Health education in schools—from information to empowerment models

CURT HAGQUIST and BENGT STARRIN
Centre for Public Health Research, County Council of Värmland, Sweden

SUMMARY

School is considered to be a very important arena for health education among children and adolescents. Within the field of health education in school, there are nowadays manifold methods, models and directions. A typology of different models for health education in schools is accounted for in this article. The typology is built up partly from the strategy for change—top-down or bottom-up—which is characterized by health education, and partly from the contextual framework—narrow or wide—within which health education is carried on. In this way, four different main types of models can be perceived. (i) Traditional educational models which are characterized by a top-down strategy for change and a narrow contextual framework. These models are mainly practised in the classroom. (ii) Modern educational models which are characterized by a bottom-up strategy for change and a narrow contextual framework. In these models the pupils take an active part. These models are mainly practised in the classroom. (iii) Planner models which are characterized by a top-down strategy for change and a wide contextual framework. In these models the entire school, and sometimes also the community outside, is included in health education. The models are often characterized by being health work for, rather than with and by, pupils, even if pupil participation is sometimes focused. (iv) Empowerment models which are characterized by a bottom-up strategy for change and a wide contextual framework. In these models participant-orientation is essential and the school environment and social conditions are considered to be important for health education. Empowerment models can partly be seen as an answer to the criticism of principle that health education is traditionally being subjected to as regards aim, direction and contents. In this paper, empowerment models are described and discussed, as a suggestion as to how school pupils can be enabled to participate in a programme of change concerning both lifestyles and environment.

Key words: empowerment; health education; schools; youth

INTRODUCTION

Health education among children and young persons in particular has been given high priority in many industrialized countries, concentrating on health-related behaviours such as smoking and the consumption of alcohol. This concentration seems to be based on more general impressions that adolescence is important in determining the future health of the individual (Hurrelmann et al., 1995), on the impression that many adult habits are established during the years of growing up (Smith et al., 1992) and on the fact that it is better to try to prevent health-damaging behaviour at an early age than to be forced later to attempt to modify an already established habit (Alexander, 1994).

Schools are regarded as constituting a very important arena for health education among children and young persons. Apparently factual, objective and unquestionable potentials of schools are often put forward, such as the ability to reach young persons on a large scale (Hansen, 1992, 1993; Rudd and Chapman Walsh, 1993).
However, critical voices have also been raised against imposing too many duties on schools in respect of preventive and health education work (Hurrelmann et al., 1995). Criticism and questioning includes the classic problem concerning the relationship between schools’ more traditional duties of providing knowledge and education on the one hand, and their responsibility for health and social training on the other. However, one main message from a review of 25 American reports is that education and health are mutually related (Lavin et al., 1992).

Nowadays, the area of health education in schools comprises a multiplicity of specific methods, models and directions. Attempts have been made to distinguish between different models (see, for example, Rundall and Bruvold, 1988). However, it is not easy to provide a picture of the combined efforts that have been made within the field of health education among children and young persons—not, in any case, if such an overall assessment is to be based on documented empirical material. This is because only a small part of all the work and projects that have been carried out in this area has been systematically evaluated (WHO, 1992; Durlak, 1995). While noting this, it is important to point out that research into prevention programmes in schools has expanded substantially since the 1960s (Durlak, 1995).

The objective of this paper is to examine various health education programmes and to describe similarities and dissimilarities between them in order to discover prominent characteristics and patterns.

We will use ‘health education’ as a sensitizing concept (Blumer, 1954) including a variety of preventive or promotive work that takes place in school.

## HEALTH EDUCATION IN SCHOOLS—A TYPOLOGY

The empirical material that serves as the basis for the analysis of various methods and models in this paper consists of a number of different texts on health education in schools. These texts have been analysed in a manner similar to that used in grounded theory (Glaser, 1978). Various perspectives and approaches have been coded, classified and compared. As a result, two main categories emerged. The first is the strategy for change (top-down or bottom-up) that characterizes health education. The second is the contextual framework (narrow or wide) within which health education is practised. By combining these two dimensions, the number of models of health education in schools can be reduced to four main types.

Figure 1 shows a typology in which various models of health education in schools can be placed. Certain existing concrete methods and models of health education in schools can easily be assigned to one of the four ‘boxes’ of the typology, while others are on a boundary or can

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**Fig. 1:** Models for health education in schools—a typology.
be assigned to several boxes. Certain models are mutually exclusive, while others are complementary and yet others are nested models, i.e. they form a constituent model within a larger model.

**Traditional educational models**

Traditional educational models are characterized by a top-down strategy for change and a narrow contextual framework. Historically, health education in schools has been operated in a very similar manner to that of traditional school teaching. It has long been based, too, on direct dissemination of knowledge, on the assumption that, if they were given the facts, pupils would make rational decisions. These traditional educational models have been practised mainly in the classroom and with the pupils mostly being passive recipients of information. The models are characterized by individualization and concentration on health-related behaviour.

These models have been gradually modified in the light of experience, with changed attitudes being seen as an intermediate ‘variable’ between the provision of facts and behavioural modification (see, for example, Rundall and Bruvold, 1988; Hamburg, 1993, Durlak, 1995).

**Modern educational models**

Modern educational models are characterized by a bottom-up strategy for change and a narrow contextual framework. Increasingly, rational teaching models have been replaced by more innovative models, often strongly behaviourally and socio-psychologically based. In contrast to traditional educational models, in these modern educational models, the pupils are active participants. However, as with traditional models, these models are also mainly applied in classrooms. The modern educational models are characterized by both individual centring and (colleague) group focusing. Social skills, resistance skills and general skills are addressed. Social learning theories, for example, now characterize many of the new approaches and methods of working that have become accepted in health education in schools. These models have concentrated on factors that influence behaviour, rather than on the behaviour itself. Within this group of more innovative models, there are many different programme directions. However, there are two main types of programmes that can be distinguished: affective programmes that aim to encourage emotional development and create social competence; and social influence programmes that attempt to provide the skills needed to meet concrete situations. The affective training group includes programmes that incorporate value-clarification, goal-setting, decision-making, self-esteem building and stress management. The social influence group includes programmes that cover resistance skills, life skills and normative beliefs (Hansen, 1993).

Resistance skill training programmes, for example, concentrate on teaching how to resist peer pressure to drink alcohol (specific peer and social resistance skills). These resistance or refusal skills programmes attempt to develop the child’s self-awareness and communication ability. Practical exercises, such as role-playing, are common in connection with this type of skill training. Programmes that concentrate on what are known as normative beliefs also belong to this type of prevention programme based on strategies for social influence.

Although the innovative programmes differ considerably in form and content from the traditional knowledge-transferring models, they are also a form of educational programme within the framework of a curriculum. See, for example, Rundall and Bruvold (1988), Bremberg (1990), Hansen (1993) and Durlak (1995) for descriptions and definitions of various modern educational methods.

**Planner models**

Planner models are characterized by a top-down strategy for change and a wide contextual framework. Over the years, the arena of health work in schools has tended to become considerably larger. In planner models the entire school, and sometimes also the surrounding community/society, is involved in health education. Although the importance of pupil participation is emphasized, these planner models are characterized primarily by the fact that they are run for, rather than with and by, the pupils. These models concentrate on both the individual and the environment.

What are known in the USA as ‘comprehensive' models seem mainly to belong to the group which, in this paper, is referred to as planner models. The concept of comprehensive health programmes was originally launched by Allensworth and Kolbe during the 1980s. Their model complemented the three ‘traditional’ elements of school health programmes—school health services, school health education and school health environment (Allensworth and Kolbe, 1987). The most important changes in principle were presumably the link to the surrounding
The more authoritative definitions of comprehensive school health programmes include that produced by the 1990 Joint Committee on Health Education Terminology (1991), and with which the American School Health Association (ASHA) associated itself (ASHA, 1994). Pupil involvement, participant orientation or empowerment are not mentioned in the above American definition of comprehensive school health education. The absence of concepts such as empowerment and participant orientation from the American definition does not mean that matters relating to the role, position or influence of pupils in comprehensive school education are ignored by the American programmes (see, for example, ASHA, 1994). In our opinion, this authoritative American definition should be seen primarily as a reflection of the fact that considerations and perspectives other than participant orientation and empowerment have been at the centre of the American debate on comprehensive school health education. More ‘traditional’ matters, such as programme management and leadership of local health programmes, for example, seem to have been given greater attention (see, for example, Davis and Allensworth, 1994). The concentration on, and views of, leadership aspects is illustrated by a recent paper by Resnicow and Allensworth (1996). Against the background of a description of the part played by a conductor of an orchestra, they argue strongly for the need for school health coordinators.

Starting in the 1980s, health education in schools changed also in many European countries. A new model of health education, known as the health-promoting school (Farley, 1991; Nutbeam, 1992; Smith et al., 1992), and having its roots in the UK, gradually achieved increasingly widespread acceptance. This model is supported by the concepts of school curriculum, school environment and community outreach, and has been described as a model that ‘balances the effort and attention given to curriculum development and classroom teaching, with action directed toward improving the school environment and improving links with the family and the wider community’ (Smith et al., 1992, p. 172). These ideas also serve as the basis for The European Networks of Health-promoting Schools, a project centred on such schools in a large number of European countries (WHO/CE/CEC, 1993). The programme presentation for the Health-promoting Schools project does not include concepts such as participation and empowerment (WHO/CE/CEC, 1993). In practice, rather substantial differences in the models for Health-promoting Schools can occur, not least to the extent of action-orientation.

### Empowerment models

Empowerment models are characterized by a bottom-up strategy for change and a wide contextual framework. There is still a lack of good examples of ground-breaking projects, not least among those with marked bottom-up perspectives. However, ‘empowerment’ constitutes a cornerstone of some of the more ground-breaking health projects (see, for example, Moon, 1991). In empowerment models, participant orientation is a basic prerequisite of health work. The school and local environments are also regarded as important elements of health education.

To some extent, empowerment models can be seen as an expression of a search for more successful methods of health education in schools. Within health education among children and young persons, the empowerment perspective can also be seen as a reaction to the adult perspective that has previously been predominant— to the benefit of a view based on empowerment in which children are seen as partners in health education work. This view means that children are regarded as being capable of representing themselves, making decisions concerning their health and participating in health care work (Kalnins et al., 1992).

### Empowerment as a concept

The concept of empowerment has been freely used in discussions on how the influence of vulnerable groups can be increased. In the scientific literature, it started to be used in connection with discussions of local development, activism and mobilization at the end of the 1970s. The concept of empowerment has become increasingly taken up in areas far from the social field. An example of this is to be found in the inclusion of the empowerment concept in management and organizational literature. In the USA, empowerment has become something of a 1990s catchword (Shannon, 1991).

Empowerment is a complex concept which contains many dimensions and aspects within itself (see, for example, Rappaport, 1987; Swift and Levin, 1987). To some extent, this is also
reflected by the fact that the concept is given varying definitions in dictionaries.

A number of attempts have been made to clarify the concept of the various dimensions contained within the empowerment concept. Empowerment can be seen as a relational concept in its meaning of giving power and authority to a person (Conger and Kanungo, 1988). In this meaning, empowerment is concerned primarily with a redistribution of resources and power. On the other hand, in its meaning of enablement, empowerment can be seen as a motivational concept (Conger and Kanungo, 1988). As such, the concept refers most closely to individuals’ need of such matters as self-determination. In an attempt further to qualify the concept discussion, Rissel (1994) has employed not only the concept of psychological empowerment but also that of community empowerment. The latter concept includes increased psychological empowerment, but also political actions with active participation, together with the redistribution of resources or decision-making that is of benefit to the local community or to the group affected (Rissel, 1994).

The distinction between psychological empowerment and community empowerment means that empowerment can be regarded both as an expanding phenomenon and as a way of fairly distributing limited resources. Greater psychological empowerment for one individual need not be at the expense of another individual. However, in principle, as community empowerment is concerned with redistribution of limited resources, a greater degree of empowerment for certain individuals represents a reduction for others.

Children, youth and empowerment

Originally, empowerment was developed as a framework approach for work among adults (Gibson, 1993). For a long time, the application of empowerment to children was conspicuous by its absence from the literature (Hegar, 1989). The concept of empowerment has started to be used both in literature on health education work in general and in more specific discussions on health education work among children and young persons (see, for example, Kalnins et al., 1992). In certain respects, children and young persons have been regarded as being in the same situation as other disempowered groups (Hegar, 1989), characterized by lack of experience, economic vulnerability and helplessness (Gibson, 1993). However, seen from an empowerment perspective, children’s situation is double-bottomed. While, on the one hand, there is a clear lack of empowerment, there are also major obstacles in the way of any change of the situation (Rissel, 1994). However, in certain respects, children differ from other disempowered groups: powerlessness, for example, is only a temporary condition for many children, and one which will improve as they grow up (Hegar, 1989). On the other hand, certain children can be doubly disempowered, as is the case when they also belong to some stigmatized group (Hegar, 1989). However, limitations of application of the empowerment model among children and young persons have also been discussed, for example from the point of view that they, as non-adults, are not always sufficiently mature to be able to decide what is best for themselves (Gibson, 1993).

An important aspect of empowerment among children and young persons is concerned with the relationship between them and adults, as this relationship can hardly be regarded as equal. Reservations have been expressed about the concept of youth empowerment, as it can be interpreted as meaning that well-intentioned adults can empower powerless youngsters. However, this cannot be done, any more than white persons can empower black or men can empower women (Hefner, 1988). Although empowerment is concerned with self-activity, adults can contribute by shaping and structuring experience in such a way as to assist young people in empowering themselves (Hefner, 1988). By creating supporting structures, efforts towards greater empowerment among children can be encouraged (Rissel, 1994).

Supportive environments—the key role of the school climate

The structural factors and local conditions in a school and the surrounding community are of importance for any local health work or programme in a school. Supportive environments are something of a key concept for both individual and collective change processes (see WHO/UNEP, 1991; Wilson et al., 1991, for a review of the concept). The current school climate and the existing school culture can be regarded as aspects of this concept, which determines the conditions for participant-orientated and empowerment-based health education in the schools (for a presentation of the concepts of school climate and school culture see, for example, Tagiuri, 1968; Insel and Moos, 1974; Moos, 1979; Anderson, 1982; Hoy et al., 1991). For example, a concrete
example could be the attitude of the local school management to pupil participation and influence in the school.

The part played by the school climate has been noted particularly in connection with school effectiveness, as well as in connection with health education. The starting point has been that it is not only the formal curriculum that is of importance for the pupils’ health and factors relating to health promotion, but also that the factors, attitudes, values, etc. that are present in the school as a whole play an important part. This phenomenon has sometimes been referred to as the ‘hidden curriculum’ (Nutbeam, 1992; Anderson, 1995). In practice, the school climate is concerned with the basic conditions necessary in order to be able to operate a successful health education programme. At a teachers’ conference in Eindhoven in 1990, this was expressed as ‘A bad school climate blocks any improvement of school’ (Jasper, 1991, p. 109).

**Empowerment models in schools—some basic features**

A feature of empowerment models is that they presuppose mobilization of persons. This means, taking an example from schools, that active participation is required on the part of the pupils if the school environment in its entirety is to be improved. The whole point is that, in such cases, there must be joint action from the pupils, as that of an individual pupil alone is insufficient. Such collective mobilization is facilitated if it is concerned with local matters such as the pupils’ own school environment. Development work must be directed by the participants: this means that those affected by it must actively be given the opportunities to participate in and control the work. It also means that the participants must be enabled actively to participate in the production of the necessary knowledge in order to enable changes efficiently to be introduced. Participant orientation is also important, as it facilitates the learning processes. The objective is to strengthen and develop the individuals’ own capabilities, which is one of the ingredients of empowerment (for a presentation of participatory research in health promotion, see Green et al., 1995).

The basic idea for a sketch of a model should be that all those involved in the school should actively participate in all the stages of the local work of change, constantly maintaining a democratic dialogue with each other. Teachers and other staff can play the role of facilitators of the empowerment process among the pupils. The starting point is pupils’ participation in identifying problems and needs. Subsequent steps are aimed at investigation and analysis, preparing a proposal for change, formulating an action programme and implementing changes. In the final stage pupils, teachers and others should jointly monitor what has actually resulted from the work.

**CONCLUSIONS**

In a historic perspective, health education in schools seems to have undergone major changes. On the whole, the development of new aspects, theories and methods of health education in schools has seemed to have followed two parallel but partly overlapping lines of development: a dominant line, with a wider perspective and placing the individual in a social context; and another that has meant that the participation and influence of school pupils and other persons has begun to be regarded seriously. By combining the contextual framework and the strategy for change, four different main types of models can be perceived.

In particular, this paper has focused on empowerment models. The empowerment strategy probably has a considerable potential in health education in schools, as it is characterized by a bottom-up perspective and a wide contextual framework.

However, the empirical base advocating empowerment models is less strong than the theoretical base. First, even the best evaluations of health programmes among adolescents seem to have paid too little attention to issues concerning the actual implementation of the programmes (see Cook et al., 1993). Second, little seems to have been done in an attempt to operationalize the concept of empowerment per se. It seems that not until recent years have empowerment evaluation and measurement issues attracted real attention.

In addition, as with all models that are in fashion, empowerment models can easily come to be regarded as a universal panacea, a previously unknown cure prescribed for this, that and the other, when needed and when not needed. Although the concept of empowerment as such is relatively new, it incorporates old ingredients such as participation and mobilization.

The vagueness of the empowerment concept,
and its lack of a consistent definition, also represent a risk of empowerment being interpreted rather too freely. The perspective within which it is viewed can also be displaced, as has occurred in the management sector—from fair and individual rights to how organizations can be made more efficient (Matthes, 1992). If transferred to health education in schools, empowerment in this meaning could also become a part of top-down models. Another related question is whether empowerment can be utilized for manipulative ends, for example in situations with decentralized and delegated decision-making. In a formal meaning, pupils and teachers can be given quite a lot on which to state their views, while at the same time their actual room for manoeuvre is strongly curtailed by limited resources and other conditions. The risk of manipulation is particularly great if efforts towards empowerment are limited to creating a feeling of participation and influence, instead of a feeling of influence, as well as actual influence and actual participation. Put in another way, there can be a real risk of empowerment not relating to a community but only to individuals. However, the risks related to empowerment models do not justify turning our back on them.

Address for correspondence:
Curt Hagquist
Centre for Public Health Research
PO Box 9104
S-65009 Karlstad
Sweden

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