Feature Article

EMANCIPATORY HEALTH EDUCATION & ENVIRONMENTAL EDUCATION: THE EMERGENCE OF THE NEW PUBLIC HEALTH

Derek Colquhoun
School of Education
Deakin University

Abstract
This paper attempts to illustrate the influence of an emerging New Public Health on the relationship between health education and environmental education. This New Public Health places health on the political agenda. In so doing it involves a critical examination of the underlying and pervasive ideology of individualism which is so embedded within conventional health education. Health education tends to focus on individual behavioural factors for health and ignores the wider environmental, social, economic and political factors. However, a new consciousness within health education serves to critique the existing relationship between individualism and health and is essentially concerned with examining the broader influences on health.

The paper concludes optimistically by suggesting that this new consciousness encapsulating the notion of an Emancipatory Health Education in schools has the potential for encouraging emancipatory social change involving a recognition of the social and environmental constraints on health. Because of this there needs to be a re-think and a re-conceptualisation of the relationship between school health education and environmental education.

Introduction
There can be no doubt that in the last few years we have witnessed an increased societal interest in health and environmental issues. This is perhaps reflected most tangibly in the recent success of the Tasmanian 'Greens' which has further enhanced the whole logging/woodchipping controversy on the (national) political agenda. This increased societal interest is also beginning to influence the school curriculum in terms of, and in particular, what is taught in the classroom. Teachers are becoming more and more aware of environmental issues which directly affect our health in one way or another.

Both health education and environmental education have had a chequered history; a history full of conflict, competition, domination and vested interests. Clearly, both subjects are becoming more and more popular as both individuals and governments realise the importance of both areas to human existence, quality of life and well-being. Not only are health education and environmental education becoming re-defined in light of the current societal/school interest in the area but in particular, the relationship between the two is also being re-examined and re-constituted.

In this paper I will suggest that health education and environmental education could enjoy a closer, more prosperous relationship which builds upon basic principles common to both school subjects. I will argue that as a result of a re-alignment of contemporary thinking in health education, the two subjects are in fact, inextricably linked especially when one considers developments in the

https://doi.org/10.1017/S0814062600002093 Published online by Cambridge University Press

area of public health which overtly politicise the socially constructed areas of health and environment.

Health Education, Environmental Education and Ideology

Despite health education's recent popularity it suffers the same fate as environmental education in that it still serves a marginal function within the school curriculum. Robottom (1987) for example, has had this to say about environmental education's place in the school curriculum:

> ... environmental education is not a high status subject in the school curriculum. Perhaps its political bent renders it unpopular with conservative teachers and school administrations; perhaps its prescribed interdisciplinary character renders it a square peg for the round hole of the conventional discipline-based subject curriculum. Environmental education has continually had to struggle for resources because it is not a high-status subject ...

For environmental education this struggle has been compounded by the debate whether the subject should be 'infused' into the curriculum or should be presented as a separate subject in its own right (see Disinger, 1987).

As Colquhoun (1989a) has pointed out for health education, primary school teachers often perceive health education as having a similar lowly status as music or physical education. Typically, primary school health education is incidental, integrated or ignored (Wright & Soulsby, 1986) and therefore in reality it rarely occurs, if at all. In the secondary curriculum the situation is no better. Health education is often delivered through physical education (Colquhoun & Kirk, 1987), home economics (Hart, 1981), biology (Hull, 1987) or personal and social education (Tones, 1987). The resultant being that rationales for health education are many and various, often lacking coherence and quite frequently citing non-educational criteria such as economic rationalism in their justificatory rhetoric (Colquhoun, 1989b).

The problems at the level of practice are indeed significant and a reality for many practitioners but health education can also be severely criticised at the level of ideology. It is at this level that both health education and environmental education can share some of the same criticisms.

Teachers experience the practical problems of their subjects in many tangible ways. these issues are often technical matters of 'how' and not necessarily of 'why' (Kemmis & Fitzclarence, 1986). It is not surprising then that the ideological content of many school subjects has gone unchallenged. Recent contributions to the debate in health education are rare (Colquhoun, 1989c; Combes, 1989; Riska, 1982; Vertinsky, 1985), however they are all in agreement in their identification of a dominating ideology.

Ideology can be viewed in its simplest sense as a 'set of perceptions about the world' (Combes, 1989). Ideologies represent 'lived meanings, practices and social relations that are often internally inconsistent' (Apple, 1982). They serve to reproduce these meanings, values, practices and relations by obfuscating, distorting, and camouflaging intentions and inequalities. Ideologies mask the taken-for-granted assumptions which are so readily accepted by many practitioners in health education and which pervade our practice.

The crux of the dominant ideology in both health education and environmental education can be conceptualised in the age old question "Whose responsibility (for maintaining health and the environment) is it anyway?" Simply, by responsibility I mean either the individual (agency) and/or the structure (the State and corporate interests). Clearly, in contemporary health education the onus is on the individual to maintain his/her health. If we accept that an individual's health is a product of environmental influences, human biology, technology and personal behaviour or lifestyle, then it would seem feasible that these aspects would be more or less equally covered in school health education. Unfortunately, this utopian dream is not the case. The dominant ideology in school health education is one which reinforces individual self-responsibility for health and therefore the other aspects such as environment, technology and human biology are often ignored.

To focus on the individualistic nature of health Crawford (1986) has coined the term 'healthism'. This involves:

> a pre-occupation with personal health as a primary - often *the* primary - focus for the definition and achievement of personal well-being; a goal which is attained primarily through the modification of lifestyles ... The etiology of disease may be seen as complex, but healthism treats individual behaviour, attitudes and emotions as the relevant symptoms needing attention (original emphasis).

Healthism reduces the complex causes or etiology of diseases to simple behavioural or lifestyle factors. Individuals are continually encouraged to adopt behaviour changes in order to maintain their health. We need to observe several 'healthy habits' such as take regular exercise, eat less salt, eat more fibre, sleep eight hours each night, and so on, if we are to live longer and maintain an illness free life. Healthism encourages individuals to take control and exhibit self-responsibility, reliance, self-discipline and will-power to avoid diseases such as coronary heart disease, stroke and cancer. There is a moral duty on behalf of individuals to adopt healthy lifestyles not just for the good of the individual but also for the good of society. The moral majority is powerful, so much so in fact, that if individuals do not exhibit normative behavioural aspects of self-responsibility such as jogging daily, then they are often castigated as weak, lacking control and self-discipline. The individual (the victim) is blamed for developing illness - there is a 'your fault dogma' which serves to depoliticise the nature of illness by deflecting attention away from social and environmental causes of ill-health and onto individual causes. Crawford (1986) calls this 'the politics of diversion' where the wider social, economic, political and environmental causes of illness are neglected or marginalised. With healthism it appears 'natural' and 'given' that individuals should take responsibility for their own health. All this is occurring at at time when Crawford (1986) suggests individuals possess little control over their own lives and even less control over the social and environmental causes of ill-health.

Healthism is the foundation for much that passes as health education in schools. It is prevalent in teaching strategies, learning experiences, school textbooks and commercial curriculum packages (Kirk & Colquhoun, 1989). It is also the cornerstone of the justificatory rhetoric of school health education since it encourages and adopts a health belief model which legitimates individualism in three ways:

(1) providing knowledge (and access to knowledge) about health and about the short-term and long-term health consequences of different choices, and exploring health-related attitudes and beliefs;

(2) teaching children the skills of decision-making, to apply the relevant knowledge to their own lives;

(3) exploring the feelings children have about themselves and how these can affect health choices ... (Combes, 1989; pp.67-68).

It seems obvious that the relationship between each of these stages is extremely tenuous at best. For example, the provision of knowledge and information does not necessarily mean that children will adopt healthy behaviours; telling children about the risks of smoking does not mean that they will cease smoking. Yet this simplistic notion is the core of contemporary health education.

Healthism has been so embedded in school health education that until now it has avoided critical scrutiny. This trend is changing however with the emergence of a new and exciting consciousness which attempts to re-define the relationship between health and its constituent parts. To grasp the significance of this movement I suggest the term emancipatory health education which I see as being a form of 'critical health education' similar in philosophy and theoretical background to the 'critical environmental education' suggested by Blake & Cocks (1987).

Emancipatory Health Education and The New Public Health

The domain of personal health over which the individual has direct control is very small when compared to the

https://doi.org/10.1017/S0814062600002093 Published online by Cambridge University Press

influence of culture, economy and environment (Dr Halfdan Mahler, Director-General, World Health Organisation, 1988).

Over the last two decades we have witnessed a move away from the behaviourally dominated traditional school health education towards a more encompassing notion of health promotion. This involves more than the simple, narrow lifestyle approach of conventional health education and also includes other important factors such as legal, fiscal, societal, and environmental measures (Player, 1987).

Such a move towards health promotion has occurred in a decade where individuals are becoming more and more exposed to environmental hazards which changes in lifestyle can do very little about. The first international conference on health promotion which attempted to address some of these issues was held in Ottawa, Canada in 1986. The conference's subsequent recommendations, commonly referred to as 'The Ottawa Charter', included five major action areas:

* build healthy public policy;
* create supportive environments;
* develop personal skills;
* strengthen community action;
* reorient health services.

The Charter involved a recognition of the limitations of individualism, the global inter-connectedness of health, the social and political nature of health, and perhaps most relevant here, an increasing awareness of the relationship between the individual and his/her environment.

The second international conference on health promotion was held in Adelaide in 1988 and recognised four action areas including:

* supporting the health of women;
* food and nutrition
* tobacco and alcohol;
* creating supportive environments.

This conference was concerned with enlightening substantive issues relating to the health of women, universal access and equity towards food, the economic and social cost of commonly used addictives such as tobacco and alcohol and the production of policies promoting health which can be achieved in an environment that conserves resources through global, regional, and local ecological strategies.

More recently, a workshop at LaTrobe University in Melbourne (LaTrobe, 1989), focused on the ecology of health and by doing so consolidated the relationship between health and environmental issues. The workshop made sixteen recommendations, nine of which I have listed below:

1. That the Australian Federal Government, in accepting the health of its citizens as a major social objective, recognises the need for sustainable health development and a new public health at a global level; and supports local and international initiatives in these directions.

2. That all levels of government require, by 1992, regular environmental and health impact statements from both existing and new development projects, and that these be released to the public.

3. That budgets for health and curative services, at all levels of government, be refocused to strengthen public health and create an infrastructure for an ecological public health ...

4. That both government departments and the private sector be held accountable for the health impact of their policies and programs, operations and development proposals; and accountability be achieved through the strengthening of health and environmental protection legislation, incorporating penalties for breaches at a level which will meet social costs of breaches as well as the cost of environmental repair.

5. That national, state and local health-related government agencies cooperate in creating appropriate structures to support intersectoral policy development and action for health.

6. That the health and environment related non-government and private sector organisations of Australia consider creating an Australian Health Coalition which acts as an advocate for the new public health, supporting lobbying activities,

policy development and action for health.

7. That the Australian Broadcasting Tribunal, as part of its public responsibility in both radio and television, monitors the presentation to the public of Australia's health issues, their relationship to global issues and the policy directions provided by the new public health.

8. That Australian tertiary education institutions reassess their undergraduate and postgraduate training and research in the fields of public health, epidemiology and environmental planning in order to teach the skills and develop the research base necessary for the development of new public health practice. A working document should be developed for use in research and evaluation of all initiatives in public health ...

9. That the Australian government contribute to the repair and maintenance of the global health commons through seeking, in the international trade area, an international agreement requiring all products to be traded at prices which cover their full environment and health cost. Pending developments of such a treaty, Australia should engage in a number of unilateral actions including:

   * prohibiting or taxing imports of forest products (from countries) which do not manage their forests on a sustained yield basis.
   * prohibiting or taxing imports of goods made under conditions which are detrimental to the health of workers, such as products made with child labour.
   * setting aside funds from such taxes to assist developing countries bear their share of upkeep of the global commons.

Within these recommendations and the new public health in general there are two recurrent themes. First, there needs to be more emphasis on the politics of health. Health is about more than simple lifestyle changes; it involves a complex relationship of many factors. The individualistic conception of health and illness needs to be surpassed in favour of a broader, more encompassing and dialectical approach which acknowledges social and environmental issues. Second, there has been an augmentation of the dialectical relationship between the individual and his/her environment. No longer is the environment to be dominated and exploited to suit the needs of government and corporate interests. It almost goes without saying that we affect and are affected by our environment. Mahler (1988) is worth quoting here on both of these issues:

> Healthy Public Policy is holistic and ecological, recognising that health in its broadest sense depends on an integrated view of people's physical, mental and social dimensions, as well as on the fact that people react to and in turn shape their environment.

In addition, and associated with the re-definition of the relationship of the individual to his/her environment, there needs to be a critique of the traditional, dominant medical definitions of health and illness which clearly serve to reinforce the individualistic and behaviouralistic nature of health and illness.

Emancipatory Health Education and Schooling

These two themes form the cornerstone of emancipatory health education in the school context. Emancipatory health education involves a critique of conventional health education, largely at the level of ideology, through the overall aim of the freeing of the constraints on an individual's health, and is therefore by necessity involved in the re-constitution of the relationships surrounding the factors responsible for health and illness. The first step in such a critique is the recognition that health and illness (like environmental issues - see Di Chiro, 1987) are socially constructed. Social constructionism is concerned with the interrogation and identification of vested interests, particularly within the relationship between the medical profession and health (see Willis, 1983). In addition, emancipatory health education argues against individual responsibility for health and the ideology of healthism as it is presented in conventional health education. Rather, emancipatory health education promotes a collaborative, community or participatory approach to health and

https://doi.org/10.1017/S0814062600002093 Published online by Cambridge University Press

environmental issues which breaks free of the purely individualistic conception of health and illness. As Freudenberg (cited in Tones, 1987) has suggested, health educators should 'involve people in collective action to create health promoting environments' as well as 'helping people to change health damaging institutions, policies and environments'.

At the core of emancipatory health education is the belief that health is about more than individual behaviour change. Rather, emancipatory health education recognises the need for a broad analysis involving a dialectical relationship between the individual and his/her environment. Because of this the traditional relationships of health education to home economics, biology and in particular, physical education, need to be questioned since the potential for emancipatory social change is limited by the apolitical nature and scope of these subjects. Physical education for example, is restricted in its possibilities because of its definition of the 'physical' (i.e., personal and behavioural). In contrast, environmental education offers an agenda which many health educators would find attractive and appealing. A closer relationship between health education and environmental education certainly has potential for involving individuals in collaborative action aimed at improving the environment, the health of individuals and therefore the global commons.

Emancipatory health education goes beyond the popular notion of 'empowerment' which is still largely embedded within a behaviourist framework. For Tones (1987) empowerment:

> seeks to facilitate genuine informed decision-making. In essence it aims to do this by not merely providing information on which decisions might be made, but rather by modifying aspects of personality. These attempts to foster personality growth involve changing the ways in which people view themselves and equipping them with a variety of skills which will help them interact more effectively with their environment. More particularly, the strategy adopted by the self-empowerment model is designed to enhance feelings of worth and self-esteem, and to promote the conviction that it is possible to be in charge of one's life.

Clearly, the notion of empowerment is situated within the health belief model which, as I have already pointed out, is central to the ideology of healthism. Furthermore, empowerment fails to take into account the fact that the links within the various components of the health belief model are at best, extremely tenuous. For example, providing information alone does not necessarily promote attitudes and beliefs which in turn are supposed to lead to healthy behaviours. In addition, and as with the health belief model, decision-making skills are central to the notion of empowerment. Unfortunately, we may foster the skill of decision-making but the empowerment model does not allow us to create the context of the decision-making. A young, single parent for example, might decide that a daily jog would improve his/her health yet may not be able to afford the equipment needed, baby sitters, travelling and so on. Emancipatory health education would encourage individuals to focus on the context of the decision by concentrating on the idea of advocacy. Baric (1988) suggests that advocacy may include:

> rebelling against the system, creating public pressure to change it, readjusting the distribution of power and initiating social reform.

Advocacy is a key element in the new public health and is concerned with re-defining the relationship between people, products and settings (Mahler, 1988) to encourage enabling strategies which allow individuals to recognise and break free from the constraints on their health. This does not mean that there will be a revolution tomorrow! What it does suggest however, is that we need to be 'committed to the pursuance of social justice or human emancipation' (Whitty, 1985). What Whitty suggests is a 'shift away from narrow education-centred professional strategies towards ones linked much more directly to other modes of political action'.

For Kirk (1988) any deliberate and conscious pursuit of emancipatory social change, whether it be through health education or environmental education, will involve three important aspects. First, there must be an ongoing critique of

the commonly held belief that the curriculum is an arena for value neutrality. In line with this Hyland (1988) has suggested that teachers of school health education can no longer afford to be a profession of 'fence sitters':

> On the face of it such a value-neutral stance is unobjectionable. We all favour teacher autonomy and the promotion of independent learning and freedom of choice. However, the position is disingenuous for, not only does it not promote freedom of choice and independence in learners, it effectively obscures the value base of health education thus concealing the inculcation of values behind a spurious objectivity.

Kirk's second point is that there needs to be communication between teachers, pupils, schools and different sectors of the community. On this point Aronowitz and Giroux (1985) argue that what is needed is a collective concern and mutual assistance brought about through teachers and schools communicating with 'ecology, feminist, peace, trade union and neighbourhood groups'. For Aronowitz and Giroux, these groups:

> can bring their collective skills and talents to bear on vital forms of resistance at the local level, for example, locally based efforts against toxic waste dumping, nuclear power, consumer fraud, racial and sexual discrimination and so on.

Equipping children and teachers to be critically aware of existing school practices and pedagogical relationships is the third of Kirk's criteria for emancipatory social change. We need to encourage both children and practitioners to ask a different set of questions. Instead of the technocratically charged questions so common in schooling today, we need to broaden our scope to look at wider issues concerning vested interests, manipulation and domination. Overall, we need to unmask or unveil the taken-for-granted assumptions which undergird much of our practice by engendering new sites for investigation and making the apolitical political or as Aronowitz and Giroux (1985) suggest, make the 'pedagogical political and the political pedagogical'. Cribb (1986) would also agree with this since he suggests that what we need is a 'political literacy' which will place health care within a social and environmental framework to investigate the 'inequalities in provision and the differential life chances and material conditions which effectively construct the health prospects of individuals'.

Finally, I think the comments by Hyland (1988) seem fitting:

> I would urge health educators to turn their backs on both individualism and value-neutrality and instead start to take positive steps to establish programmes founded on social morality and justice rooted firmly in critical analysis of the social determinants of health and illness.

Conclusion

In this paper I have suggested that health education and environmental education could enjoy an enhanced and prosperous relationship within the school curriculum. This re-definition of the relationship between the two subjects has occurred as a result of a new and exciting emergence and interest in the new public health. At the core of the new public health has been an attempt to place health on the political agenda. Dissatisfaction with the behaviourally orientated conventional health education has encouraged health educators to critically appraise their subject in light of a social and cultural trend which stresses the need for ecological and environmental awareness. School health educators are beginning to shrug off the shackles of myopia and are beginning to reflect upon, and critique, their subject and its relationship to other areas of the curriculum. Emancipatory health education has, as a school subject, greater potential for encouraging emancipatory social change than conventional health education could ever hope to achieve. But to achieve this potential, a dialectical relationship between health education and critical environmental education is necessary.

References

Apple, M. Education and Power, Ark Paperbacks, Boston, 1982.

Aronowitz, S. & Giroux, H. Education Under Siege: The Conservative, Liberal and Radical Debate Over

https://doi.org/10.1017/S0814062600002093 Published online by Cambridge University Press

Schooling, Routledge & Kegan Paul, London, 1985.

Baric, L. "The new public health and the concept of advocacy", The Journal of the Institute of Health Education, 26, 1988, pp.49-55.

Blake, T. & Cock, P. "Environmentalism and Education", Australian Journal of Environmental Education, 3(1), 1987, pp.3-9.

Colquhoun, D. "Images of healthism in health based physical education", in, D. Kirk, & R. Tinning, (eds.), Curriculum Issues in Physical Education, Falmer Press, Lewes, (forthcoming), 1989a.

Colquhoun, D. Economic Rationalism and School Health Education. Paper Presented at The Health Revolution Conference, Bendigo C.A.E., June, 1989b.

Colquhoun, D. Healthism and Health Based Physical Education: A Critique. Unpublished Ph.D Thesis, University of Queensland, 1989c.

Colquhoun, D. & Kirk, D. "Investigating the problematic relationship between health and physical education: An Australian study", Physical Education Review, 10(2), 1987, pp.100-109.

Combes, G. "The ideology of health education in schools", British Journal of Sociology of Education, 10(1), 1989, pp.67-80.

Crawford, R. "A cultural account of 'health': Control, release and the social body", in, J. McKinlay, (ed.), Issues in the Political Economy of Health Care, Tavistock, London, 1986.

Cribb, A. "Politics and health in the school curriculum", in, S. Rodmell & A. Watt, (eds.), The Politics of Health Education, Routledge & Kegan Paul, London, 1986.

Di Chiro, G. "Applying a feminist critique to environmental education", Australian Journal of Environmental Education, 3(1), 1987, pp.10-17.

Disinger, J. F. (ed.), "Trends and issues in environmental education: Environmental education in school curricula", ERIC Clearinghouse for Science, Mathematics, and Environmental Education, Columbus, 1987

Hart, W. "Health education in the home economics curriculum", in, J. Cowley, K. David, & T. Williams, (eds.), Health Education in Schools, first edition, Harper & Row, London, 1981.

Hull, T. "Science and health education", in, K. David & T. Williams, (eds.), Health Education in Schools, second edition, Harper & Row, London, 1987.

Hyland, T. "Morality, individualism and health education", The Journal of the Institute of Health Education, 26(2), 1988, pp.80-83.

Kemmis, S. & Fitzclarence, L. Curriculum Theorising: Beyond Reproduction Theory, Deakin University Press, Geelong, 1986.

Kirk, D. Physical Education and Curriculum Study: A Critical Introduction. Croom Helm, London, 1988.

Kirk, D. & Colquhoun, D. "Healthism and physical education", British Journal of Sociology of Education, (forthcoming), 1989.

LaTrobe University, 2020: A Sustainable Future". Workshop Recommendations, April, 1989.

Mahler, H. Healthy Public Policy: The Vision. Report on the Second International Conference, Adelaide, 1988, pp.10-14.

Player, D. "Education as health promotion: A health perspective", in G. Campbell (ed.), Health Education: Youth and Community, Falmer Press, Lewes, 1987.

Riska, E. "Health education and its ideological content", Acta Sociologica, 25, Suppl, 1982, pp.41-46.

Robottom, I. Environmental Education: Practice and Possibility, Deakin University Press, Geelong, 1987.

Tones, K. "Health promotion, affective education and personal-social development of young people", in, K. David & T. Williams, (eds.), Health Education in Schools, second edition, Harper & Row, London, 1987.

Vertinsky, P. "Risk benefit analysis of health promotion: Opportunities and threats for physical education", Quest, 37, 1985, pp.71-83.

Whitty, G. Sociology and School Knowledge: Curriculum Theory, Research and Politics, Methuen, London, 1985.

Willis, E. Medical Dominance, Allen & Unwin, Sydney, 1983.

Wright, M. & Soulsby, K. Health Education Study Guide, ECT 447, Deakin University Press, Geelong, 1986.