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Ecological and political economy lenses for school health education: a critical pedagogy shift

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Abstract

Purpose – The purpose of this paper is to critically examine school health education in the USA and present alternative approaches for more critical and comprehensive health education.

Design/methodology/approach – An ecological model framework is used to identify the limitations and opportunities for improvement in school health education in the USA. An argument is made for school health education that embraces ecological approaches, political economy theory, and critical pedagogies.

Findings – US schools have been tasked with providing health education that is primarily rooted in individualistic approaches. Often missing from this education is recognition of the social and structural determinants of health that greatly influence one's ability to practice the health behaviors promoted in schools. This raises pedagogical and ethical concerns, which can be addressed by teaching health education that is grounded in ecological and political economy understandings of health and in critical pedagogies that allow students to more comprehensively and accurately understand health, how their worlds influence health, and their agency within those worlds.

Practical implications – This paper offers justification for a critical model of school health education and for the professional preparation of school health educators that is grounded in critical pedagogy and ecological approaches.

Originality/value – This work complements other research on critical health education by adding explicit integration of the ecological model and the political economy theory within critical pedagogies.

Keywords Teaching, USA, Educational practice, Health education, Schools, Social change

Paper type Conceptual paper

Introduction

Schools carry a particular role in supporting child and adolescent health across the USA. As described in Gard and Pluim's (2014) critical history of US school health education, schools have long been used as instruments for public health interventions that are focused on individual behavior change. Schools are tasked with addressing complex health and social problems that get reduced to individual behaviors. Today, we have school health education curricula focused on decreasing rates of, for example, smoking, drug use, obesity, and pregnancy – and primarily through behavior change strategies. School health education is ripe for critical exploration that reconsiders what we are teaching students about health. More specifically, how might we best teach students to think critically about the complexities of health and all that influences health outcomes?

This paper approaches these critical questions using the lens of an ecological model to identify the opportunities for improvement in US school health education. We propose that school health educators integrate the ecological model, political economy theory, and critical pedagogies so that students learn about the complex interactions between structural, social, and individual influences on health. Also, we consider how to prepare school health education teachers to teach in ways that support this kind of learning about health.

Using an ecological model

An ecological model allows for more critical approaches to health that go beyond superficial understandings of individual behavior as being the sole determinant of health (see Figure 1).
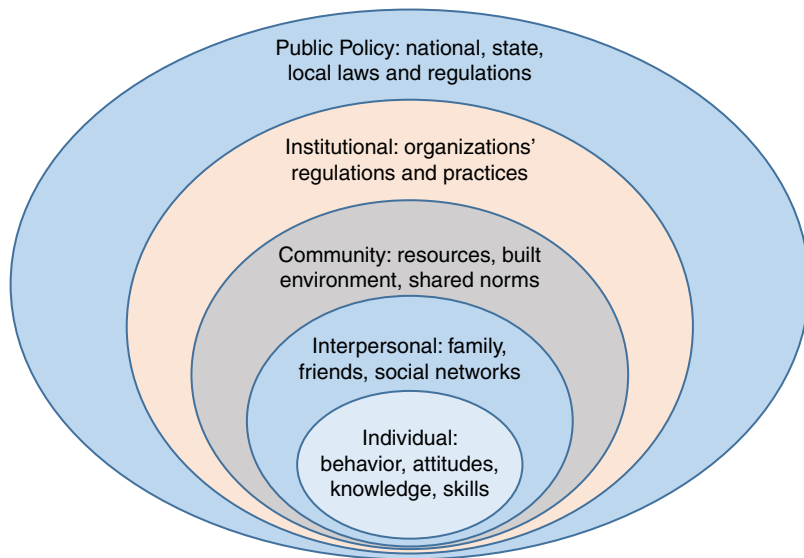
Figure 1.
Ecological
model – five levels of
influence on health

The ecological approach that we propose here is grounded in two key assumptions: health and health behaviors are influenced by factors at the individual, interpersonal, community, institutional, and public policy levels; and these factors influence each other across the different levels (McLeroy *et al.*, 1988; Sallis *et al.*, 2008).

This ecological model allows for critical understanding not only of health outcomes, but also of the social and structural determinants of health inequities (e.g. inadequate and unsafe housing, low wages and underemployment, incarceration, food insecurity, environmental toxins, racial segregation, low-quality education, and violence) (Adelman *et al.*, 2008; Bailey *et al.*, 2017). Understanding why one's address is one of the most predictive determinants of health requires an analysis of the policies and institutional practices that systematically discriminate against and segregate communities of color, low-income communities, immigrants, LGBT communities, people with disabilities, and other marginalized groups (Galea *et al.*, 2011). An ecological approach reveals relations of power, privilege, oppression, and resistance and their influences on health outcomes.

While US schools have been slow to incorporate the multiple influences on health in health education curricula, ecological models of health have long been embraced by organizations focused on understanding and addressing health inequities. For example, the Centers for Disease Control and Prevention (CDC) and the World Health Organization use social ecological approaches to critically examine the inequities embedded in a range of health issues – from cancer to violence – and to create appropriately comprehensive interventions (CDC 2013, 2015; Dahlberg and Krug, 2002). The World Health Organization explains that an ecological framework inextricably links health to social justice as it reveals the unjust systems that create avoidable disparities in health:

> Having health framed as a social phenomenon emphasizes health as a topic of social justice more broadly. Consequently, health equity (described by the absence of unfair and avoidable or remediable differences in health among social groups) becomes a guiding criterion or principle (Solar and Irwin, 2010, p. 4).

Ecological approaches allow for deeper understandings of the social injustices and structural inequities that lead to health disparities, and change is then focused on creating a

more just and equitable society. Providing this kind of critical health education for students moves their thinking upstream, identifies the intersectional aspects of socially constructed determinants of health (e.g. race, gender, sexuality, national origin, socioeconomic status, education, etc.), examines the structural forces that create those social determinants (e.g. public and private sector policies and practices), and reveals the complex and inequitable conditions in which individual and community health occur.

For example, an ecological analysis of student nutrition reveals the many influences on what a student eats, such as: the foods they like (individual); the foods provided to them by their family (interpersonal); the foods eaten by their peers (interpersonal); the foods made available and affordable to children in schools (institutional) and to their families in their neighborhoods (community); the products made by food producers and the targeted advertising of particular foods to this student population (institutional); and the laws and regulations that guide food production, prices, safety, and distribution (public policy). As noted by the ecological model, these multi-level factors also influence each other. For example, the US Farm Bill (public policy) subsidizes the production of corn, which incentivizes food manufacturers (institutional) to produce cheap snack foods sweetened with high fructose corn sirup; these snack foods in turn are distributed disproportionately in low-income neighborhoods (community) and schools (institutional) where low-income families are more likely to buy them (interpersonal) and children are more likely to eat them (individual) (Nestle, 2002). This analysis could be extended to include many other factors that influence nutrition, but the key point here is that nutrition cannot be understood solely as an individual behavior determined by individual choice (Sallis *et al.*, 2008). Therefore, to truly understand healthy nutrition, students need to learn about the full ecological contexts of nutrition.

Limitations and harms of an individual focus
Despite ongoing calls for ecological approaches in US health education – from Jane Addams and John Dewey in the early twenty-first century (Gard and Pluim, 2014) to countless educators of present day (Minkler, 1999; Sallis *et al.*, 2008) – school health education curricula remain primarily focused on behavior change. One oft-repeated critique of behavior-focused health education concerns the unrealistic expectations and damaging effects of its suggestion that individuals are solely responsible for their health. As Minkler (1999) argues, "an overriding emphasis on personal responsibility blames the victim, by ignoring the social context in which individual decision making and health-related action takes place" (p. 126). Furthermore, simply teaching students about healthy behaviors has not proven effective in changing behaviors or, in the long run, in decreasing morbidity and mortality rates (Gard and Pluim, 2014; St Leger, 2004).

Fitzpatrick and Tinning (2014) warn that teaching uncritically with behavior-focused aims contributes to the phenomenon Crawford (1980) coined as healthism – "the preoccupation with personal health as a primary – often the primary – focus for the definition and achievement of well-being; a goal which is to be attained primarily through the modification of lifestyles" (p. 368). This healthism is infused with moral judgment, as represented in definitions of "good" and "bad" health behaviors. It becomes the individual's obligation to maintain their health through their behaviors, while the political and economic forces that have far-reaching impacts on health and health behaviors remain unacknowledged (Freudenberg, 2014; Nestle, 2002).

What is health education for?
If behavior-focused curricula represent an inadequate approach to school health education, then what does a more comprehensive approach look like? To answer this, we first ask a critical question which has been raised by others (see Fitzpatrick and Tinning 2014;

Leahy *et al.*, 2016) – as health educators, are we educating for health and/or about health? Is our main purpose to teach students how to behave in ways that promote health, or do we aim to provide an education with health viewed as a subject of study through which students learn about their world and grow? As educators ourselves, we propose that teaching solely for health and not about health in its full ecological contexts is insufficient in the context of educational environments that purportedly aim to increase critical thinking, knowledge of disciplines, and understandings of the social and physical world. Quennerstedt *et al.* (2010) call for health education that shifts away from imposing pre-formed messages about individual health and moves to "an approach to health education that takes as its starting point the learning that occurs in the lives of young people" (p. 97), including the ecological influences in their own lives. Teaching about health in ways that consider all of the influencing contexts allows students to better understand the effects of social structures and systems and consider how those systems may be influenced for the betterment of individuals, communities, and society.

Political economy as framework for health education

An ecological approach in school health education requires a theoretical framework that explains how social structures and systems influence health. Political economy theory provides a helpful framework for understanding these upstream influences and, in particular, how they create inequities that influence health. Framing health inequities as the result of the unequal distribution of power and wealth, using a political economy lens highlights four key constructs for best analyzing health outcomes: a historical analysis of the political and economic contexts of current health outcomes; the role of the state in framing, legitimating, and addressing health problems, the influences of organizational and structural power in creating, perpetuating, and countering inequities; and the relevance of consciousness raising for social change (Minkler *et al.*, 1995). Overall, a political economy lens uses historical and structural analyses to identify the broader structural forces of power that disproportionately produce ill health among marginalized populations. Importantly, it also names the relevance of raising the public's critical consciousness and mobilizing people as a "cohesive political force" to challenge the inequities created by corporate and state power (Minkler *et al.*, 1995, p. 117). One recent example is the emergence of the Black Lives Matter movement in the USA, which has effectively raised critical consciousness about the disproportionate use of police violence against African Americans and has resulted in numerous actions across the country calling for police reform and even police abolition.

Freudenberg (2014) employs a political economy analysis to understand the systematic production of illness and premature death through corporate practices in six US industries – food, tobacco, alcohol, pharmaceutical, gun, and car production. His research details how these health-harming industries represent "the triumph of a political and economic system that promotes consumption at the expense of human health" (p. viii). Political economy analyses can similarly be applied to examine how and why numerous other industries have gained and manipulated power in the pursuit of profits while harming the public's (and planet's) health, for example, the coal industry, the prison industry, war industries, and health care industries. Starting from a political economy analysis of racial inequities, researchers have examined how structural racism – as manifested in systems of housing, transportation, education, labor, criminal justice, and immigration – detrimentally impacts the health and well-being of people of color (Krieger, 2003; Williams and Mohammed, 2013). Health education that truly educates students makes visible these powerful political economy influences on individual health and helps "link 'personal troubles' with 'public issues'" (Minkler *et al.*, 1995, p. 119). Without such political analyses, students of health education are given false impressions that health is only influenced by individual behavior and not by the world around them.

If we are teaching students about health, then we must encourage them to think critically and at a more macro level about how structural conditions influence health. Even if we are teaching students for health, then being honest with students about all of what health encompasses means not reducing it to simple formulas of health behavior change. Integrating ecological and political economy approaches into school health education curriculum gives students a more comprehensive sense of health as something that is best supported by "creating conditions in which people *can* be healthy" (Institute of Medicine, 1988, our emphasis).

Pedagogical approaches for critical health education
Teaching critical understandings of health through ecological and political economy analyses requires pedagogical approaches consistent with such analyses. Furthermore, while teaching about the upstream influences on health is imperative, if we leave students with a sense that the doom and gloom posed by structural inequities perpetuated by powerful institutions and political systems is insurmountable, we risk damaging their sense of possibility, capacity, and control in their lives. Such lack of control can be toxic to individual and community health (Wallerstein and Bernstein, 1988) and certainly would not serve the aims of health education. Therefore, we need pedagogical approaches that allow students to not only gain critical understandings of these upstream influences on health, but also gain confidence in their agency and ability to effect change where possible. Importantly, this approach must be walked with care to avoid contradicting an ecological understanding of social determinants by suggesting that they can all be overcome through individual action.

To inspire this possibility for change, health educators can connect these ecological and political economy approaches to the lived experiences of students themselves and the particular cultural contexts of their families, neighborhoods, and schools. For critical understandings of health, students must be able to connect with health issues through their own particular ecological contexts including: their individual behaviors and beliefs; influences of family and friends; social norms, values, and resources in their community; practices and policies of institutions with which they interact; and public policies and ideologies that affect their lives in obvious and less obvious ways. Simply put, deeper learning happens when curriculum is relevant to young people's lives (Dewey, 1916; McLaren, 2015; Rodriguez, 2013). Furthermore, connecting curriculum to students' lives creates opportunities for students to envision actions that can affect their worlds. In doing so, students increase their sense of control and agency – something that is integral to health, growth, and education (Wallerstein and Bernstein, 1988).

Critical pedagogies
Critical pedagogies, which draw from critical theory and cultural studies, encompass a range of pedagogical approaches that encourage students to understand their worlds and challenge the taken-for-granted assumptions in those worlds. As described by Shor (1992), critical pedagogy facilitates:

> […] habits of thought, reading, writing, and speaking which go beneath surface meaning, first impressions, dominant myths, official pronouncements, traditional clichés, received wisdom, and mere opinions, to understand the deep meaning, root causes, social context, ideology, and personal consequences of any action, event, object, process, organization, experience, text, subject matter, policy, mass media, or discourse (p. 129).

Critical pedagogies help students deconstruct health knowledge, which, as Wright (2014) argues, "is not constructed from a neutral position but from ideological or discursive positions, some of which are more apparent than others" (p. 246). In a school setting, where

"knowledge" is valued and reproduced, critical pedagogies allow students to explore where that knowledge comes from, whose knowledge is valued and represented, and what kinds of knowledge are invisible or demeaned in the production of incomplete and even inaccurate "truths." Indeed, school settings and processes can themselves become sites for historical and cultural analysis as they often reproduce the same unequal relations of power (e.g. race, class, gender) that produce social and health inequities (Duncan-Andrade and Morrell, 2008). More specifically, the ideological positions of neoliberalism and individualism that have informed the individual behavior focus of traditional health education become prime targets for examination and disruption through critical pedagogies in health education.

Critical pedagogies engage students in facilitated processes of deconstructing sources of knowledge, co-creating knowledge through reflection and dialog grounded in their lived experiences, and engaging in praxis, which Freire (1970) defined as "reflection and action upon the world in order to transform it" (p. 36). Praxis positions students as teacher learners who engage in dialog with each other about their concerns, while exploring the broader social and political contexts of those concerns, and engaging in social action to influence those contexts (Wallerstein and Bernstein, 1988). This praxis "creates a cycle of awareness, action, and reflection whereby people are empowered constantly to analyze and act upon the material conditions of their own lives" (Duncan-Andrade and Morrell, 2008, p. 27). Critical pedagogies that build praxis into the learning processes foster critical thinking, value collaborative learning, and involve students actively in curriculum that values, and is grounded in the contexts of their own lives. These experiences support students in becoming informed and engaged citizens by fostering agency, social action, and empowerment. In contrast to traditional forms of health education, critical pedagogies ensure that "learners have an opportunity to critically engage with health information rather than to simply be passive recipients of it" (Matthews, 2014, p. 600).

At the root of critical pedagogy is the practice of critical thinking. As Hooks (2010) describes, "The heartbeat of critical thinking is the longing to know – to understand how life works" (p. 7). Arguably, one of the roles of health educators is to inspire among our students a longing to know about how health happens, not just in one's own body on a physiological or psychological level, but also in one's neighborhood and across communities. Unfortunately, Hooks (2010) continues, "children's passion for thinking often ends when they encounter a world that seeks to educate them for conformity and obedience only" (p. 7). As noted here, and by many others previously, much of health education is delivered in the service of conformity and obedience to particular health behaviors, body types, and narrow, damaging, blaming, and stigmatizing definitions of health (Leahy, 2014; Simpson and Freeman, 2004; Wright, 2009). Critical pedagogies not only move away from this kind of "education for obedience," they directly challenge it.

Critical pedagogies that put students' lives and knowledge at the center of learning, and that challenge oppressive social and structural processes, ultimately contribute to creating more equitable education environments. Airhihenbuwa (1994) argues that while much health promotion privileges white, middle class, patriarchal discourses serving goals of neoliberal individualism, critical approaches to health education center marginalized lives in the curriculum "and affirm differences in cultural expression, thus empowering learners to produce knowledge based on their social and cultural experiences" (p. 346). While traditional health education approaches often ignore, stereotype, or even stigmatize students of color, students in poverty, LGBT students, and students with disabilities (Elia and Tokunaga, 2015), critical pedagogies value and make visible the lives of all students, shift power relations, highlight the injustices of systems of oppression, and encourage students to challenge such injustices (Matthews, 2014). The centering of otherwise invisible, marginalized lives is essential in the pursuit of meaningful learning about and for health equity and social justice.

There are a number of practical critical pedagogical learning activities that can be employed in health education in schools. One such activity involves having students work in small groups to critically examine popular press (television, magazine, newspaper, and/or online) advertisements for food and drink marketed to youth. The students could identify such aspects as the type of food or drink advertised, to whom specifically (e.g. gender, race, age, class) such items are marketed, the political economy contexts (e.g. history, power holders and relations, role of the state, public's consciousness of these contexts, who benefits and who is harmed by these products), and any health effects of such products. The aim of such a group activity would be to not only increase students' media literacy as they collectively deconstruct the potential health implications of the advertised items themselves, but also to consider the social and structural forces that construct these messages and how corporate entities and the state view (and control) specific communities, their bodies, and their social positioning.

Critical health education approaches have been integrated into curricula in Australia, New Zealand, and the UK, to name a few. For example, the new Australian Curriculum: Health and Physical Education (AC: HPE) includes a critical inquiry approach as one of its key pillars (Leahy *et al.*, 2013). Notably, the aims of critical inquiry are contested and its varied implementation sometimes loses its critical edge. As Leahy *et al.* (2013) warn, a truly "critical" critical inquiry approach does not mean that students identify specific risks in their environments so that individuals can avoid those risks – a common interpretation of critical inquiry in which "students are continually asked to engage critically with barriers and then expected to overcome them" (Leahy *et al.*, 2013, p. 182). Instead, they call for a socio-critical inquiry approach that explores the taken-for-granted beliefs about health and physical education, systems of power that create inequalities, and influences of social and cultural contexts on meanings of health. This socially informed critical inquiry counters the tendency to misuse critical approaches in the service of neoliberal discourses that individualize risk and, instead, better serves "the educative intentions of the AC: HPE" (Leahy *et al.*, 2013, p. 182).

Critical thinking and social justice
Within health education, critical pedagogies can contribute to social justice by challenging the body surveilling, behavior focused, pre-packaged health education messages that perpetuate narrow views of health, reproduce inequities, support submission to the status quo, and presume "that students can only acquire knowledge but not produce it" (Airhihenbuwa, 1994, p. 349). Critical pedagogies foster thinking that challenges "health education's fascist tendencies" to impose messages and strategies in schools "that reinforce the discipline and control of the body" (Fitzpatrick and Tinning, 2014, p. 132). Such disciplining health promotion agendas are often imposed upon school health education settings with standardized health messages about obesity, sex and pregnancy, alcohol and drug use, that often blame and stigmatize individuals and communities without acknowledging the broader contexts of health (Elia and Tokunaga, 2015; Leahy, 2014). These messages are internalized by teachers and students who then reproduce individual behavior change discourses of safety, risk, insecurity, stigma, and fear. For many young people, these health education discourses are "the source of damaging self-evaluations and positionings" (Wright, 2014, p. 245). As Wright (2014) argues, critical health education provides students with the opportunity to discuss and interrogate these discourses, define health in their own terms, and in ways that are relevant to their lives.

Overall, critical health education pedagogies aim to do more than "fill in" the incomplete portrayals of health that are focused on individual behaviors; they directly challenge those incomplete portrayals, identify the ways in which such portrayals influence students themselves, recognize who these portrayals serve and who they harm

in the service of discipline and oppression, and inspire a re-thinking and re-creation of health discourses.

Take, for example, the behavior-focused health education mantra to get more exercise. A recent study published in *The Lancet* reported the $67.5 billion global price tag of health care costs due to "a pandemic of physical inactivity" and called for individuals to do one hour of exercise daily to prevent such health care costs (Ekelund *et al.*, 2016). As the *New York Times*, *National Public Radio*, and other news agencies described the study findings, there was no mention of why so many people across the globe get so little physical movement in their day. A critical health education approach would pose questions to students about how they experience and perceive this information: What are the key messages here, and what is not being said? What supports or inhibits your own level of activity? From an ecological perspective, what conditions exist in your families, neighborhoods, and communities that influence activity levels? From a political economy perspective, how have political and economic conditions and pressures changed over time to create this increase in sedentary lifestyles, and what entities have been most influential in those changes? How have decades of stagnant wages and increasingly high costs of living influenced the number of hours people spend at work? How have working conditions which require people to sit most of the day either working or commuting made an hour of exercise a day difficult to achieve, let alone prioritize? How much of the high cost of physical inactivity is due to price gouging by the medical and health care industries? Overall, what are the root causes and contexts of this increase in sedentary behavior and the costs associated with it? Furthermore, a critical health education approach would also ask why these study findings were presented in such a narrow framework in the first place. Who is served by such reporting, and who is harmed? Finally, given what we have learned through this critical dialog, how might we as a society better support healthy environments for all? A critical pedagogy approach provides students with comprehensive education about the political, economic, social, ideological, and individual contexts of health, and it challenges individual-focused approaches that stigmatize behaviors and people who engage in those behaviors.

In summary, utilizing critical pedagogies in school health education would support: understanding of political, economic, cultural, and ideological contexts of health and related systems-level thinking about structural conditions that influence health and health behaviors; exploration of who defines "health" and "illness," why they are defined that way, who benefits from these constructions, and, importantly, who may be harmed by them; explicit integration of the specific contexts and lived experiences of students themselves in the learning (and teaching) of health education; and praxis that allows students to put this critical understanding of health into meaningful social action.

Professional preparation for critical health education teachers

For health educators to employ these critical pedagogies in school settings, they must be prepared in their university education. This means not only learning about the ecological and political economy contexts of health and health inequities, but engaging in that learning within the contexts of critical pedagogies and reflective praxis that they will facilitate with their future students in school health education settings. Doing so means that involving aspiring health educators in a practice that encourages critical thinking about health in all of the ways previously described. This includes critical self-reflection about power, privilege, and the social positions (e.g. race, class, gender, age, role) that teachers themselves hold in the contexts of schools and their students. Recognizing their own identities and social positions – and the intersectionality of those positions – is essential if health educators are then expected to engage their own students in critical education and self-reflection processes. To challenge social conditions that produce inequities, one must be aware of their own participation and positions within those conditions.

A commitment to education, equity, and ethics

We have argued here for critical health education that embraces ecological approaches, political economy frameworks, and critical pedagogies. Ultimately, we see the imperative of critical health education in its support of three key values that we hold dearly in health education work – education, equity, and ethics.

Education

Leahy *et al.* (2016) point out that health education and research on its effectiveness have long been misguidedly focused more on health behavior changes than on the core tasks of education itself. That is, health education in schools has primarily served as a vehicle for health promotion rather than as a subject of study that offers a wealth of opportunities for critical thinking, problem solving, literacy, and other learning through a subject that is relevant to everyone's life – health. In the USA, public schools have been repeatedly critiqued for not creating conditions that prepare students to think critically in democratic societies (Dewey, 1938; Ozer and Wright, 2012; Sarason, 1996). Focusing attention on education requires us to carefully consider this: what are we educating students for? To us, health education provides a learning space to enhance critical thinking through the exploration of the ecological contexts of health in a way that is grounded in the lives and social contexts of students themselves. Furthermore, as Fitzpatrick (2014) explains, critical pedagogies provide a place for people to critique narrow forms of health education that focus on behavior change and body surveillance in restrictive, unrealistic, and often stigmatizing ways. Such critical reflection allows students to "speak back to, or at least unravel, discourses of healthism" (p. 185) that can actually harm their health. Importantly, critical pedagogies create educational environments where students learn about health in ways that set them up to act upon their worlds and to create conditions that are not only good for health, but are also good for democracy.

Equity

As professors in a public university, we work with students daily who experienced the detrimental inequities in elementary and secondary public school systems long before they arrived in our classrooms. We believe that it is our duty to provide students with high-quality education that is relevant, that honors their lives and skills, and that supports their sense of agency and possibility in the world. Critical health education contributes to a movement toward educational and health equity by valuing the knowledge, skills, and capacities of all students and by putting them at the center of a learning environment that is built on practices of equity and social justice. As students, they do not just study equity; they practice it through their engagements with each other as teacher learners and through critical and collective action. Similarly, as teachers, we do not just teach equity, we practice it through the facilitation of learning environments that value and support the lives of our students and our shared roles as teacher learners.

Ethics

We noted here the limitations of individualizing health education discourses that present incomplete information by ignoring the conditions and systems that influence health. These discourses often stigmatize people who do not fit narrow definitions of healthy behaviors and healthy bodies. This calls forth the ethical dimension of our work in health education, given that stigmatization inflicts harm on people's identities and their sense of value in the world. Obesity discourses in health education provide particularly alarming examples. As Fitzpatrick and Tinning (2014) describe, an "obese body in

contemporary times is held up as an example of both illness and ugliness" (p. 139). It is no surprise that obese children are among the most likely to be bullied in schools (Lumeng *et al.*, 2010). Health education that focuses on individual behaviors and narrowly constructed messages about health can be particularly damaging to young people who may exhibit preoccupations with appearance and body shape (Wright, 2009). Such stigmatizing messages do not support the health or education of our students. As health educators, we should be facilitating learning environments that support students' sense of self, value, and strength rather than elevating some narrowly defined "healthy" group while casting out those who fall outside of that box due to body size, lunch box contents, or aerobic capacity.

Critical health education provides quality educational experiences for critical thinking and transformative learning. It promotes equity by engaging students in the praxis of using their critical thinking to create individual and collective actions in support of health equity. Finally, it attends to ethics by moving away from blaming or judging individuals, and instead valuing all students for what they bring to the collective process of teaching and learning about health. Overall, critical health education replaces a focus on individualism with a focus on education as it inspires students to discover their collective agency in building healthy communities.

Conclusion

As we began this paper in the fall of 2016, US presidential candidate Donald Trump was stirring up a toxic frenzy of hatred toward immigrants, Muslims, women, African Americans, disabled people, and others through his bigoted and inflammatory campaign speeches. The millions who supported his candidacy embodied a rising level of distrust, desperation, and fanaticism that was (and is) fueled by ideological discourses of fear, individualism, racism, and xenophobia. As we complete this paper in the summer of 2017, Donald Trump has been elected as the President of the USA. As reported by the Southern Poverty Law Center (2016), within the first 10 days of his election, there were 867 reported incidents of harassment or intimidation across the country, and "many harassers invoked Trump's name during assaults, making it clear that the outbreak of hate stemmed in part from his electoral success." White nationalist and white supremacists groups, embolden by his election, now tour college campuses to recruit members and sometimes incite race riots (Southern Poverty Law Center, 2017). In the meantime, the Trump administration's policies regarding immigration, the environment, criminal justice, and international relations demonstrate that his campaign promises were not just words; they are now policies. Similar trends have been seen in Europe, Australia, and elsewhere as global austerity, and the rise of far right and neo-fascist entities play out in the banning of Muslim immigrants, repeals of anti-racism legislation, attacks on labor unions, and nationalistic discourses (Passant, 2016).

Walking into our classrooms during these challenging times presents important questions for us as teachers. Given the pain, fear, anger, and uncertainty that many of our students feel in their lives and in our world, what is our role as educators in health education? How do we teach about health in the midst of violence and vitriol spewing from the ends of guns, the policies of the state, the actions of corporations, and the mouths of politicians and their supporters? We teach with an eye on social justice and equity. We teach with an eye on critical thinking, civic engagement, and the role of social movements and social change. As we consider how to best educate our students to meet these challenges, let us consider how best to educate them so that they understand the full contexts of health and of their world more broadly, and so that they feel equipped with the sense of what can be done individually and – most importantly – collectively to support equity, health, and well-being in communities and society.

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