EDITORIAL

Reveille for Radicals!
The paramount purpose of health education?

In 1993, I was moved to write an Editorial on ‘Radicalism in health promotion’ (Tones, 1993). This inclination was triggered by an item provided by the International People’s Health Council (IPHC) which appeared in the News section of that same issue. Its analysis of health and inequity provides a challenge for health education.

The policies of today’s dominant power structures—tied as they are to powerful economic interests—have done much to precipitate and worsen humanity’s present social, economic, environmental and health crisis. Those who prosper from unfair social structures are resistant to change. They also have vast power and global reach. So today, changes leading toward a healthier world order must be spearheaded through a world-wide grassroots movement that is strong and well-coordinated enough so it can force the dominant power structures to listen and finally to yield. (p. 297)

Since that time, WHO and other key institutions and individuals have continued to emphasize the importance of the social and environmental determinants of health. Consequently nations have been exhorted to address problems of inequality and adopt policies that foster equity. The 51st World Health Assembly passed a major Resolution on Health Promotion urging member states to adopt a raft of libertarian and empowering measures to implement the many and various declarations formulated by WHO—including the most recent Jakarta Declaration for Health Promotion in the 21st Century (WHO, 1997, 1998). Yet inequalities in health between rich and poor still exist, and, in many cases, have increased.

This Editorial will suggest that the definition and purpose of Health Education should be convincingly ‘re-framed’, and its contribution to Health Promotion re-assessed and re-vitalized. This latter task is becoming especially important as terminological and conceptual confusions over the definition of health promotion and its relationship with public health have, if anything, become more rather than less convoluted [(Tones and Tilford, 2001), pp. vii–ix)].

Defining health education

Health Promotion is a synergistic combination of Health Education and ‘Healthy Public Policy’. My concern here is primarily with the nature of the contribution of health education to policy implementation. Unlike health promotion, it is not difficult to provide an uncontroversial definition—as follows.

Health education is any intentional activity that is designed to achieve health or illness related learning, i.e. some relatively permanent change in an individual’s capability or disposition. Effective health education may, thus, produce changes in knowledge and understanding or ways of thinking; it may influence or clarify values; it may bring about some shift in belief or attitude; it may facilitate the acquisition of skills; it may even effect changes in behaviour or lifestyle. [(Tones and Tilford, 2001), p. 30]

Clearly, this is a ‘technical’ definition—which is why it is relatively unproblematic. Debate and disagreement is immediately generated, however, when we ask about the purpose of health education.

In other words, when we ask what particular kinds of learning are appropriate and ethical. The debate about education in general has a long history and pertains equally to discussion of health education. In short, educational philosophy has often declared that ‘true’ education must have the following two key characteristics:

- It must be ‘voluntaristic’: it must respect and contribute to the learner’s autonomy.
- Its ‘teaching’ methods and their outcomes must be ethically and morally sound; so, training people to kill or, less dramatically, to lie and cheat would not be considered educational!

Accordingly, the use of techniques such as indoctrination, or even persuasion, is not acceptable. The purpose of education should not primarily be
to change behaviour. It should be concerned to create understanding (as opposed to rote learning). It should provide skills to help the learner make ‘rational’ decisions. It might also be expected to help people clarify their values to assist in voluntaristic decision making.

Following this ethical formulation, the traditional ‘preventive model’ of health education would not be true education—since it frequently uses persuasion to coerce individuals into adopting ‘medically approved’ behaviours. Moreover, it has often been decidedly economical with the truth, e.g. by conveniently ignoring those major social, economic, environmental and political factors that determine health and illness. It is not surprising that it has been derided as ‘victim blaming’ (and, arguably, marginalized in the years following the publication of the Ottawa Charter!).

**Limitations of an ‘educational model’: the need for critical health education**

It must, of course, be concluded that a model based on the kind of philosophy mentioned above is without fault. Those espousing a preventive approach would (rightly) criticize ‘pure’ education as ineffectual since it is improbable that it would result in desirable behaviour change. Of more importance to the present debate is the fact that ‘pure’ education will not generate the kinds of public pressure and political action that is central to the process of creating and rallying radicals!

The term ‘critical education’ has been used in this Editorial to provide a linguistic and conceptual link with ‘critical theory’ in general, and, more specifically, with ‘critical research methodology’ [see, e.g. (Connelly, 2001)]. The factor common to these various ‘critical’ initiatives is a conviction that the purpose of the interventions in question should be to generate change (typically social and political change) not merely academic knowledge.

The first point worthy of note is that critical health education is not merely concerned with values clarification: it is rather concerned with ‘values development by design”—to borrow a term from Dalis and Strasser (Dalis and Strasser, 1981). It is acceptable and indeed desirable to ‘clarify’ values associated with ‘controversial issues’ (although the definition of controversy is inevitably socially constructed). On the other hand, health education should be clearly committed to actively prosecute certain values. For instance, it is not acceptable to politely and diffidently skirt around health issues on the grounds that different ethnic and cultural values must be revered. Of course, diversity should be respected, but the value of tolerance must be subservient to more urgent moral imperatives. Some ideologies, doctrines, social norms and practices are intrinsically unhealthy, and should not be tolerated. For instance, WHO has, over many years, stated unequivocally that democracy and equity are fundamental values. By definition these are global guidelines for what is or is not acceptable. Thus the oppression of women, for example, is unhealthy and unacceptable along with specific practices such as genital mutilation. These cannot be regarded as quaint and peculiar cultural quirks: they are actually wrong!

**Strategies for action**

Despite changes in nomenclature, critical education has a venerable tradition. It has, for example, been central to heated debates about the nature and purpose of school curricula. The notion of the school as a coercive socialization agency has often been challenged. For instance, Postman and Weingartner asserted that teaching should routinely be a ‘subversive activity’ and the curriculum, among other things, should serve the highly important purpose of ‘crap detecting’ (Postman and Weingartner, 1969/1981)! The similarities between the following quotation and the IPHC declaration cited above will hopefully be apparent.

In our society, as in others, we find that there are influential men at the head of important institutions who cannot afford to be found wrong, who find change inconvenient, perhaps intolerable, and who have financial or political interests they must conserve at any cost. Such men are, therefore, threatened in many respects by the theory of the democratic process...[There are also] obscure men who do not head important institutions who are similarly threatened...
because they have identified themselves with certain ideas and institutions which they wish to keep free from either criticism or change.

(p. 15)

The school is but one setting in which critical health education should operate. The following contexts and strategies have frequently been associated with radical-political goals.

Critical consciousness raising

The socio-political concerns and methodology of Freire are well known and have been influential for those committed to developing radical programmes. The driving force of the Freierean principle is *praxis*—the translation of reflection into action. Its goal is the empowerment of disadvantaged individuals and communities.

Health skills and action competences

Various curriculum programmes have been developed—primarily for schools—which aim to provide clusters of skills which are designed to be empowering. The terms life and health skills embrace a variety of competences—some more radical than others! They are, however, all characterized by the belief that knowledge alone is rarely sufficient to achieve action. Of particular importance to the present discussion is the group of social interaction skills associated with assertiveness and with the provision of competences to help people work in groups and organize for political action. The term *action competence* has been extensively developed in Denmark—which was responsible in 1969 for the production of a radical handbook for school pupils, *The Little Red School Book* (Hansen and Jensen, 1971)! Schnack provides a valuable review of action competences in the context of health and environmental education (Schnack, 2000).

Media advocacy

Public Health Advocacy has been viewed as one of the most significant components of health promotion since it first achieved wider acclaim in the Ottawa Charter. Its general principles and ideology are fully illustrated—and operationalized—by Chapman and Lupton (Chapman and Lupton, 1994). Central to Chapman and Lupton’s formulation is the use of media advocacy, i.e. the use of mass media as a means of critical consciousness raising in pursuit of social and political change. A flavour of the origins of this approach is provided in Chapman’s Preface to the book.

We were a handful of earnest idealists just spitting into the wind of the real determinants of drunk driving, diazepam dependency, and teenage cigarette use. Whatever aggregated little gains we might have made in changing community knowledge and attitudes, these were swamped day after day by major structural determinants of drug and alcohol abuse such as price, licensing policy, and especially the promotional activities of the tobacco and alcohol industries. Together with a few equally disillusioned colleagues, I helped form a pressure group in 1978 called MOP UP (Movement Opposed to the Promotion of Unhealthy Products).

Health education, as defined earlier, is located in the ‘A to Z’ of largely subversive techniques listed by Chapman and Lupton. The fact that it can be successful in achieving its radical goals is illustrated by the success of MOP UP in influencing policies. Indeed, its successor BUGA UP (Billboard Utilising Graffiti Artists Against Unhealthy Products) made a major contribution to achieving the banning of tobacco advertising in Australia.

Dilemmas and paradoxes and the conditions for learning

I have little doubt that the kinds of radical health education incorporated in the strategies mentioned above can achieve success. However, this will only happen if Gagne’s precepts for achieving successful learning are not ignored (Gagne, 1985). Those precepts are to ensure that the appropriate conditions for different kinds of learning are provided. For instance, the proper use of Freirean consciousness-raising techniques involves the employment of counselling skills by the community activist or change agent in addition to using appro-
appropriate learning resources such as video to trigger reflection on social and environmental conditions (Figure 1). Less obviously perhaps is the importance of providing appropriate lifeskills/action competences to increase the likelihood of radical community initiatives achieving success. It may
also be necessary to create a ‘community coalition’
of the great, the good—and the powerful—to avoid
failure and demoralization.

Even where appropriate conditions have been
met, critical health education must address a num-
ber of dilemmas. For instance, the prime goal
of health promotion is one of empowerment. Em-
powerment involves removing social and
environmental barriers that limit freedom to act.
However, many policies measures, e.g. many fiscal
and legal measures, actually limit choice to adopt
what authorities consider as unhealthy behaviour.

Does the process of ‘re-framing’ health issues
as advocated by Chapman and colleagues actually
militate against the principle of voluntarism. Does
it involve persuasion and attitude change rather
than empowerment?

Again, educationists are suspicious of persua-
dion and attitude change measures and urge the use
of empowering techniques. However, are these
measures acceptable when health educators seek
to influence anti-health groups and politicians?

Critical research and evaluation

A final observation about critical health education/
promotion concerns the evaluation methods that
should be used to assess success. In short, given
the value attached by critical health promotion to
client empowerment and social change, traditional
research methods are frequently irrelevant and
inappropriate. The notion of catalytic validity, i.e.
that the research process itself should contribute
to desirable outcomes, should be central to the
radical research agenda. Accordingly, while partici-
patory research is highly desirable, the random-
ized control trial is rarely relevant (Green and
Tones, 2000). Action research is especially impor-
tant to the ideology and practice of critical health
education and should be routinely employed. Emancipatory Action Research has particular
relevance ([Tones and Tilford, 2001], p. 176). Its
main radical and empowering features are:

- Collaborative process between project and
evaluator.
- Responsibilities shared between participants.
- Improvement and development of practice.
- Involves a shared radical consciousness.
- Focused on transformation of organizations.

In conclusion, if health education is to maintain
its integrity and contribute maximally to the radical
goals of health promotion, serious consideration
should be given to consolidating the paradigm
shift from victim blaming to emancipation for
empowerment.

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