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# HOW IS HEALTH EDUCATION BEING TAUGHT AND EXPERIENCED? A LITERATURE REVIEW

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## **Abstract**

*The purpose of this review was to analyse qualitative studies on health education and highlight how it is taught within the classroom, including the implicit messages about health expressed and the particular pedagogies embraced. Connected to this, post-primary student experiences in health education are explored. Reviewed literature included qualitative and peer-reviewed research from 2009 to 2022. Despite some of this research stemming from international contexts, the resulting findings and discussions presented will directly relate to health education in Aotearoa New Zealand. The review revealed the persistence of two dominant and somewhat contradictory themes: dependence on fear- and risk-based discourses, and the utilisation of critical pedagogy. The review also highlighted a discrepancy between junior and senior health education. Implications for educators, future research and teacher education programmes are also discussed with a focus on the Aotearoa New Zealand context. This review will lend itself to broadening the pedagogical approaches taken by health educators and the effects these have on student experiences.*

## **Keywords**

Health education; secondary school; discourse; pedagogy; student experiences

## **Introduction**

In many countries, school health education is endorsed as a learning area that can transform the health literacy, attitudes, skills, and overall health of individuals, communities, and societies (Begoraty et al., 2009; Dixon, 2020; Leahy et al., 2015). Given its potential, it is important to understand what schools, educators, and health education, more broadly, are emphasising in regard to health. Health education itself is a rather extensive and “unwieldy” subject (Leahy et al., 2015). It is a learning area that applies and combines knowledge from a plethora of disciplines with aspects of sociology, biomedical science, psychology, political studies, history, and many others, interwoven and utilised by health educators (Wright et al., 2018). The intricate integration of such diverse disciplinary knowledge, coupled with an abundance of competing discourses and differing pedagogies, adds levels of complexity to an already ambiguous learning area.

Health education’s strong connection to communities and societies also makes it susceptible to influences from society (Leahy et al., 2015). For example, political agendas, stereotypes, and historical trends, among other influences, contribute to the subject’s ambiguity, diversity, and ever-changing nature. As such, the role of the health educator involves traversing multiple concepts, knowledge forms, and pedagogies to create a relevant, educative programme of learning. This translation may not always be effective or immune to personal bias and perceptions, thus creating possibilities for conflicting experiences within the learning area.

Particular topics, including oral health, sexual education, and health promoting behaviours within school health education have received large amounts of attention within the research literature (Sinkinson & Burrows, 2011). Emphasis on health promotion research within the health education setting has seen a considerable increase in recent years. The limited published literature reviews within the school health education field nationally, and internationally, creates a need for this current literature

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review. One recent leading literature review within the field of research, Dixon and Robertson's (2022) close read of three New Zealand based sources, focused on three main paradigms within health education, including the moral, democratic, and sociocritical paradigms. This review aims to provide direction in regard to the remaining uncharted dimensions of health education, both nationally and internationally. Notably, whilst this review draws upon international literature, the findings and conversations are aimed to be relevant and useful to the Aotearoa New Zealand educational context. By attempting to address such gaps, there is a possibility to inspire teachers to question the pedagogies and content choices within their Health Education programme. The freedom offered by health curricula can also make room for complacency and uncritical practice.

Within the literature, health education has been defined in several ways, with the operational definition ultimately influencing the aims, purpose, and implementation of such education. For example, De Vries et al. (2018) defined health education simplistically, as a process of educating both about health, and the factors which influence this. This definition leaves room for significant interpretation and understanding. Whilst Green and Kreuter (2005) understood health education as arranged learning experiences with the intent to reinforce behaviours that are favourable for positive health outcomes. Such a definition, again, leaves room for diverse perceptions. However, it also centrally positions health within a discourse characterised by a focus on behaviour change and individualism. As such, health is positioned as “something” an individual chooses, controls, and must change themselves, keeping understandings largely removed from broader factors. Varying definitions of health education ultimately lead to different content and curricula, hence the diversity across iterations of international school health education.

For the purposes of this literature review, the definition of health education is aligned with the World Health Organisation's definition, which frames health education as any learning experience intended to aid individuals and communities in enhanced health, through the improvement of knowledge and attitude (Baumann & Karel, 2013). However, this understanding has been narrowed to only include learning experiences that occur within a school context supported by a subject curriculum. Additionally, it has been expanded to include more than an advancement of knowledge, but also students' ability to observe issues, concepts, and perspectives, with a more critical and questioning viewpoint.

### ***Health education in Aotearoa New Zealand***

Health education within the Aotearoa New Zealand context is uniquely placed in comparison to its international counterparts (Fitzpatrick & Burrows, 2017). Health as a learning area is one of three subjects categorised within the HPE curriculum and is a compulsory subject for students until the end of Year 10 (ages 14 to 15) (Ministry of Education, 2007). Arguably, there is no predetermined content within such a curriculum and, therefore, educators are afforded considerable freedom (Robertson, 2015).

Gillian Tasker's work in the Health and Physical Education 1999 New Zealand Curriculum established a pivotal point in the nature of health education as a learning area in Aotearoa secondary schools (Ministry of Education, 1999). Unlike its other subject counterparts, health did not have a supported curriculum until 1985 (Robertson, 2021). Therefore, the construction of the Health and Physical Education 1999 New Zealand Curriculum was significant in the development of a conceptual framework that provided a flexible, interrelated, and socio-critical starting point for educators to draw from. Whilst over 25 years old, the major tenets of the document, including the underlying concepts still remain relevant in the current curriculum today.

The “big ideas”, or four underlying concepts, create a platform in which a socio-critical approach may be enacted (Dixon & Robertson, 2022). These four connected and interrelated concepts are:

- Hauora, a Māori concept of health, which provides a holistic understanding of health, beyond a traditional westernised biomedical perspective (Robertson, 2021).

- Attitudes and values refer to the particular attitudes and values that are connected to learning experiences and outcomes within the health and physical education (HPE) learning area.
- The socio-ecological perspective is an approach that allows students to analyse and observe the interrelationships between the determinants of health, a culmination of social and environmental factors that affect the well-being of individuals, groups, and communities (Robertson, 2021).
- Health promotion is a concept that involves students in the construction of both personal and collective action for the development and maintenance of supportive environments, both emotionally and physically (Ministry of Education, 2007).

### ***Positionality and goals of this review***

This literature review will make connections predominantly to the New Zealand secondary schooling context. This is the geographical context in which the researcher is situated as an emerging researcher and educator, and the context in which the researcher experienced health education as a student. While this is not a universal experience, it has contoured the purpose and direction of this literature review. The researcher further identifies as a cis-gendered, heterosexual female of Pākehā ethnicity. Positionality information is included as lived experiences and perspectives influence and shapes the way in which research questions have been constructed and findings have been presented.

The purpose of this review is to contribute to the dialogue within this limited research field, offering a multilayered view of the current experiences and challenges of health education in Aotearoa New Zealand schools. By exploring health education in secondary schools within Aotearoa New Zealand and countries with important similarities, this review is intended to increase Health and Physical educators' critical awareness of the content and delivery of curriculum and personal perspectives. The following research questions were developed to achieve this:

What dominant pedagogies are being utilised in secondary school health education?

What are students' experiences of health education?

## **Methods**

### ***Selection of literature***

To conduct the search, I used a key terminology search in the platform Google Scholar, and databases including ProQuest Central, SAGE, and Taylor and Francis Online. The specific terms used within the search included “health education” OR “health curriculum” AND secondary OR high OR middle school OR post-primary. Following initial searches, particular criteria and parameters were set in the selection of research articles; these included:

1. Published between 2009–2022
2. Research was collected and conducted in secondary school contexts
3. Focused on “health education” or “health curriculum”
4. Published in peer reviewed journal articles

These criteria were utilised to establish a data set that presents relevant and recent global health education research within secondary contexts. As this area of education is still developing, 2009 was selected as a cut-off date to include research based on new changes to the New Zealand Curriculum (Ministry of Education, 2007).

The initial searches produced variable results, with many either unrelated to secondary health education, or too narrow, with a focus on a specific topic within health education. For example, articles were removed for focusing on particular content such as oral or sexual health education (Freeman et al.,

2016). Examination of the literature's titles and abstracts acted as an initial dismissive tactic, in which several articles were removed due to unsuitable characteristics.

### **Initial data extraction**

Once the research articles were determined to have fit the inclusion criteria, key characteristics and elements of each were extracted and entered onto a spreadsheet. These elements included in-text citation, full APA 7th citation, title, source (database), purpose of the study, research location, description of participants, methods used to obtain the data, and the framework or approach used to analyse the data. In addition, a shortened outline of the findings of each study was recorded, and if relevant, connected to one, or both of the research questions. These findings were connected to a research question and subsequently to the identified themes. Notably, a study's findings were not restricted to connection with a particular theme, and crossover was common.

### **Analysis of attributes of the literature**

This review analysed nine studies from January 2009 to December 2022. The nine studies were based across multiple countries, including New Zealand (44.44%), Australia (33.33%), England (11.11%), and Canada (11.11%). Four studies focused on students as participants (44.44%), alternatively two studies focused on teachers (22.22%). Another two studies used preservice teachers as participants (22.22%), and only one study combined teachers and students as participants (11.11%). The research selected all utilised a qualitative research approach; however, the methods used varied slightly. Two studies analysed student work, such as reflective writing or transcripts (22.22%), three used interviews (33.33%), two utilised surveys (22.22%), and the final two used a combination of classroom observation and interviews (22.22%).

**Table 1. Overview of the Reviewed Sources Organised by Date**

<b>Title</b>	<b>Authors</b>	<b>Research location and participants</b>	<b>Purpose</b>
A case for connecting school-based health education in Aotearoa New Zealand to critical health literacy	Dixon et al. (2022)	New Zealand  Data was collected from 25 people from across Aotearoa who had studied health education to the end of Year 13.	Investigate the possibility for secondary health education to enhance critical health literacy skills.
Putting assemblage to work to explore pedagogical practices in health education in Aotearoa New Zealand	Dixon et al. (2021)	New Zealand  Data was collected from 25 participants from across Aotearoa New Zealand who had studied health education to the end of Year 13 (the final year of schooling).	Understand the learning experience of health education of people who studied this learning area until Year 13.

What does critical health education in schools look like? Two ethnographic narratives of critical practice	Fitzpatrick & Allen (2019)	New Zealand  Data was collected from two senior health educators in Aotearoa New Zealand for two different schools.	To evaluate the critical practice of two health educators and connect these to five pedagogical themes.
The perceived value of health education in schools: New Zealand secondary teachers' perceptions	Hargreaves (2013)	New Zealand  Data was collected from 25 secondary school health education teachers representing 10 regions in New Zealand.	To recognise New Zealand secondary health educators' perception of various stakeholders, including principals, other staff, BOT's, students, and parents/caregivers and their valuing of health education as a subject. Understanding this perceived value would also help to identify enablers and barriers to effective implementation of school health education policy.
In search of the socially critical in health education: Exploring the views of health and physical education preservice teachers in Australia	Wright et al. (2018)	Australia  Data was collected from 13 preservice health and physical education teachers.	Explore the potential in implementing a socio-critical approach in the secondary health classroom.
Working against "pedagogic work"	Fane & Schultz (2017)	Australia  Data was collected from 31 preservice teachers, enrolled in a first-year Health Education course.	Explore the ways in which these preservice teachers engage with and understand the socio-critical health discourses.
Assembling a health[y] subject: Risky and shameful pedagogies in health education	Leahy (2014)	Australia  Data was collected from eight teachers across three different secondary schools.	To analyse and explore how neoliberal logics of risk shape curriculum and practice within the health classroom.

High school health curriculum and health literacy: Canadian student voices.	Begoray et al. (2009)	Canada  Data was collected from 33 students aged 14–15 years old, enrolled in Planning 10.	To examine the student experiences in the Planning 10 health component and how this education influenced students' health literacy.
The role of school-based health education in adolescent spiritual moral, social and cultural development	Chester et al. (2019)	England  Data was collected from 3731 young people, aged 11, 13 and 15 years old.	To explore the relationship between personal, social, health and economic (PSHE) education in secondary schools and the outcomes within adolescent spiritual moral, social, and cultural development.

The studies were subjected to elements of thematic analysis (Braun & Clarke, 2006) to establish dominant themes and patterns within the data. A theoretical thematic approach to the analysis was taken, in which the author's analytical interest in the field shaped this process. This process began with the author first familiarising themselves with the data, which required reading and re-reading the 10 studies, recording initial thoughts throughout. The emerging researcher then began identifying codes semantically, which meant that subsequent codes tended to be closely associated with the specific research questions. The author's decision to identify themes at a semantic level resulted in an initial surface level examination, followed by progression towards deeper interpretation and theorisation of such themes (Braun & Clarke, 2006). Following the establishment of codes, the author combined several relevant and suitable codes together to form a single theme. The applicable studies were then connected to this theme; notably, there was flexibility in this, where some studies were connected to several themes. For example, Dixon et al (2021) presented information and findings that suited three of the five themes. Once initially established, these themes were reviewed and refined to ensure a true reflection of the data was presented.

Based on the selected research studies, the researcher's knowledge and experience within the field, and the adoption of thematic analysis, four themes were selected and discussed further, and subsequently connected to an appropriate research question. They were fear and risk-based discourses, critical pedagogy, positive experiences and valuing of health education, and disparities in junior and senior health education student experiences. In separating the findings into themes, this review does not intend to construct unyielding division. Rather, these are intended to highlight the prominent and important findings in relation to secondary health education, whilst also acknowledging the interrelationships between many of the main findings and subsequent discussions.

### Findings and discussion

The research suggests several major themes relating to health education in secondary schools, each of which contributes to the illumination of deeper elements within the subject. Further elaboration and analysis of such themes present a disjointed perspective of health education and students' experiences within this subject.

### **Dominant pedagogies being utilised in secondary school health education**

The studies highlight two main discourses and pedagogies that shape the subject of Health. These include the presence of fear- and risk-based discourses and the support of critical pedagogy. Within Health classrooms of Aotearoa New Zealand, these discourses and pedagogies present a dilemma for kaiako in this space, who must endeavour to interpret and balance these within their everyday practices.

#### **Fear- and risk-based discourses**

The acknowledgement of fear and risk discourses within health education was a prevalent finding across several studies (Dixon et al., 2021; Leahy, 2014; Wright et al., 2018). Interestingly, each study applied a different perspective on the use and experience of risk discourses. For example, two Australian studies looked at how educators relate risk to the purpose of health education and positioned their role in aiding the mitigation of such risk (Leahy, 2014; Wright et al., 2018). In their study of risky and shameful pedagogies, Leahy (2014) indicates that risk plays a central role in the objectives of health education. The majority of interviews with Australian secondary health educators concluded that students and youth were established as “at risk” and vulnerable (Leahy, 2014). The list of potential “risks” young people face is rather lengthy and is often reflected in content and classroom practice where teachers dedicate large amounts of time to ensure this “vulnerability” is realised. Risks of obesity, sexually transmitted infections, drug use, teen pregnancy, and reduced mental health are often composed and taught with elements of risk, shame, and guilt.

Comparably, the Australian study by Wright et al. (2018) showed that preservice health and physical educators perceive their role as a mitigator of risk for their students in a similar light as practising teachers. These educators in this study presumed that through the education of risk, and establishing how this will impact students’ lives, they would make a positive difference. Despite being framed with positive intentions, this also reinforces that young people are “at risk” and need assistance by others to make healthy choices. Dixon et al.’s (2021) work presents a different perspective of risk pedagogies: a student perspective. They completed in-depth interviewing with 25 people within Aotearoa New Zealand who had completed health education to the end of Year 13. Admittedly, the participants acknowledge that senior, NCEA level health has limited experiences with risk discourses. However, the persistence of fear- and risk-based discourses in junior health education was evident, with one respondent acknowledging the discomfort and disturbing nature of both the content and approaches being taught, giving particular reference to the topic of STI education (Dixon et al., 2021). This particular student highlighted the use of disturbing images and intense feelings of discomfort through being subjected to this style of teaching. The direct negative impacts this had on this student and others within the Aotearoa study indicates the considerable immediate and long-term harm and danger these discourses promote. For health educators, this is a space where careful consideration of approach is required to ensure positive, authentic learning experiences.

This prevalence of fear-based approaches within health education highlights a slippage between policy and practice (Dixon & Robertson, 2022). Ultimately, the use of fear- and risk-based pedagogies contradict both the underlying concepts within the HPE Curriculum as well as the professional responsibility to learners within Aotearoa New Zealand’s teacher’s code of conduct (Education Council New Zealand, 2017; Ministry of Education, 2007). This disconnect between policy and practice undermines the commitment educators make to providing high quality and effective teaching experiences (Education Council New Zealand, 2017). The damaging implications that fear- and risk-based discourses inflict on learners undermines the goal of providing a safe and constructive learning environment. The establishment of fear- and risk-based pedagogies not only contribute to the reduction of students’ ability to learn such content, but also endangers their well-being as affirmed by the students’ experiences. Nevertheless, the limited cadre of research that focuses on what health education looks and feels like in schools, both within the Aotearoa context and beyond, restricts the ability to understand the full scope of these impacts.

### **Critical pedagogy**

A commonly supported pedagogical approach within health education is critical pedagogy. In the context of HPE, Fitzpatrick (2013) defined critical pedagogy as involving five key elements: building the environment, deconstructing power, playfulness, studying critical topics, and embodied criticality. Fitzpatrick's subsequent study of critical practice in the health education classroom defines and outlines classroom practices that reflect these elements of critical pedagogy in health education (Fitzpatrick & Allen, 2019). This ethnographic study followed the critical teaching practice of two health educators within two separate schools based in Aotearoa New Zealand and revealed similarities and differences in their application of critical pedagogy within the health classroom.

The two educators in Fitzpatrick and Allen's (2019) study utilised similar strategies to building the learning environment, including building relationships and getting to know learners beyond their "role" as students. The study also examined their different expressions of deconstructing power, including challenging gender stereotypes, racism, and school-imposed hierarchies, including the teacher student relationship (Fitzpatrick & Allen, 2019). One educator sought to deconstruct power through modelling openness and vulnerability, whilst the other teacher utilised enhanced student autonomy and leadership within classroom practices. The two participants within Fitzpatrick and Allen's (2019) research demonstrated inherently different forms of embodied criticality, a more complex feature of critical pedagogy, with strong consideration of the educator, their identity, and the conscious actions they implement (Fitzpatrick & Allen, 2019). One educator was praised for his passion for health but used language like "toughen up" and just "not be angry" which reinforces social norms. The other health educator also revealed contradictions in criticality. While the female teacher presided with the dominant stereotype of a white, female, cis-gendered health teacher, she also disrupted the "sporty" expectation, as she depicted a creative and arty persona (Fitzpatrick & Allen, 2019).

The activation of critical pedagogy enhances levels of criticality within learners. Dixon, et al.'s (2022) participants discussed this in great detail, with many commenting that health education allowed them to broaden their understanding of the "bigger picture". Additionally, the respondents credited health education with significant increases in their interpersonal skills and the impact this has had on relationship formation, and possibilities outside of education (Dixon et al., 2022). The critical awareness of personal perceptions, assumptions, bias, and questioning of commonly held beliefs in regard to health-related issues was also connected to the experiences of critical pedagogy with health education. One opposing Australian study revealed a separation between critical pedagogy in practising health and physical education teachers and preservice teachers (Fane & Schultz, 2017). Within their findings of preservice teachers' reflective writing, there were several contradictions which suggest a conflict between pedagogy and practice. Many of those interviewed sought to challenge traditional transmission methods, however, would revert back to "old ways" once it was discovered that this change was unsustainable (Fane & Schultz, 2017). Additionally, the perception of the teacher as the "arbiter" of good health and health knowledge suggests an uncritical and static pedagogical approach.

These findings from several studies suggest strong support and need for critical pedagogy and its continual use in health education, yet evidence of inconsistencies with its application are also apparent. Fitzpatrick and Allen's (2019) detailed and practical definition of critical pedagogy is a useful framework, providing tangible strategies for implementation; however, it also demonstrates certain complexities and dilemmas for educators. Critical pedagogy moves beyond the application of criticality within discussions and topics, and challenges educators and some of the key tenets of the teaching roles (Dixon, 2020). The relinquishment of "power" and control within the classroom, one of the defining elements of critical pedagogy, is rather removed from traditional, authoritative teaching styles. The uncertainties which arise through critical pedagogy, in regard to success or the attainment of knowledge, can be daunting for educators and can make the "traditional style" of teaching control more appealing. Additionally, the particular awareness of and reflection about one's own practice that critical pedagogy requires is rather confronting and can result in harsh conclusions about one's teaching (Larrivee, 2000). The potential for negative evaluations of one's teaching role, and the outcomes these inspire for

learners, requires resilience to shift teaching practice from differing approaches. This significant adaptation of practice uncovers certain barriers for educators and the implementation of such an effective pedagogy. Such barriers include limited time, support, professional knowledge, and development. Time and support for the transition is required in order to maximise the potential, and the longevity of the approach (Larrivee, 2000).

### ***Students' experiences of health education***

Several studies discussed the benefits and advantages students gain from their engagement in health education. Such benefits are associated with learning, as well as with character development. Alternatively, some research also argues that these benefits are not experienced by all who participate in health education. This inconsistency can be worrying, considering in many countries Health is a compulsory subject through to a certain year level.

### ***Benefits of health education***

A number of studies acknowledged the benefits of health education and the positive experiences that occurred for students (Chester et al., 2019; Dixon, et al., 2021; Hargreaves, 2013). When interviewing 25 students who had completed health education throughout their entire secondary school career in Aotearoa New Zealand, Dixon and colleagues (2021) noted many of the responses were positive. However, of significance is the linkage of such experiences to senior health education, rather than junior health education. Students highlighted that the autonomy and environment of health education were unique to other mainstream secondary classes. The capacity to choose meaningful and personalised topics, be actively involved, and interact with others in a respectful and safe environment fostered a space for significant learning opportunities and growth to occur (Dixon et al., 2021). A further favourable benefit of health education was the ability to connect with communities. A particular level two NCEA assessment was discussed by several participants, with many noting the powerful impact this had on not only their development as a learner but their development as a person. It is these experiences that promote skills and development, beyond classroom capabilities, that Chester et al. (2019) acknowledge and connect with health education. Respondents in their England-based study discuss an increase in both self-esteem and confidence. Additionally, increased pro social behaviour and decreases in antisocial behaviour, such as bullying and fighting, were also found to be shared benefits of health education. Ultimately, the majority of participants felt a positive impact of health education; however, it was discussed that a smaller minority of students did not share such impacts. This is supported by Hargreaves' (2013) Aotearoa based research, which revealed that a large portion, 71% of respondents, value the experiences, relevant learning opportunities, and "high achievement" that health education offers.

### ***Disparities in junior and senior health education student experiences***

One theme within the research articles that was less prevalent yet still of interest was the discrepancies between student experiences in junior health education and senior health education. Evidence suggests that experiences in junior health education seem to result in "negative" experiences, which removes opportunities for criticality, whilst senior health Education allows such criticality to flourish (Sinkinson & Burrows, 2011). Two studies documented this as a regular experience in health education, despite these studies being based in different countries with differing curriculum (Begoray et al., 2009; Dixon, et al., 2021). Student experiences in junior health education were often reported as "negative", with the critique of both the content and teaching approaches used. In their study of the Canadian student experience within a junior health programme, students reported that the content and topics covered in Health were not only repetitive and overly generalised, but also lacked relevant or personalised content (Begoray et al., 2009). Whilst these concerns regarding content were not echoed within their Aotearoa New Zealand study, Dixon et al. (2021) discovered mutual student concern for the pedagogical approaches used within junior health education. In their study, students reported reduced interactions

in junior health, alongside a routinely used didactic teaching style (Dixon et al., 2021). Similarly, in a Canadian study, students strongly felt that the transmissive model dominantly utilised within junior health consequently resulted in their passive role as a learner, as well as “boring” experiences (Begoraty et al., 2009). Interestingly, for those students who do continue health education within senior levels, their experiences contradict those within junior health (Dixon et al., 2021). Within senior health education, a more critical pedagogical approach is utilised and realised, with many respondents appreciating the “freedom” of content, the reciprocal learning relationship between teacher and learner, and the ability to analyse issues more deeply and question the status quo (Dixon et al., 2021).

It is disheartening, that many junior students may “miss out” on the opportunity to experience the potential and opportunities of health education. These less beneficial learning experiences can result in an unsatisfactory experience in junior health, consequently leading to a significant decrease in students pursuing health education beyond junior years. Such diminished experiences of compulsory junior health may be linked to the lessened status of health education when compared to other subjects within high school curricula (Sinkinson & Burrows, 2011). Connecting this to Hargreaves’ (2013) study, despite the majority of students valuing health education, importantly, there was a large portion who did not. Interestingly, this study found that it was not just students that perceived health education to be a minor or unimportant subject: 44.4% of educators and 45.7% of senior management also held this viewpoint (Hargreaves, 2013). Such negative perceptions of health education by a considerable number of educators could potentially undermine students valuing and appreciating health education. This lack of recognition from staff is concerning, given the vast potential of health education, and the impacts it can have for learners.

### **Implications**

The findings, and subsequent discussions of this review, solidify the challenging and messy nature of health education. The fluidity of health curricula can be considered both a blessing and a difficulty for health educators, resulting in inconsistencies and contradictions within practice. To navigate this, educators need to place importance on not only what is being taught, but how it is being taught (Fane & Schultz, 2017). Consideration, and the challenging of one’s practice requires a certain level of vulnerability and discomfort to be explored, before sustainable changes to teaching practice can become embedded. Such awareness of both content and pedagogical approaches requires reflective criticality. As described by Larrivee (2000), such critical reflection is not a linear process, nor can it be prescribed. It is a cyclical process, in which the individual consciously and continuously challenges and questions their underlying beliefs, assumptions, and prior experiences that motivate their behaviours and practices as an educator. This reflection is often coupled with confusion and uncertainty; nevertheless, it is necessary to initiate greater development. The enactment of such critical awareness can be difficult; however, effective implementation will allow for growth as an educator and also inspire learning for students.

The health educator in Aotearoa New Zealand is uniquely placed in the sense that generally, they must also “fit” and perform the role of a physical education teacher. This dual role requires the health and physical educator to balance and negotiate tensions and competing discourses. Sinkinson and Burrows (2011) comment on how this negotiation can be extremely challenging and how often physical education, including its discourses and priorities, is usually placed “first”. The utilisation of critical reflection is crucial here, as the educator must consider the impacts of their own unconscious bias and preference towards physical education as a subject.

Further contribution to the limited body of research in the field of health education, particularly within the Aotearoa New Zealand context, would help support positive and sustainable changes within health educators teaching practice. Evidently, the literature on health education in secondary schooling contexts is still developing, which places restrictions on possibilities for challenge and change. With relevant and timely research being constructed and critiqued within the health education field, this may facilitate ongoing professional development and growth for teachers’ practice “on the ground”.

Of the limited research available for this literature review, noticeably two made connections to preservice health educators and gaps within their experiences (Fane & Schultz, 2017; Wright et al., 2018). Beginning health teachers are predominantly reinforcing passive forms of teaching practice. Such legacies are not beneficial for teachers or learners and only serve to continue an outdated view of health, and non-inclusive pedagogies. To support health educators in their developing practice, the role of teacher education in initialising socio critical and reflective practice from the outset is vital. The installation of these innovative and effective pedagogies within teacher education stages may result in the increased adoption and sustainment within full time teaching practice. If critical pedagogies are made more accessible—in the sense that preservice teachers see and feel how such frameworks are implemented within tertiary education—such connection to one’s own learning can increase the likelihood of an adoption within their teaching philosophy. Exiting preservice teachers will enter the profession with an enhanced view and criticality above existing graduate teachers. Furthermore, the potential repercussions this has on their students will invoke exciting and inclusive learning opportunities.

## Conclusion

Whilst there have been some considerable and important contributions to the health education field, research within secondary schools in Aotearoa New Zealand remains restricted. Nevertheless, new frameworks and curriculum updates are supporting health educators to promote effective and beneficial learning experiences within school health. This review suggests that such positive experiences and advancements in learning are achievable, with the adoption of critical pedagogy. Critical pedagogy, as described by Fitzpatrick and Allen (2019), allows educators to approach and implement strategies to positively shift their pedagogy. The consideration of five holistic elements allows several areas of teaching practice and identity to be explored and critiqued.

Data from this review revealed triumphs and tensions within health education, as well as particular challenges for health educators. The intention of this review is to inspire discussion among teachers of health education in secondary schools, and to invite increased awareness and judgement of their practices. It is clear that there are some firmly embedded practices in health education, such as risk pedagogies. It is these practices that teachers must battle with and balance, in order to create enhanced learning experiences and learning environments for all students.

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