lack of credibility emphasizes the marginalization of health promotion, especially within schools that foster a more traditional academic ethos. The PSHE syllabus does not offer widespread opportunity for critically informed debate. As Dadds (Dadds, 1999) noted, the involvement of students in their own pedagogical experiences is essential to the quality provision of education. It would be difficult to suggest that the prescriptive nature of the current syllabus is capable of accommodating an in-depth critical pedagogical approach to health promotion. Tones and Tilford (Tones and Tilford, 1994) noted that policy makers in the UK have failed to recognize the importance of evaluating a subject (health education) that has had low status within the curriculum.
Educative-research projects (using critical pedagogy) should be designed and implemented within schools in the UK, to provide working examples of critically oriented health-promoting practice. Projects of this nature could move away from tightly defined evaluations of prescriptive curricular provision and concentrate on analysing the impact of student-centred health education, mapping the transformative changes that occur in the participants’ (students and teachers) understanding of health promotion. For teachers and researchers, the value of such programmes in terms of identifying particular pedagogical styles that may contribute to greater understanding of the health debate is obvious. Whilst the WHO has recently placed considerable emphasis on the importance of health promotion within schools, there has not yet emerged a coherent strategy for ensuring that schools become environments in which students and teachers link the goal of health improvement to the imperatives of general schooling. It is possible to argue that the implementation and evaluation of programmes of health promotion in schools, with a critical pedagogical component, would offer a method by which people could begin to unlock the potential for social transformation.

It was Schön (Schön, 1983) who brought the concept of ‘reflection’ into the centre of an understanding of what professionals do. Schön (Schön, 1983) opposed the dominant model of ‘technical-rationality’ (a positivist epistemology of professional practice) as the basis of all ‘professional knowledge’. Testing out theories and programmes of health promotion would allow both researchers and teachers to develop educational ideas and frameworks that are grounded in the reality of experience. Teachers, students and researchers could write-up recordings, keep learning diaries, talk things through with supervisors and engage in regular dialogue. This act of reflecting on practice would enable those involved in health promotion in schools to develop sets of questions and ideas about their activities and practice.

Evaluating programmes or schemes of health promotion of this type would be reliant upon gaining access to the worldviews of the participants. This can only be achieved through the utilization of qualitative research methods—in particular the employment of methods like story/dialogue workshops (Labonte et al., 1999). Nettleton and Bunton argued that:

Health promotion techniques that aim to listen more attentively to the views of lay people, by using qualitative interviews, participant observation or health diaries, penetrate into the lives and mind of subjects. [(Nettleton and Bunton, 1995), p. 47]

The story/dialogue method is a qualitative research technique that attempts to create structured group dialogue around case stories that address particular generative themes. The idea of generative themes is congruent with the wider educational principles of the Teaching for Understanding (TfU) model advanced by Gardner and Blyth (Gardner and Blythe, 1998). In this paradigm, students, teachers and other key actors within the health promotion ‘community’ would be encouraged to articulate their experiences of school-based initiatives, classroom activity and support networks for the health-promoting school from their own perspective.

Story/dialogue workshops are a flexible research tool and can vary in size from 20 to over 200 participants. They can vary in length from 1 to 3 full days. As an example, a workshop for teachers could be designed to include at least 1 full day in which smaller story groups (a ‘subgroup’ of usually five to 10 participants) meet to discuss case stories (experiences of health-promoting programmes and pedagogy) which are based on a generative theme (e.g. ‘The importance of engaging students in their own learning’), using dialogue as a means of assisting the participants in creating theories and models of good practice (Labonte et al., 1999). This idea of evaluating programmes from the perspectives of the participants is supported by the critical theory approach of both Habermas (Habermas, 1984) and Freire (Freire, 1970). In this context, the story/dialogue groups would be aimed at fostering an ongoing process of social transformation within schools.
involved in health promotion in the UK. Although originally developed in the field of criminology, the principles of ‘realistic evaluation’, as described by Pawson and Tilley (Pawson and Tilley, 1997), support the idea of new frameworks for assessing the effectiveness of programmes of health promotion. Their approach is also concerned with considering the context, mechanisms and outcomes of particular programmes—in other words ‘what works’, ‘for whom’ and ‘why’. Indeed, they argued that their approach could provide for the production of lessons and schemes that can be appropriately used within the construction and refinement of social policy and practice. Pawson and Tilley (Pawson and Tilley, 1997) noted that it was important that any programmes implemented and evaluated in this way need informed and critical application in regard to the details of particular social and cultural contexts.

There is growing support for the idea that conventional scientific norms—an exclusive focus on quantitative data and the idea of objectivity—are an insufficient way of evaluating health promotion. Indeed, Springett [(Springett, 2001), p. 100] has argued for qualitative participatory approaches to health promotion and evaluation that have been designed to empower people and which can be a ‘real catalyst for change’. Participation of this sort means engaging in dialogue at all stages of the research evaluation and shifting power in favour of those being researched. This is in stark contrast to the positivist models of research that have dominated health promotion and evaluation in the past (Springett, 2001). The development of story/dialogue groups as a key part of school-based, health promotion strategies would be designed to enable teachers and students to make clear their theories and views on health promotion within schools; and to consequently subject these views to peer-led critical scrutiny. Student story dialogue groups would remove the idea that the evaluation of health promotion programmes is focused solely on the perspectives of ‘adults’ and the students would be encouraged to exchange their opinions in relation to the effectiveness of the health-promoting school.

The overall objective of such groups is to uncover the perspectives of all of the participants, which can then be used to inform the subsequent design of new initiatives or programmes for health-promoting schools.

**Critical pedagogy and health promotion**

Within these suggested programmes of health education/promotion, there is a need to incorporate a critical pedagogical approach. Critical pedagogy is expressed in both content and process. Those interested in applying pedagogical reform to models of health promotion should distance themselves from traditional positivist paradigms of orthodox knowledge transmission and instruction. As noted, within the context of a highly prescriptive and pressurized school curriculum (as in the UK), the room that teachers have for manoeuvre is limited. It is incumbent upon the government to offer schools and communities opportunities to become involved in critical discussion of health promotion issues. The challenge for policy makers and educators involved in health promotion is to encourage school students to become ‘active producers of meaning’ [(Dehler et al., 2001), p. 504]. This should be based, in part, on the diverse experiences of the students, rather than on educational dynamics that make students passive consumers of information. The literature on lay health beliefs has indicated that those involved in health promotion, including school-based educators, should take account of and be sensitive to the language and the concepts of their intended audience (Bunton et al., 1995). Indeed, critical pedagogy requires alternative teaching methods that foster dialogue, critical reflection and social transformation. This is not to say that content is unimportant. Indeed, in the context of critical pedagogy, it is possible to argue that content and process are interrelated. Critical pedagogy necessarily involves providing students with access to a range of information and evidence that is relevant to their health-related discussion and debate. It is
then the task of the teachers to facilitate critical analysis of this information (content).

In this way, school students are offered a greater amount of access to health promotion issues, and are encouraged to share their experiences and understanding, resulting in a form of emancipatory learning (Habermas, 1984). Emancipatory learning is not concerned with instrumentalist objectives. Rather, its purpose is to foster and develop understanding and knowledge about the nature and causes of unsatisfactory social, political, cultural and economic circumstances in order that people might create strategies to alter them. Programmes of health promotion aimed at emancipatory learning can help citizens to gain more autonomy and independence, and to bring about change in the interests of equality and social justice.

**Conclusion**

Programmes of health promotion utilizing a critically informed approach to health promotion within UK schools would undoubtedly contribute to the empowerment of young people, schools, parents and communities. Empowerment, in this context, would represent the ability of school students and teachers to gain greater understanding and control over the personal, social, economic and political factors that directly affect them (Judd *et al.*, 2001). Programmes of this type would offer much in terms of the ongoing debate within health promotion research, policy and practice. Health promotion programmes are likely to be most effective when they are sensitive to local social and political realities, and when they are embedded within appropriate theoretical, pedagogical and cultural frameworks. For children, including those from socially disadvantaged areas, this could provide not only a greater level of access to important information, but also the potential to increase their awareness and understanding of health promotion. Empowerment strategies using appropriate educational programmes (and using critical pedagogy) and adequate qualitative interpretive research strategies for their evaluation are not separate and independent, but rather are closely and importantly inter-related. From an educational and health promotion perspective, therefore, the inclusion of critical pedagogical approaches within health promotion curricula and qualitative interpretivist paradigms of research could be considered essential.

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**References**


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