

A CURRICULUM FOR EXCELLENCE REVIEW OF RESEARCH LITERATURE

HEALTH AND WELL-BEING

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Introduction

Relevant sources were identified by performing literature searches using mainly, but not exclusively, the on-line databases ERIC and International ERIC. Searching was generally limited to journal articles and research reports published in English within the past ten years, though older material identified as a result of checking reference lists was included if it seemed important. Searches were performed using the keywords: health and well-being, health education, school health education, health education pedagogy, health education and progression. The lists produced were sifted for promising titles and abstracts checked. This process resulted in a master list of 20 research reports and these sources provide the basis for the review which follows.

There does not appear to be a great deal of literature relating to pedagogical issues within health education; there is, however, a wide range of research articles and discussion papers on the concept of children's health and well-being as it relates to their overall school experience. One very prominent and over-arching perspective emerging from most of the research is the importance of the whole school approach; an embracing of a holistic approach to health and well-being within the school. Without that, curricular developments within personal, social and health education are fairly limiting.

Recent literature on health education pedagogy has tended to be focused on specific topics such as drug education and sexual health education. Despite this limitation, some important elements of pedagogical approaches emerge.

This literature review intends to set out, in a systematic manner, the case for a focus on developing the wider health promoting school ethos as a means to making health education curriculum and pedagogy meaningful for children and young people.

Health and well-being defined

The World Health Organisation (WHO) when defining health, has consistently referred to social and psychological well-being, as well as the more obvious physical elements. Phrases such as 'a resource for everyday life', 'satisfy needs' and 'realise aspirations' underlined health promotion policy in the 80s (WHO 1986) and more recently, at the World Health Assembly in May 1998, the Member States of WHO affirmed:

...the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and

worth of every person, and the equal rights, equal duties and shared responsibilities of all for health (World Health Organisation 1998).

To a great extent, health education and health promotion developments within schools over the last 30 years have been led by the WHO principles relating to, for example, democracy, equity, empowerment and sustainability. The concept of health and well-being as a central tenet of school life is strongly supported and seen as fundamental to the development and attainment of all children and young people.

New Zealand's new health and physical education curriculum, as well as encompassing the WHO concept of well-being, has underlying it, the Maori philosophy 'Hauora'. There are four components to Hauora which are mutually supportive: Taha hinengaro (mental and emotional well-being); Taha whanau (social well-being); Taha tinana (physical well-being) and Taha wairua (spiritual well-being) (Burrows and Wright 2004). The new curriculum recognises that an individual cannot be solely responsible for his or her health 'outcomes' and that communities and public agencies also have a role and a responsibility. Self-actualisation, the ability or capacity to understand one's own 'unique' potential is a main goal of the new curriculum. The focus on aspects of mental health is very much influenced by the increasing rates of youth suicide and mental health problems among young people in New Zealand.

The same authors reported on the details of a national monitoring project undertaken in the late 90s and the results of which provided support for the development of the new syllabus indicated above (Wright and Burrows 2004). Pupils in year 4 (8-9 year olds) and year 8 (12-13 year olds) were asked about their perceptions of 'being healthy' and 'a healthy person'. The results were unsurprising; the older pupils were more likely to make more reference to drugs and alcohol and refer to emotional aspect of health, whereas the younger pupils were more inclined to focus on the physical aspects of health and well-being. The authors' argument is that there was a tendency for all pupils to *know* about various health-related issues; whether that *knowing* would lead to behaviour change, was at least questionable. They refer to the pupils being 'well versed in health-ism discourses'. The health education programmes were responsible for that, but Wright and Burrows suggested that the approach previously used in New Zealand led to an assumption of 'certainty'. They felt it was necessary for the pedagogy to promote a climate of enquiry.

Students need to learn to become inquirers, to develop tools to work with uncertain knowledge which do not immobilise or cause fear and anxiety but which allow for action and choice (Wright and Burrows 2004).

They emphasise the importance of the pupils having a 'socially informed' understanding of health knowledge.

A theoretical model for school health and well-being is proposed by Finnish researchers. This is based on an earlier sociological theory of welfare developed by Allardt in the 70s and re-visited in the late 80s (Allardt 1989). Their argument is focused on the need for health education programmes in school to move away from a conceptual basis of health and health promotion to one that is based on the sociological concept of well-being.

Within the model, the interconnection between well-being, teaching/education and achievements/learning are clear. Within the 'well-being' dimension of the model, there are four key components of: *having* (i.e. school conditions such as surroundings and services); *loving* (i.e. social relationships such as group dynamics and teacher-student relationship); *being* (i.e. means for self-fulfilment such as value of student's work and increase self-esteem) and finally, *health* (i.e. health status such as illnesses and psychosomatic symptoms). While the paper expands on each aspect of the model, the authors acknowledge that discussion on appropriate pedagogical methods to support the model are beyond the scope of their paper.

A large scale study conducted in Belgium, focusing on well-being in Flemish schools used panel interviews (total of 342 pupils) to provide a basis for a questionnaire which was issued to over 2000 pupils. The Flemish government believes that pupil well-being is an important indicator for quality of education and the education inspectorate therefore required some kind of tool or instrument to measure well-being within the school context. Positive effects on well-being resulted from, for example, active participation in the classroom, and teachers treating pupils with respect. It appeared that pupils strongly preferred active methods and the use of diverse media (Engels et al. 2004).

A review of research on emotional health concluded that there is 'a dearth of good research and evaluations of research' in relation to the promotion of emotional and mental well-being in young people in the United Kingdom (Edwards 2003). This extensive review explored, among other aspects, the range of peer support initiatives and ways in which young people themselves have developed coping skills. While suggesting that further exploration of these initiatives is desirable, Edwards does suggest that young people themselves would prefer that adults showed respect for skills young people already have rather than 'impose' adult-developed programmes.

Health and attainment

Links between good health and well-being and attainment have been established for many years. It is not within the capacity of this paper to detail these. However, an extensive literature review carried out in 2000 by the then, Scottish Council for Research in Education (SCRE), highlighted the range of health factors that can influence attainment (Powney, et al. 2000).. Factors such as poor physical or mental health, specific conditions relating to, for example, hearing or speech and some environmental influences can contribute to a reduction in attainment. On the other hand, physical activity can contribute to higher motivation. The authors were cautious about any claims relating to nutrition and attainment.

The health promoting school

The health promoting school concept is now well established in Scottish education (Learning and Teaching Scotland 2004). Principles such as equity, democracy, participation, partnership, collaboration and supportive environments, underpin the philosophy of the health promoting school; a social model of health where the entire

school community and its environment contribute to young people's health and well-being (WHO 1997).

While many developments have taken place over the years throughout Europe, it is the monitoring and evaluation of the effectiveness of the approach that is still seen as crucial (Inchley, et al., 2000; Rasmussen and Rivett, 2000 and Stears, 2000). Stears describes an evaluation tool based on an 'eco-holistic' model, one which takes account of external and internal factors and the relationships between them (Stears 2000). The tool or instrument, was used to collect data from three perspectives: national (the Welsh Office, higher education institutions, and other government and non-government organisations); local sources included local authority advisers and health authorities; school level focused on ten schools in Wales and included data from head teachers, health education co-ordinators and pupils. Clear results emerged. At national level, a need for a mandatory curriculum for Personal, Social and Health Education (PSHE) was identified and the need to enhance provision within initial teacher education. At local level, health professionals available to support work in schools were identified and at school level, it was clear that links with family and communities were progressing well.

As the instrument was being developed, it was trialled in schools in East Kent. One aspect worth noting here is that, when data from the views of teachers and pupils on the processes used to determine health issues to be addressed in school was fed back to the participating schools, teachers were surprised by the margin of disagreement between the two groups. There was obvious potential here for addressing issues regarding communication and relationships within the school.

If schools are truly health promoting and hold, therefore, to the principles of democracy, equity and participation, then there are pedagogical implications. To what extent do schools consult pupils on the content and processes of health education? Are class-based values reflected elsewhere in the school? For example, are values relating to friendship and camaraderie which are part of personal, social and health education seen to be in action throughout the school community? To what extent do teachers create the right climate for learning? Data from four countries' participation in the WHO international survey on health behaviours is discussed in relation to the importance of school climate and students' satisfaction with school as a means to achieving health and educational goals (Samdal, et al., 1998). This particular study focused on data from Finland, Latvia, Norway and Slovakia. The quality of the relationships with teachers in the classroom, being treated fairly and providing a sense of safety within the school environment were considered important contributors to pupils feeling involved and this in turn contributed to enhancing their well-being and health.

Context for learning

It is clear from the research and the discussion papers indicated in the earlier sections of this paper, that health education in schools and the related pedagogical implications require to be based on a social model of health. For a long time, a behaviourist model has operated, where children and young people are seen as wholly responsible for their health decisions; developing in them the knowledge and skills to make decisions

about their health. While that is still extremely relevant, there is another dimension which has to take account of the often complex circumstances of the real community (and the social setting) in which the young people live (Beckett 1990). While Beckett's discourse is rather dated (however it still has currency), there are similar themes emerging from Nutbeam's key paper on health literacy and the challenges posed for health education and communication strategies (Nutbeam 2000).

A review of drug education approaches conducted by Lowden and Powney (1999) concluded that there can be limitations to school-based drug education (in part due to the difficulty in addressing all the varied needs of the pupils). The authors suggested that working closely with external community-based organisations and groups would enable the differing needs of the young people to be met, again ensuring that the social setting is taken into account (Lowden and Powney, 1999).

Getting the context right is essential. Where young people are sharing and challenging views on health issues and considering their own values and beliefs, the context for that has to be carefully considered. A study undertaken across six schools in the east of Scotland, involved a large number of in-depth interviews and group discussions, with a focus on sex education, revealed the level of difficulty involved in setting the context (Buston, et al., 2002). Almost three quarters of the pupils interviewed individually in the study indicated being uncomfortable in the classroom. At times the content was responsible; however, it was factors relating to classroom atmosphere that were dominant. The study identified four inter-related themes which appeared to be important in reducing discomfort: *teacher as protector* (issues relating to the teacher being able to control the class, prevent ridicule); *teacher as friend* (having a friendly atmosphere, approachable); *trust between pupils* (not having discussions spread around the school) and *sex education as fun* (being able to be light-hearted as a means of being relaxed with one another).

Similar findings arose with a follow-up study from a training programme established through the Scotland Against Drugs Education Sector Initiative. This focused on the secondary school stages. In considering the longer-term impact of the training, researchers conducted a series of focus groups with pupils from 8 schools. Pupils enjoyed the drug education lessons and indicated that enjoyment was an important factor in successful lessons as well as being actively involved; personal qualities, such as being able to establish a rapport with the pupils was also considered important (Lowden and Quinn, 2004).

Methodological implications

The same research revealed that the changes in learning and teaching approaches contributed to effective lessons. The use of participatory methods and subsequent increase in opportunity for discussion enhanced their experience. Lessons were more stimulating and active compared to those using more didactic methods (Lowden and Quinn, 2004).

On the same theme of drug education, an evaluation of a primary school drug drama project involving a health promotion service and a theatre's education department, indicated that the participatory, experiential approach enabled the children (10-11 year olds from 41 schools in England) to increase their knowledge significantly about

drugs and also contribute to a reduction in stereotypical views of drug users (Starkey and Orme, 2001).

Wright and Burrows (2004) offer a cautionary note regarding the efficacy of an empowerment-based sex education programme. Based on his research relating to the development of a teacher-delivered sex education programme (Sexual Health and Relationships-Safe, Happy and Responsible SHARE), Wight discusses the difficulties with identifying and expressing needs, something that is considered an important part of consultation. Good relationships and trust between the young people is essential. Also, where young people are unaware of the options for sex education content and methods, they are likely to be limited in their selection when consulted. This can relate also to choice of providers, such as school nurses and local health promotion professionals.

A study in Norway of 947 adolescents aged 13-15 into the use of participatory methods revealed that methods involving group discussion increased the perception of social support and indirectly decreased experiences of stress (Natvig, et al. 2003). Pupils gained support from one another through verbal activity and teacher involvement in class discussion added to the sense of social support.

Conclusion

This review has limitations. Time constraints have meant that the search for relevant literature was reduced in scale and depth. Also, disappointingly, the search failed to reveal very much directly linked to breadth, depth and progression as they relate to health and well-being.

Scottish research relating to health behaviours (for example work undertaken by Candace Currie and her team at the Child and Adolescent Health Research Unit (CAHRU) and Patrick West from the Medical Research Council's Social and Public Health Sciences Unit) has not been part of this review. However, it is important to stress that when considering any developments in the health education curriculum, both content and process, the behaviours, views and needs of young people about their health behaviours must be taken into account.

There are some fundamental aspects that emerge clearly from the review that might be considered worthy of attention.

1. Health and well-being encompasses a number of elements relating to physical, social, emotional and spiritual dimensions. These in turn, are linked to the broad concept of the health promoting school.
2. The health promoting school is based on a social model of health where the entire school community and its environment contribute to young people's health and well-being.
3. Health education within the classroom is not going to be effective unless all other aspects of the school life reflect the same values and promote the same beliefs.
4. Promoting a climate of respect, trust and support is particularly relevant for discussion of sensitive health-related issues.
5. Participatory methods can contribute to improved interaction and motivation.

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