MEDS Public Health and Preventive Medicine (2022)
Clausius Scientific Press, Canada

DOI: 10.23977/phpm.2022.020214
ISSN 2616-1915 Vol. 2 Num. 2

Sport Pedagogy and Public Health: Building a Culture of Health

Colin G. Pennington

Tarleton State University, School of Kinesiology, Department of Sport Science
Corresponding author: cpennington@tarleton.edu

Keywords: Physical education, public health, health education, sport pedagogy, health professionals

Abstract: Quality physical education is a form of public health. When done effectively and with holistic child-development goals, the physical educator is simultaneously a 'health' educator. This article will provide an overview of basic and essential understandings of health education from a public-health perspective; exploring cultural influences and health-theory as constructs to be adopted in kinesiology and sport pedagogy. An overlapping view of their professional could streamline the work of - and maximize the effectiveness of - health and physical education practitioners in their practices, interventions, and community outreach approaches. Scholars and practitioners of kinesiology, sport pedagogy, and physical educators must make efforts to understand public health education, policy, and culture in order to enhance their effectiveness in the pursuit of their field's goals.

1. Introduction

Physical education is a form of public health. The physical educator could view themselves as an extension of the allied health professionals with a vison of developing healthy people. Many scholars have explored the role physical education has played in promoting health-enhancing behaviors on K-12 pupils (Pennington, Shiver, McEntyre, & Brock, 2022). Such inquires have revealed that physical educators are rarely equipped with the skills to develop pupils' health behaviors immediately following certification (Pennington, et al., 2022). Fortunately, however, physical educators who receive training specifically on enhancing physical health in pupils have demonstrated promise when given the appropriate tools (Pennington, 2020a), time to grow into their teaching philosophy (Pennington, 2020b), and are met with pupils who exhibit 'readiness' to participate activity (Pennington, 2021).

The principles learned for research and interventions at the K-12 levels of education have been implemented at the university setting, as well, also with promising results. Scholars of kinesiology and sport pedagogy have been successful at providing opportunities for faculty and staff to engage in long-term health-enhancing behaviors when the appropriate resources are provided (McEntyre, Brock, Pennington, Wolfe, & Peak, 2020).

I respectfully suggest that scholars of kinesiology, sport pedagogy, and physical educators could increase their community value by understanding the health-related cultural and legislative elements which guide and govern community and public health (Pennington, 2022). Such an understanding

would enable a multi/intra-disciplinary approach to community health and wellness. I also respectfully suggest that, when done effectively and with holistic child-development goals, the physical educator is simultaneously a 'health' educator. This article will provide an overview of basic and essential understandings of health education from a public-health perspective; exploring cultural influences and health-theory as constructs to be adopted in kinesiology and sport pedagogy.

2. The Role of the Health Professional: Positive Examples

The Robert Wood foundation would consider itself to have fully adopted the responsibility of health education and advocating for a healthier society. The Robert Wood foundation boasts having funded programs and projects that have addressed the outer rings of the social-ecological model, including community, institutional, and societal levers (Mockenhaupt & Woodrum, 2015). This wide approach is necessary for success, because the nation's health problems are so complex, costly, and cross so many systems that collaboration across sectors is essential for large-scale, sustainable health improvements (Mockenhaupt & Woodrum, 2015); perhaps even rethinking of what the social ecological model looks like is also necessary for large-scale, sustainable health improvements (Golden, McLeroy, Green, Earp & Lieberman, 2015). When using a social-ecological approach (or an inside out version, with health-related and other social policies and environments at the center) the role of the health/physical educator must be defined. Health and physical educators may ensure that policy and environmental resources are publicized to and understood by policy makers and the public. Additionally, health/physical educators can collect and disseminate information about a host of opportunities in their communities. In this sense, health/physical educators are "bridge builders" uniting groups around health (churches, schools, employers; Golden et al., 2015). Health/physical educators can transform their practice to make redistributing the resources that shape health a primary goal, thus building bridges (Freudenberg, Franzosa, Chisholm & Libman, 2015). It is important to consider the constructs of power redistribution (Freudenberg et al., 2015) and diversity of personal relationships health professionals may have (Golden et al., 2015) it meeting the aforementioned goal. Health professionals can leverage their own social networks to connect people across power, and advocate for inclusion of more diverse voices in the organizations and groups to which they belong (Golden et al., 2015) – this cannot be understated, and must be further explored and pursued (Pennington, in press 'a', in press 'b').

The ways in which Golden and colleagues (2015) expressed the roles and potential of public health researchers caused me to recall an initiative made by a research approach in sport pedagogy. Health education and promotion researchers may consider using *appreciative inquiry* (AI) to investigate meaningful interventions (Cooperrider & Whitney, 2001). Two basic questions underpin any AI initiative: (1) what, in this particular setting and context, gives life to this system - when it is most alive, healthy, and symbiotically related to its various communities? and (2) what are the possibilities to provide opportunities for more effective forms of organizing? (Cooperrider & Whitney, 2001).

Appreciative inquiry strives to begin with a positive question or an affirmative topic. It is faster, according to its proponents, 'to go through the front door of enthusiasm' and focus on positive attributes that may fuel change (Enright, Hill, Sandford, & Gard, 2014). Appreciative inquiry research in education has described how effective teachers support learning, and how student voice supports inclusion and social justice, as well as enhances respect and shared responsibility in student interactions. Appreciative inquiry research in physical education has been implemented with some success (Pennington & Nelson, 2020; Pennington, 2019), and I believe AI in health education may have similar successes. Perhaps the deficits of health education intervention we meet are the result of deficit assumptions that are built into the theories that we use to explore them. Many of the theoretical frameworks that dominate research derive from a grievance narrative of some kind (such as class,

race, or gender) -- and I certainly acknowledge research exploring these foci of marginalization are extraordinarily valuable. Nevertheless, if we expect a negative cause for the status quo, perhaps that is all we will find, when there *has* been progress worthy of exploring, interpreting, and announcing.

3. Community Health Education

Virtually every research variable that has been explored from a public-health lens can be perceived as a dependent health-related variable. An article composed by Stempski, Liu, Grow, Pomietto, Chung, Shumann, and Bennet (2015) expressed an important need aimed at reducing the rates of obesity and drowning - two great public health priorities. A community outreach and intervention research program in which I have been a team leader, 'Swim to the Top', hinged on the connection between the African-American community and drowning. The purpose of 'Swim to the Top' was twofold: (1) the swimming goal was to provide effective swim instruction, and make children proficient survival swimmers. Additionally, (2) we aimed to make children aware of proper health choices, and teach them how to become healthier – this goal is squarely in-line with the goals and missions of physical education, sport pedagogy, and thus health education. Ultimately, the research team observing 'Swim to the Top' wanted to learn if providing a community program for African-American children will improve their perceptions of their ability to swim, their actual swimming ability, as well as their fitness and nutrition literacy.

There is also a strong correlation between obesity and the African-American community, connecting the aims of Stempski et al. (2015) with 'Swim to the Top', again reaffirming the multiple points of connection between health and social variables within both health and physical education. Focusing our health agendas toward specific social groups has benefits which may include increasing equity in the affected groups as well as health.

4. Bridging the Gap

Being the 'bridge' between practice and community is a critical role of the health professional, and an additional theme from literature in the field of public health. Comprehensive implementation of equity-focused health impact assessment is the essential building block in constructing socially responsible policy and practice (Mittlemark, 2001). Programs that increase the publics' understanding of the determinants of health could lead to the empowerment of citizens to play a more active part in decisions influencing their health. "All politics are local", you have likely heard. Important health-related planning, policy -making and action originate at the local level. The reasons behind the failures of wide national policies aimed at health behaviors are obvious. Although, it is in my opinion that enacting local changes and advances to health promotion to success could be a first-step to *potential* nationwide adoption of similar policies; some sweeping federal legislation regarding policies directly related to health (drug and alcohol use, and driving laws) have, of course, been fairly successful. Observing local programs and effectively evaluating the impact of these programs connects health professionals and the entire discipline to the community.

5. Overcoming Culture to Achieve Health

A thoughtful composition by Mack, Liller, Baldwin and Sleet (2015) illustrates the utility of an approach that incorporates a social-environmental perspective in identifying and selecting interventions to improve the health and safety of individuals. Mack et al. (2015) express how socioeconomic factors influence exposure to specific hazards towards initiating behavior change. Elements of such an approach are observable in corporate industry; for example, at a company called 'Brismet'. Brismet is an international producer of alloy and stainless-steel tubes and piping for highly

corrosive applications. As recently as 2007, Brismet was an industry example of possessing a *negative* culture of safety. Employees did not respect or adhere to policies aimed at eliminating workplace accidents or reducing loss of work time resulting from accidents brought on by unsafe practices. This includes gross infractions such as unlicensed employees operating heavy machinery to not wearing ear plugs, welding mask, hardhats, et cetera. People generally have to be incentivized to behave in particular ways. In the case of Brismet employees in the early 2000s, there was no system enforced aimed at increasing safe practices at the plant. Under new leadership, there was a strong implementation of demerits and rewards for safe practices. New leadership sought to develop a culture of safety. This was not without great resistance from employees who had been socialized to work and operate in their old ways. The following quote is from Brismet's *current* mission statement:

"All operating units of Synalloy Metals promote strong core values that encompass Safety, quality, productivity, community service, employee development, financial growth and shareholder value. We operate under a comprehensive Safety Program to reshape our culture and reduce our accident rates to world class levels..."

Indicating safety as the first listed core value and highlighting the safety program in the second sentence of the mission statement is one way the company emphasizes the cultural shift towards adopting safety as a priority. From the effort of leadership in the past fifteen years, Brismet now has an outstanding culture of safety and accident prevention. Rarely is a culture 'health-enhancement' adopted by a population without a catalyst of sorts. Health professionals [including physical educators] must prioritize health *and* serve as the catalyst for their communities.

6. Health Education in the Medical Care Setting: Framing Role in a Positive Manor

The role of the health education specialist is, again, an emergent theme in public health literature. For example, as expressed by Chambliss, Lineberry, Evans and Bibeau (2014) the health education specialist in our practice serves concurrently as health educator, health coach, and practice quality coordinator. Chambliss et al. (2014) defines these roles in a positive manner, focusing on what they are qualified to do and what credentials are recommended for practice. Further, Nutbeam (2008) describes the two distinctive concepts that reflect health literacy, respectively, as a clinical "risk", or a personal "asset". Personally, I prefer framing the assets of a community or individual rather than taking a deficit approach. In their own way, some in sport pedagogy mirror the call by Nutbeam (2008) to view individual and community assets. The Australian Health and Physical Education curriculum have made an explicit philosophical move away from a focus on risk towards a strengths-based approach. As a result, it emphasizes questions such as 'What keeps me healthy and active?' rather than 'What risks, diseases and behaviors should I learn to avoid?' This strengths-based approach to health-based physical education represents a shift away from deficit- or risk-based models of health and is strongly influenced by health theory, positive, health and an assets model of health.

7. Health Literacy and Physical Culture

Nutbeam (2008) introduced a key component of developing a culture of health: health literacy. Health literacy is seen as an asset to be built, as an outcome to health education and communication that supports greater empowerment in health decision-making. One would expect that improving health literacy would lead to a greater locus of control or self-efficacy. It certainly could lead to desired outcomes through the lens of the health belief model. Hre is an observable connection between health literacy and what sport pedagogy refers to as: a "physical culture". Wright (2004) has defined physical culture as "the meanings, values and social practices concerned with the maintenance, representation and regulation of the body". Popular physical culture then might be understood as the frequently encountered or widely accepted meanings, values and social practices concerned with the

maintenance, representation and regulation of the body, and most often disseminated through popular culture, for example television, magazines, popular music, internet. Popular physical culture serves as a site and medium for young people's learning and has an impact on their relationship with physical education, physical activity and on their construction of their embodied identities. Scholars have argued for many years that physical education curricula must better reflect and contribute to popular physical culture, and one may feel health education seeking to promote a healthy physical culture in adolescents could contribute to improving the overall culture of health for the general public.

One such way our cultural of health could be advanced would be through adopting the health promotion approach of hospitals laid out by Afshari, Mostafavi, Keshvari, Ahmadi-Ghalnaviye, Piruze, Moazam, Hejab and Eslami (2016). Again, the bridge between the health and medical practitioners and the people is a key message. There is education and information for patients and families at the hospitals; patients receive information about treatment, care, and factors affecting their health. However, the information dissemination may not be effective – perhaps due to lack of collaboration with other health professionals in patient education, limited time of nurses, or patient and work overload (Afshari et al., 2016). If health professionals can be better bridges of information and promotion to the community, a shared cultural of health and enhanced health literacy is to be gained.

8. Conclusion

To restate, quality physical education is a form of public health. An overlapping view of their professional could streamline the work of - and maximize the effectiveness of - health and physical education practitioners in their practices, interventions, and community outreach approaches. Scholars and practitioners of kinesiology, sport pedagogy, and physical educators must make efforts to understand public health education, policy, and culture in order to enhance their effectiveness in the pursuit of their field's goals.

References

[1] Afshari, A., Mostafavi, F., Keshvari, M., Ahmadi-Ghahnaviye, L., Piruzi, M., Moazam, E., ... & Eslami, A. A. (2016). Health promoting hospitals: a study on educational hospitals of Isfahan, Iran. Health promotion perspectives, 6(1), 23.

[2] Cooperrider, D. L., & Whitney, D. (2001). A positive revolution in change: Appreciative inquiry. Public administration and public policy, 87, 611-630.

[3] Enright, E., Hill, J., Sandford, R., & Gard, M. (2014). Looking beyond what's broken: towards an appreciative research agenda for physical education and sport pedagogy. Sport, Education and Society, 19(7), 912-926.

[4] Freudenberg, N., Franzosa, E., Chisholm, J., & Libman, K. (2015). New approaches for moving upstream: how state and local health departments can transform practice to reduce health inequalities. Health Education & Behavior, 42(1_suppl), 46S-56S.

[5] Golden, S.D., McLeroy, K.R., Green, L.W., Earp, J.L. I Lieberman, L.D. (2015). Upending the social ecological model to guide health promotion efforts toward policy and environmental change. Health Education and Behavior, 42(1S), 8S-14S.

[6] Mack, K. A., Liller, K. D., Baldwin, G., & Sleet, D. (2015). Preventing unintentional injuries in the home using the Health Impact Pyramid. Health education & behavior, 42(1_suppl), 115S-122S.

[7] McEntyre, K., Brock, J. D., Pennington, C. G., Wolfe, A., & Peak, K. (2020). Building a culture of health: A university model for employee wellness. Journal of Advances in Sports and Physical Education. 3(10), 1-4. DOI: 10.36348/jaspe.2020.v03i10.00X.

[8] Mittelmark, M. B. (2001). Promoting social responsibility for health: health impact assessment and healthy public policy at the community level. Health promotion international, 16(3), 269-274.

[9] Mockenhaupt, R., & Woodrum, A. (2015). Developing evidence for structural approaches to build a culture of health: A perspective from the Robert Wood Johnson Foundation. Health Education & Behavior, 42(1_suppl), 15S-19S.

[10] Nutbeam, D. (2008). The evolving concept of health literacy. Social Science and Medicine, 2072-2078.

[11] Pennington, C. G. (accepted, in press a). Diversity, Equity, and Inclusion in Kinesiology Departments. The Physical Educator.

[12] Pennington, C. G. (accepted, in press b). Increased Diversity and Retention in Kinesiology Departments. Texas Association of Health, Physical Education & Dance.
[13] Pennington, C. G. (2022). Concepts and Issues in Public Health: Culture, Psychology, and the Ecological Approach. Journal of Educational Studies and Multidisciplinary Approaches. 2(1), 8-16. https://doi.org/10.51383/jesma.2022.16.
[14] Pennington, C. G., Shiver, T., McEntyre, K., & Brock, J. (2022). Physical Education Preservice Teachers' Perspectives on Teaching Health-Related Fitness. The Physical Educator. 79, 117-130. DOI: 10.18666/TPE-2022-V79-I2-10214.
[15] Pennington, C. G. (2021). Applying the Transtheoretical Model of Behavioral Change to Establish Physical Activity Habits. Journal of Leisure and Recreational Patterns. 2(1), 1-8. https://jerpatterns.com/index.php/jerp/article/view/6.
[16] Pennington, C. G. (2020a). Applying the Health-Related Fitness Model and CSPAP to Address Physical Activity Concerns in Physical Education. Journal of Physical Fitness, Medicine & Treatment in Sports, 68(1), 6-8. DOI: 10.19080/JPFMTS.2020.08.555730.
[17] Pennington, C. G. (2020b). Models based instruction: The Sport Education curriculum model and accruing physical activity. Curriculum and Teaching Methodology. (3), 1-10. DOI: 10.23977/curtm.2020.030101.
[18] Pennington, C. G. & Nelson, L. (2020). Physical Activity Contribution of a Modified "Dancing Classrooms" Pilot on Middle School Students Using Accelerometer Technology and Heart Rate Telemetry. The Physical Educator. 77(2), 230-256. https://doi.org/10.18666/TPE-2020-V77-I2-9794.
[19] Pennington, C. G. (2019). Creating and Confirming a Positive Sporting Climate. Journal of Physical Education, Recreation & Dance. 90(4), 15-20. https://doi.org/10.1080/07303084.2019.1568936.
[20] Stempski, S., Liu, L., Grow, H. M., Pomietto, M., Chung, C., Shumann, A., & Bennett, E. (2015). Everyone Swims: A community partnership and policy approach to address health disparities in drowning and obesity. Health Education & Behavior, 42(1_suppl), 106S-114S.
[21] Wright, J. (2004). Analysing sportsmedia texts: Developing resistant reading positions. https://ro.uow.edu.au/edupapers/14.