Health Education sits ‘in’ the New Zealand Curriculum
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The following article is a draft of ideas taking shape for a larger piece of writing about Health Education in the NZC. Middle leaders and teachers of Health Education are invited to respond to this and contribute to the NZHEA newsletter with examples from their own school and own teaching or leadership practice, offer alternative interpretations, or expand the focus to include the way the NZC Vision, Principles and Values have shaped their school curriculum and how their Health Education programme reflects this.

Health Education in The New Zealand Curriculum (MoE, 2007) is influenced by the elements of the NZC that apply to all learning areas. The point about Health education sitting ‘in’ the NZC is to give focus to the fact that, like all learning areas (and subjects derived from these), teachers of Health Education are accountable to the same requirements of schooling as other subject teachers, and this has implications for the ways teaching and learning programmes are designed, planned and taught. The mantra that sits around that NZC is that said document ‘sets the direction for teaching and learning’ (NZC, 2007, p6). Health Education is well placed to respond to the overarching elements – the vision, principles, values, effective pedagogy, key competencies and the school curriculum design and review aspects, of the NZC. It is a major project to explore all of these connections, with only brief links to some of these elements being made here.

The key competencies (MoE, 2007, p12-13) are not measurable outcomes in themselves, but competencies that are learned, developed and used across all years of schooling learning and across all learning areas (TKI, n.d.b). Developing student capacity for increasingly complex thinking, for example, occurs across the eight levels of achievement objectives of the curriculum and the three levels of NCEA Achievement Standards (a shift from demonstrating understanding at NCEA Level 1, develops into a critical analysis by the time students are achieving at NCEA Level 3). Competencies such as relating to others, participating and contributing, and managing self are readily incorporated in Health Education learning programmes. Tasker (2006), in a pre-NZC examination of student learning in senior secondary Health Education programmes, showed how the key competencies were incorporated into Health Education and reported the value students saw in the knowledge and critical insights they were developing as part of their learning.

The inclusion of effective pedagogy in the NZC is an advance on earlier New Zealand understandings of curriculum which presented a curriculum as ‘what’ was taught and did not include guidance on ‘how’ the curriculum would be taught. To date the most comprehensive illustration of pedagogical theory into practice, reflecting the NZC statement, features in Aitken & Sinnema (2008). Numerous illustrations of effective pedagogy, and readings about pedagogy in the NZC fill the community pages of Te Kete Ipurangi website (TKI, n.d.f).

The NZC requirement for creating supportive learning environments, encouraging reflective thought and action, enhancing the relevance of new learning, facilitating shared learning, and making connections to prior learning and experiences (NZC, MoE, 2007 p34-36), were part of the everyday practices for teachers who had access to PLD following the release of the 1999 HPE document, well before these aspects of ‘effective pedagogy’ appeared in the NZC (MoE, 2007).
Shaw (1994) alluded to the type of pedagogy upon which Health Education teaching and learning came to be based.

“... the curriculum becomes a process of development rather than a body of knowledge to be covered. Ideally it is a multi-faceted matrix, with a myriad of inter-connections (personal, societal, and ecological) to be explored by teachers and students working together (Doll, 1989). According to this concept of curriculum, a teacher’s role is facilitative and reflective, rather than predominantly instructional. The post-modern curriculum is based on negotiation of personal meaning and relevance. It also involves participation and intervention in mutually interacting webs and processes to achieve new levels of critical awareness. To be effective in exercising this role, teachers need to understand how a curriculum empowers some students and disempowers others in reproducing the social inequalities in society. Particularly important in practice then, teachers need to be able to incorporate students’ past experiences into mainstream curricula, especially the experiences of students who otherwise could be marginalised. This is the only way to ensure all students gain insight and personal power through the classroom curriculum.” (Shaw, 1994).

Health Education teachers who had experience of the 1999 HPE curriculum document (MoE 1999) and the professional learning and development (PLD) that accompanied this, likely had access to learning about constructivist approaches (if not in theory then certainly in practice), through teacher workshops such as those funded to support the Caring for Yourself and Others (Tasker, 1998) resource. References to constructivist approaches and critical pedagogy in early Health Education resourcing were few, for example the Curriculum in Action Making Meaning Making a Difference (MoE, 2004) includes Kanpol (1994) among the ‘further reading’ list. In essence the claim to constructivist approaches at this time was in contrast with previous didactic, transmission of health knowledge type approaches, to suggest students in Health Education should have access to learning based on their needs and be able to construct knowledge for themselves.

Alongside the inclusion of effective pedagogy in the NZC, research from the University of Waikato Te Kōhatahitanga project (a project which aimed to improve educational outcomes for Māori students) directly or indirectly introduced to many New Zealand secondary schools the notion of a ‘culturally responsive pedagogy of relations’ (Bishop, Berryman, Cavanagh & Teddy, 2007) which favours the generic terminology and language of ‘discursive’ pedagogical approaches rather than naming constructivist approaches or critical pedagogy as such.

For the moment it remains unclear what has happened to these early Health Education claims to constructivist approaches to teaching and learning. As NZC understandings of effective pedagogy are given focus through schooling improvement developments such as Te Kōhatahitanga, and have come to dominate the (expected) practice of all teachers, questions have to be asked which aspects of these previously promoted teaching approaches have been maintained. Whether it is a case of same practice but different name, or if Health Education teaching practice has fundamentally changed in response to contemporary education sector policy and strategy requirements, needs to be explored.

With the demise of some funded in-service PLD where constructivist approaches were modelled and practiced (for example the then-ALAC funded PLD that accompanied Caring for Yourself and Others and the Mental Health Foundation (MHF) funded PLD for Mental Health Matters during the late 1990s and early 2000s), it is uncertain if teachers still have opportunity to learn these practices in PLD courses. NGO funding, like that previously provided by ALAC or the MHF, disappeared as limited health sector funding was re-prioritised and NGOs restructured. That said, some teacher PLD, such as that offered by Family Planning for sexuality education, is still accessible at a cost. Some HPE learning area PLD, responsive to
schooling improvement imperatives, is provided through the National Workshops programme facilitated by National Coordinators in Secondary Student Achievement PLD contract (TKI, n.d.c; TKI, n.d.d), and through NZQA Best Practice workshops (NZQA n.d). The changing PLD climate in New Zealand and the introduction of Investing in Educational Success (MoE, 2015a) inclusive of Communities of Learners (CoLs) and the Teacher-Led Innovation Fund means that teachers and leaders who are inquiry-savvy in their pursuit of schooling improvement projects can make a case for Health Education specific PLD. As yet, this is unchartered territory. The MoE has also signalled a national PLD focus for HPE beginning in 2017 (MoE, 2015b).

Arguably, the introduction of ‘teaching as inquiry’ as an aspect of effective pedagogy has been highly influential for developing teaching effectiveness in New Zealand schools. Health Education has long promoted the development of programmes based on student needs but it took the refinement of this as ‘teaching as inquiry’ to give shape to what this means in practice. As a pedagogical approach, teaching as inquiry requires teachers to ask “what is important (and therefore worth spending time on), given where my students are at?” and “what strategies (evidence-based) are most likely to help my students to learn?” (NZC, 2007, p35).

A teacher using a teaching as inquiry approach for learning programme design and planning will use a wide range of data and information about their students to make teaching and learning decisions (see the teaching as inquiry pages on the TKI website for what teaching as inquiry means, and the research it is based on, TKI, n.d.e). As yet teaching as inquiry processes in Health Education are not well illustrated and it has been signalled by the sector that this is an area where added resourcing would be useful for teachers. Illustration or exemplification of teaching as inquiry in action needs to show how programme design and planning is informed by a relevant combination of: student achievement data (longitudinal, literacy and numeracy, subject specific, past NCEA results for senior students, data for individual students and for whole cohorts); data about learning progress from formative assessment practices; student voice about their interests, what they want to be learning about and what helps them learn; cultural and social data; student learning goals and qualifications/pathways planning data; school wide priorities and development goals for learning identified through school self-review; parent and whānau aspirations for their children; community events and expertise; knowledge of local contexts and resources; the school’s own vision for their school curriculum; current well-being issues impacting the community, country, and globally; recent health data relevant to the community and the students; and resource availability. The requirement for teachers to practice this way is now established by the Education Council of Aotearoa New Zealand (EDUCANZ), in the Practicing Teacher Criteria (PTC) (EDUCANZ, 2015) whereby teachers need to show evidence of the PTCs in practice every three years for re-registration.

Reflecting on Health Education developments cannot ignore the perennial issue of Health Education delivered by external providers, and one-size-fits-all, pre-packaged ‘programmes’ which are not based on learners’ needs. On one hand schools are encouraged to engage with people and organisations in their communities but on the other hand, pre-planned ‘programmes’ offered by some organisations do not reflect Health Education in the NZC, or quality teaching and learning. To a teacher, a teaching and learning programme is unique to every class and meets the needs of learners in that class, as determined through the teaching as inquiry approach. External providers are at best a resource whose presentation should be negotiated and incorporated into the learning programme designed by the teacher with their students. The contribution external providers make to student learning outcomes is under-evaluated. The ERO sexuality report (ERO, 2007, p51) ‘found no direct correlation between the use of outside providers and effectiveness’. The ERO (2015a, 2015b) reports did not revisit the matter of external providers.

Robertson’s (2013) internal report for the MoE compiled a list of alcohol and other drug programmes, resources, providers and services to highlight for the education sector, as well as social, health and justice sectors, the confusion about the roles, responsibilities, and claimed purposes and outcomes of (external) providers. A recurrent area of confusion lies around
whether externally provisioned programmes or services make a contribution to 'prevention' of unhealthy behaviours (for example the delayed onset of the use of alcohol, as problematic as this is to measure), and ‘intervention’ on behaviours already developed (such as a reduction in risky alcohol related behaviours). Some Health Education programme providers have produced evaluations, such as the primary school based Life Education (Boyd, Fisher & Brooking, 2009), and the Police DARE to Make a Choice programme (Lievore & Mayhew, 2007). These types of reports typically make claim to the programme being aligned with aspects of the NZC document and specifically the HPE learning area, and report impact of the programme only in terms of knowledge gained related to the programme aims, rather than student learning progress and achievement in the NZC.

To determine how each element of the NZC has influenced the shape of Health Education is difficult without extensive research. On the surface of it, Health Education can certainly demonstrate a meaningful contribution to the vision, principles and values of the NZC and the development of students’ key competencies. Precisely how these elements of the NZC have shaped Health Education knowledge and teacher practice warrants investigation, with effective pedagogy in particular requiring close attention.

References


Te Kete Ipurangi (n.d.a) Curriculum in Action (series). Available 06/09/2015,


