

Health Education in *The New Zealand Curriculum*

Health Promotion as an underlying concept in Health Education

**Position statement
&
Professional learning and development resource**



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2017

Health Promotion as an underlying concept in health education: Position statement and professional learning and development resource

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First published, 2017

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Funding from HPA (Health Promotion Agency) contributed to the development of this position statement and resource.

Recommended citation:

Robertson, J. (2017). *Health promotion as an underlying concept in health education: Position statement and professional learning and development resource*. NZ: New Zealand Health Education Association (NZHEA).

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Introduction and purpose

In conjunction with the preparation of the Health and Physical Education (HPE) learning area statement for *The New Zealand Curriculum* (NZC), published by the Ministry of Education in 2007, a series of papers was produced to support the development of teachers' understanding about aspects of teaching and learning in HPE. One of these papers was titled '*Making sense of health promotion in context of health and physical education curriculum learning*' (Robertson, 2005).

Twelve years later and ten years since the release of the NZC, it is a long overdue task to revisit and revise this document.

This response is necessary at this time due to the plethora of demands on the education space to promote student health and wellbeing, and the ongoing misunderstandings about the nature and purpose of HPE as a learning area, and health education as a subject, in the curriculum.

Purpose of this document

In addition to providing revised statement about health promotion in health education, this resource responds directly or indirectly to a number of recent education sector reports that have relevance for the subject.

National reports specific to health education

A number of reports and support resources specific to teaching in health education have been produced since the NZC was released. These include the following.

The 2014-2015 Ministry of Education revised guidelines to support the delivery of health education in schools:

- *Sexuality education: a guide for principals, boards of trustees, and teachers* (MoE, 2015)
- *Relationship Education Programmes: Guide for Schools* (MoE, 2015)
- *Alcohol and other drug education programmes - guide for schools* (MoE, 2014).

All of these documents can be sourced at <http://health.tki.org.nz/Teaching-in-HPE/Policy-guidelines>

The National Monitoring of Student Achievement report (NMSSA, 2013) showed that at year 4, almost all students were achieving at the expected level of the NZC in HPE, but by year 8, only 50% of students were achieving at the expected level of the NZC. Aspects of this study focus on health promotion-type activities. This cyclical study is being repeated in 2017.

Annual examination assessment reports for NCEA continue to highlight strengths and weaknesses in student achievement related to conceptual application of health promotion across the levels.

A NZCER literature review from the Review and Maintenance Programme (RAMP) (Boyd & Hipkins, 2015), highlighted the paucity of literature specific to teaching and learning in HPE and that the HPE community is '*still building a body of knowledge about what the changes in the 1999 and 2007 HPE learning area mean for practice*' (p.54). This knowledge building includes considerations of '*the implications of the unique place of the HPE learning area, and its focus on health promotion ... in contributing to wider wellbeing and school goals*' (p.54).

Promoting student wellbeing in schools

A focus on promoting student wellbeing in schools has increased substantially in recent years, with a number of initiatives as well as new resources and reports being provided to support **whole school approaches**. Education Reviews Office reports that focus on whole school approaches to promoting student wellbeing include:

- *Wellbeing for success: effective practice* (ERO, 2016a) and the accompanying *Wellbeing for success: a resource for schools* (ERO, 2016b) which contains a set of effectiveness indicators linked to the dimensions in the overarching *School Evaluation Indicators* (ERO, 2016c)
- *Food, Nutrition and Physical Activity in NZ Schools and Early Learning Services* (ERO, 2017)
- A further review of sexuality education is underway (due for publishing in 2018, with the last such report being 2007).

In addition the New Zealand Council of Educational Research (NZCER) provides schools with survey tools, resources and reports on student wellbeing (Boyd, Bonne & Berg, 2017).

Community expectations

Pressure on the education system from health sector groups, and media reporting of health and wellbeing concerns voiced by the public and advocacy groups about content they think the ministry should insist is taught in schools, regularly shows misunderstanding the role of teachers and leaders in schools, and what the evidence shows ‘education’ contributes (or doesn’t) to health and behavioural outcomes. Overall, there remains a high level of public (and cross sector) confusion about teaching and learning in health education in the NZC around issues such as, students with diverse sexual and gender identities, sexual health and sexual violence, food and nutrition and physical activity, bullying and mental health.

Overview of this document

Part A: NZHEA position statement

The position statement provides an explanation of health promotion as an underlying concept and how this concept is interpreted and applied specifically in health education to shape health education knowledge. We acknowledge that this is a health education understanding and may not wholly reflect the approach taken by physical education and home economics that also draw from the HPE learning area.

Part B: Resources for professional learning and development

In response to a number of the issues raised in the position statement, and the reconsideration of aspects of the 2005 paper, a number of PLD discussion activities are provided for leaders and teachers for in-service PLD, and for initial teacher education.

Part C: Revisiting the curriculum project paper

As a way to revise and update our thinking and understanding about health promotion as an underlying concept in HPE since the ‘*Making sense of health promotion in context of health and physical education curriculum learning*’ (Robertson, 2005) paper was written, we have asked and responded to a succession of questions around the understandings have we retained, continued to develop and deepen, shifted or changed, or newly added.

Audience

The intended audience for this document is primarily teachers designing and planning teaching and learning programmes in health education. It will also have application for in-service professional learning and development (PLD) and initial teacher education (ITE) providers, and resource developers, as well as external providers supporting teachers in schools to deliver high quality health education teaching and learning.

Our knowledge

As a subject association, our 'knowing' about health promotion in HPE is the accumulation of two decades of experience producing resources to support the implementation of health education in the NZC (including NCEA at secondary level) and providing PLD for the development of teachers' pedagogical content knowledge. As well as this we contribute to the curriculum resourcing and PLD aspects of whole school approaches to the promotion of student wellbeing.

September 2017.

Part A. NZHEA position statement

Health promotion as an **underlying concept** of the Health and Physical Education learning area in *The New Zealand Curriculum*

Health promotion – a process that helps to develop and maintain supportive physical and emotional environments and that involves students in personal and collective action.

(HPE learning area statement, NZC, p.22).

This statement describes the way the underlying concept of health promotion is understood and intended to be used in health education teaching and learning programmes.

1. Health promotion as an underlying concept, along with the other HPE underlying concepts, shapes health education knowledge.

As an underlying concept of the Health and Physical Education (HPE) learning area in *The New Zealand Curriculum*, ‘**health promotion**’ forms an essential part of the knowledge foundation along with the concepts of **hauora and wellbeing**, **the socio-ecological perspective**, and **attitudes and values**.

Understanding of health promotion as an underlying concept is shaped by:

Hauora and wellbeing

Emphasises a focus on a holistic understanding of wellbeing and the interdependence of the mental and emotional, social, spiritual, and physical dimensions of wellbeing (and not single dimension understandings, or only biomedical understandings of ‘health’).

The socio-ecological perspective

Emphasises that health promoting actions occur at a:

- **personal** or individual level,
- between people in their **interpersonal** communications and their ways of supporting and responding to others, and
- at **community or societal** level where they contribute collectively.

Attitudes and values

Emphasises that any health promoting actions must show respect and a sense of care and concern of self, others and society, and reflect the values of social justice such as fairness and inclusiveness.

In combination, and applied to a range of health-related contexts, health education knowledge is framed by the health education statement in the NZC.

Health education

In health education, students develop their understanding of the factors that influence the health of individuals, groups, and society: lifestyle, economic, social, cultural, political, and environmental factors. Students develop competencies for mental wellness, reproductive health and positive sexuality, and safety management, and they develop understandings of nutritional needs. Students build resilience through strengthening their personal identity and sense of self-worth, through managing change and loss, and through engaging in processes for responsible decision making. They learn to demonstrate empathy, and they develop skills that enhance relationships. **Students use these skills and understandings to take critical action to promote personal, interpersonal, and societal wellbeing** (NZC, p.23).

2. The **action competence learning process** frames and guides the health education expectations of the health promotion process.

Action competence learning process

The action competence learning process **is a process for engaging in health promotion**. It provides a framework that enables students to take individual or collective action. The term "action competence" means the development of those competencies (understandings and skills) that enable students to take critical action. The issue selected for action should be one that students have chosen so that it has meaning and relevance for them. Issues will emerge out of the themes or contexts that are currently being studied.

Source: *The Curriculum in Action, Making Meaning Making a Difference* (p.28, MoE, 2004, based on the model by Tasker, 2000).

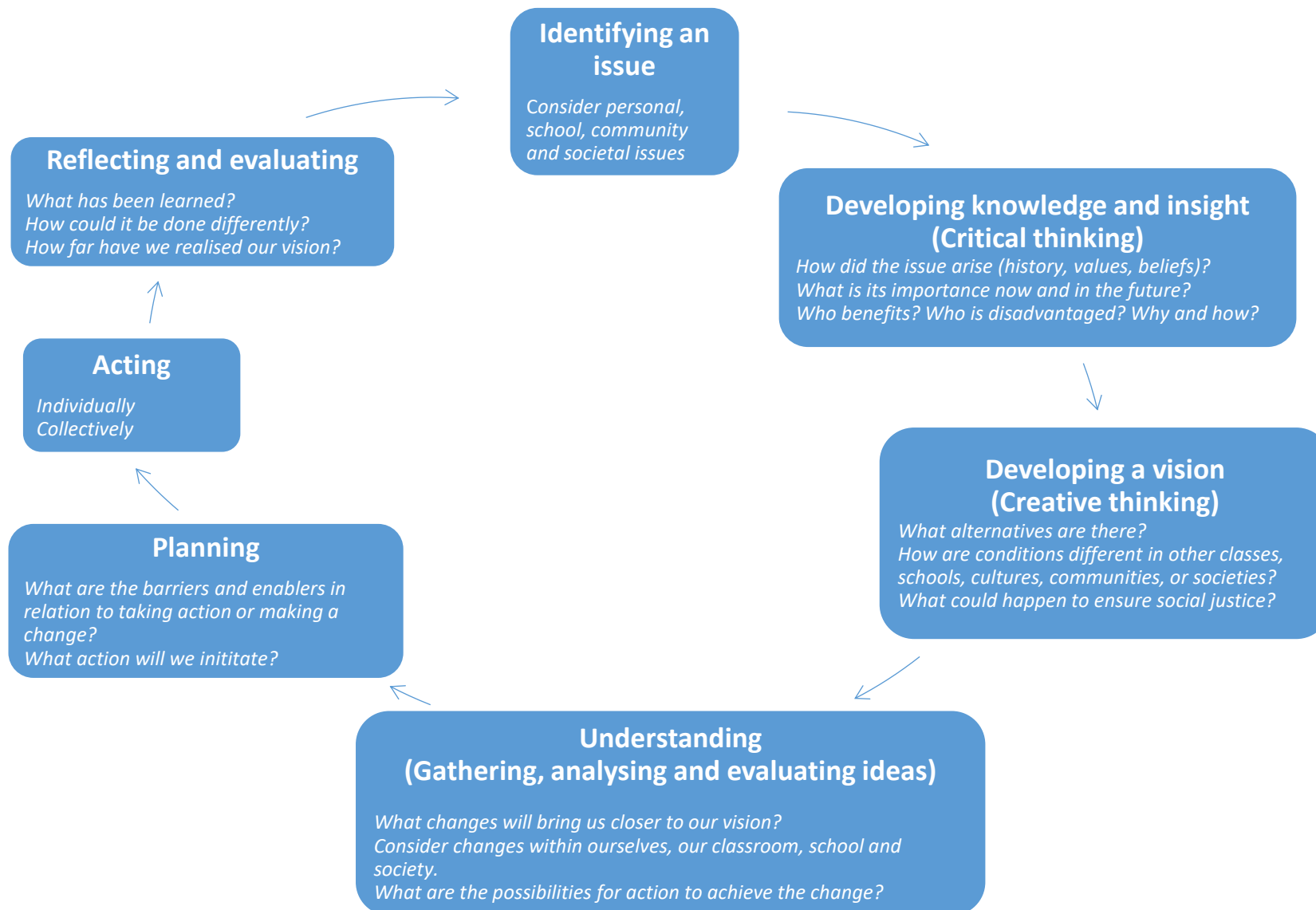
The action competence learning process (ACLP – see the diagram on the following page) is a type of HPE specific inquiry learning **process** that incorporates essential features of health education knowledge, such as how to act to maintain or enhance and sustain wellbeing individually and collectively, with learning processes like critical thinking.

This model emphasises the importance of the **learning process and outcomes of the learning** as students engage in each stage of the ACLP, rather than whether or not wellbeing outcomes are actually achieved through taking action.

Underpinning this model are generic understandings of SMART goals (ie goals for action that are specific, measurable, achievable, realistic, and time bound).

This version of the ACLP model is from *The Curriculum in Action: Making Meaning Making a Difference Years 11-13* (Ministry of Education, 2004, p.28).

Source: <http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Teaching-and-learning-approaches/Action-competence-learning-process>



3. Successful outcomes of health promotion in health education relate to the learning process, *NOT* the behavioural or health outcomes of the actions.

Whether or not the actions taken (based on the ACLP) result in health or wellbeing outcomes is not the measure of learning success. It is the **learning of knowledge, skills and understandings needed to engage and participate in the process of health promotion** that is the purpose of learning in the NZC.

The actions can be a complete 'failure' in terms of achieving the goal(s), as long as the process is followed, and the reflection and evaluation can identify possible reasons why the process was unsuccessful.

Teachers assess student learning through informal processes that monitor student learning progress, and formal collection of evidence to show that expected levels of learning are being achieved (or exceeded).

In health education, teachers will assess a range of learning outcomes related to the development of health promotion related knowledge and skills.

Evidence of learning could include:

- Knowledge and demonstration of a wide range of skills required for taking health promoting action – positive self-talk and self-nurturing strategies, managing stress and physical activity for recreation, decision making and problem solving, effective listening and being assertive, compromise and negotiation, giving and receiving constructive feedback, showing respect and empathy, advocacy through letter writing and campaigning, *and so on*;
- Knowledge and understanding of the parts of the process e.g. critical thinking leading to identification of the issue or wellbeing need, what changes need to occur, and what action needs to be taken to achieve wellbeing;
- Knowledge about the overall health promotion process as a consequence of taking individual or collective action. This is most readily exemplified in Health Achievement Standards 1.1 (personal goal setting) and 2.3 (collective health promoting action) where students document their own process. With support, primary and junior secondary students could be compiling individual or group portfolios of evidence to show learning about aspects of the health promotion process.

See also Position statement #6, and PLD Activity 6 in Part B of this resource.

4. Health promotion in health education is about the promotion of wellbeing

The distinction between the terms 'health' and 'wellbeing' remain problematic.

Popular understandings of 'health'

Popular and cross-sector meanings of 'health' tend to imply biomedical considerations to do with the physical body or medicalised understanding of mental health (and perhaps the sense of wellbeing that may be associated with physical health), despite the World Health Organisation (WHO) definition describing a holistic and multi-dimensional understanding of health beyond just an absence of disease. Out of necessity, the terms 'health' and 'wellbeing' need to be defined in context of the situation they are being used.

For NZC HPE purposes

The inclusion of hauora in the NZC as an HPE underlying concept makes it clear that 'wellbeing' is a holistic understanding and includes the inter-related dimensions of physical, social, mental and emotional, and spiritual *wellbeing*.

What is health and physical education about?

In **health** and physical **education**, the **focus is on the wellbeing** of the students themselves, of other people, and of society through learning in **health-related** and movement **contexts**.

Hauora – a Māori philosophy of wellbeing that includes the dimensions taha wairua, taha hinengaro, taha tinana, and taha whānau, each one influencing and supporting the others.

[Footnote] *In health and physical education, the use of the word hauora is based on Mason Durie's Te Whare Tapa Whā model (Durie, 1994). Hauora and wellbeing, though not synonyms, share much common ground. Taha wairua relates to spiritual wellbeing; taha hinengaro to mental and emotional wellbeing; taha tinana to physical wellbeing; and taha whānau to social wellbeing.*

Health promotion – a **process** that helps to develop and maintain supportive physical and emotional environments and that **involves students in personal and collective action**.

(NZC, p.22)

A range of other models of wellbeing that reflect the diversity of learners can be used to **complement** learning about wellbeing in health education, **in addition** to the concept of hauora and the whare tapa whā model

For comparison - WHO global definitions

- **WHO principles (or definition of health):** Health is a state of complete physical, mental, and social wellbeing and not merely the absence of disease or infirmity.
Source: <http://www.who.int/about/mission/en/>
- **WHO health education:** Health education is any combination of learning experiences designed to help individuals and communities improve their health, by increasing their knowledge or influencing their attitudes.
Source: http://www.who.int/topics/health_education/en/

- **WHO health promotion:** Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.
Source: http://www.who.int/topics/health_promotion/en/
- **WHO on wellbeing:** Mental health: a state of wellbeing - Mental health is defined as a state of wellbeing in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.
Source: http://www.who.int/features/factfiles/mental_health/en/

The succession of Education Review Office reports on student wellbeing produced during 2015-2016 avoid defining 'wellbeing'. However, the NZCER report (Boyd, Boone and Berg, 2017) use Durie's (2003) whare tapa whā model – adapted for application to whole school approaches to the promotion of student wellbeing.

5. The health education understanding of health promotion is derived from theory and makes use of a range of health promotion models that have application to the HPE underlying concepts

Ottawa Charter

When the *Health and Physical Education in the New Zealand Curriculum* (MoE, 1999) document was developed, the World Health Organisation **Ottawa Charter** (1986) was influential for providing understanding of the health promotion **process**.

The Ottawa Charter for Health Promotion (WHO, 1986) provided much of the impetus for the change to using a socio-ecological approach for health education and health promotion. This charter recognised that major health gains were linked not so much to advances in medical knowledge as to increases in wages and living standards and to public health initiatives accompanied by policy changes at government and community levels.

The Ottawa Charter identifies nine broad prerequisites for health: peace, education, food, shelter, income, a stable ecosystem, sustainable resources, social justice, equity.

It advocates "a socio-ecological approach to improve health in which people and their environments are considered to be inextricably linked" (WHO, 1986).

The Curriculum in Action: Making Meaning Making a Difference Years 11-13 (Ministry of Education, 2004, p.15).

Source: <http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Key-concepts>

The five principles of the Ottawa Charter, building healthy public policy, creating supportive environments, developing personal skills, strengthening community action, and re-orienting health services provided a framework whereby students and teachers could:

- *come to understand how the environments in which they live, learn, work, and play affect their personal wellbeing and that of society;*
- *develop the personal skills that empower them to take action to improve their own wellbeing and that of their environments;*
- *help to develop supportive links between the school and the wider community;*
- *help to develop supportive policies and practices to ensure the physical and emotional safety of all members of the school community.*

HPE in the NZC (Ministry of Education, 1999, p.32).

Source a copy of the Ottawa Charter at:

<http://www.who.int/healthpromotion/conferences/previous/ottawa/en/>

Resourcing to support curriculum implementation subsequent to the 1999 document introduced other theories and models of health promotion.

Bangkok Charter

The addition of the WHO **Bangkok Charter** (2005) offered another set of principles to identify ‘*actions, commitments and pledges required to address the determinants of health in a globalized world through health promotion*’. These principles are:

- advocate for health based on human rights and solidarity
- invest in sustainable policies, actions and infrastructure to address the determinants of health
- build capacity for policy development, leadership, health promotion practice, knowledge transfer and research, and health literacy
- regulate and legislate to ensure a high level of protection from harm and enable equal opportunity for health and wellbeing for all people
- partner and build alliances with public, private, nongovernmental and international organizations and civil society to create sustainable actions.

Source a copy of the Bangkok Charter at:

http://www.who.int/healthpromotion/conferences/6gchp/bangkok_charter/en/

Te Pae Mahutonga

For local relevance, and as an expression of the way the principles of the Treaty of Waitangi might be viewed as a framework for health promotion, Mason Durie’s **Te Pae Mahutonga** model, based on the Southern Cross constellation, is used.

The four central stars of the Southern Cross represent four key tasks of health promotion:

- Mauriora (cultural identity)
- Waiora (physical environment)
- Toiora (healthy lifestyles)
- Te Oranga (participation in society)

The two pointers represent:

- Ngā Manukura (community leadership), and
- Te Mana Whakahaere (autonomy).

See: *Ngā kāhui pou: Launching Māori Futures* (Durie, 2003, Chapter 9). Online source of the model:

<http://www.health.govt.nz/our-work/populations/maori-health/maori-health-models/maori-health-models-te-pae-mahutonga>

‘Health education models’ of health promotion

The demands of NCEA assessment have meant that secondary teachers of health education have had to deepen their understanding of health promotion in order to guide students through planning and implementing health promoting actions at NCEA Level 2, and critically analysing health promotion models at NCEA Level 3. The resource, *The Curriculum in Action: Making Meaning Making a Difference Years 11-13* (Ministry of Education, 2004) introduced teachers and students to what have become known as the ‘health education models’ for health promotion. These models are:

- Behaviour change
- Self-empowerment
- Collective action.

These models were based on Don Nutbeam's work for the WHO. The *Health Promotion Glossary* (Nutbeam, 1998) and *Theory in a Nutshell: A Practical Guide to Health Promotion Theories 2nd edition* (Nutbeam & Harris, 2004) provide a brief and accessible synopsis of health promotion terminology and theories.

Although there are many more models than these three, in combination they provide a useful foundation for student learning as they include a range of principles of health promotion that feature recurrently in public health campaigns.

Extract from *The Curriculum in Action: Making Meaning Making a Difference Years 11-13*

Behavioural change model

The behavioural change model came into use before the other two approaches. Many early New Zealand health campaigns were based on this model, and it is still widely used, in conjunction with other models, as part of comprehensive health campaigns.

The behavioural change model is a preventive approach and focuses on lifestyle behaviours that impact on health. It seeks to persuade individuals to adopt healthy lifestyle behaviours, to use preventive health services, and to take responsibility for their own health. It promotes a 'medicalised' view of health that may be characterised by a tendency to 'blame the victim'. The behavioural change model is based on the belief that providing people with information will change their beliefs, attitudes, and behaviours. This model has been shown to be ineffective in many cases because it ignores the factors in the social environment that affect health, including social, economic, cultural, and political factors.

Self-empowerment model

This approach (also known as the self-actualisation model) seeks to develop the individual's ability to control their own health status as far as possible within their environment. The model focuses on enhancing an individual's sense of personal identity and self-worth and on the development of 'life skills', including decision-making and problem-solving skills, so that the individual will be willing and able to take control of their own life. People are encouraged to engage in critical thinking and critical action at an individual level. This model, while often successful for individuals, is not targeted at population groups and is unlikely to affect social norms.

Collective action model

This is a socio-ecological approach that takes account of the interrelationship between the individual and the environment. It is based on the view that health is determined largely by factors that operate outside the control of individuals. (See the information about determinants of health in the Appendix.)

This model encompasses ideas of community empowerment, which requires people individually and collectively to acquire the knowledge, understanding, skills, and commitment to improve the societal structures that have such a powerful influence on people's health status. It engages people in critical thinking in order to improve their understanding of the factors affecting individual and community wellbeing. It also engages them in critical action that can contribute to positive change at a collective level.

Given the importance of determinants of health, the use of a collective action model is more likely to achieve healthy outcomes, both for individuals and for groups within society.

(Ministry of Education, 2004, p.14).

Source: <http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Socio-ecological-perspective/Defining-health-promotion/Models-of-health-promotion>

6. Health promotion (or rather, the promotion of wellbeing) requires knowledge and skills to be able to act independently as an individual, interpersonally with others, and collaboratively as a group or collective.

Students learn knowledge and skills to take action independently as an individual, interpersonally with others, and collaboratively as a group or collective, in developmentally more complex and insightful ways across their years of learning in health education. These skills, underpinned by knowledge of why they are used and in which situations these skills would be applied, are developed across a range of learning contexts.

Socio-ecological approach to health promotion	Examples of actions (which become more developmentally complex with increasingly levels of the NZC)
Personal actions	<p>Having knowledge and skills for:</p> <ul style="list-style-type: none"> • Self-management e.g. stress management, time management, self-nurturing • Positive self-talk (rational thinking) • Expressing feelings appropriately • Effective interpersonal communication (<i>see the list of interpersonal actions below</i>) • Decision making - taking personal responsibility for acting in ways that promote wellbeing • Asking for help from trusted others • Help seeking - accessing and using systems and agencies (e.g. at school or in community) that support wellbeing • Personal goal setting, action planning, implementing, reflecting and evaluating (ACLP used for personal action).
Interpersonal actions	<p>Using interpersonal skills appropriate to situations to support the wellbeing of the other person and/or support the relationship between people, such as:</p> <ul style="list-style-type: none"> • Effective communication, effective listening, negotiation and compromise, using 'I' statements, assertiveness, problem solving, giving constructive feedback • Respectful communication • Supporting and caring • Showing empathy • Valuing others - respecting the diversity of others.
Collective actions that contribute to community or societal health promotion	<p>Using knowledge and skills when working collectively to take action e.g.</p> <ul style="list-style-type: none"> • Advocacy – letter writing, petitioning, campaigning • Group processes for identifying issues, e.g. questioning, surveying, interviewing • Goal setting, action planning, implementing, reflecting, and evaluating (ACLP used for collective action) • Critical thinking to understand situations – e.g. who is advantaged/ disadvantaged, seeing different perspectives and using these understandings to make decisions about actions • Campaigning, presenting, advertising.

7. Critical action is that which responds to identified needs and the factors that contributed to the situation in the first place AND actions which reflect the HPE attitudes and values of respect, care and concern, and social justice.

Defining critical thinking and critical action

- **Critical thinking** is "examining, questioning, evaluating, and challenging taken-for-granted assumptions about issues and practices"
- **Critical action** is "action based on critical thinking"

Health and Physical Education in the New Zealand Curriculum (Ministry of Education, 1999, p.56).

Attitudes and values – a positive, responsible attitude on the part of students to their own wellbeing; respect, care, and concern for other people and the environment; and a sense of social justice.

(NZC, p.22).

The action competence learning process used to guide identification, planning implementation and evaluation of health promoting action requires **critical thinking**, using questions like the following, to identify the issue leading to action to promote health or wellbeing.

Questions for critical thinking

- What do you know about this issue or situation?
- How did you come to know this?
- How do you feel about this issue or situation?
- What is the evidence for this knowledge?
- What are your beliefs about this knowledge? Why do you believe this?
- What information is missing from this picture?
- Why is this information missing?
- Have the social, cultural, economic, political, and/or ethical aspects of this situation been considered?
- Whose voice is heard in this writing, article, or classroom activity?
- Whose interests are being served? Who has the power in this situation?
- Who is being advantaged?
- Who is not being heard or served?
- Who is being disadvantaged?
- What are the inequalities that exist in this situation?
- What needs to change?
- How can you contribute to this change?

Source: *The Curriculum in Action: Making Meaning Making a Difference Years 11-13* (Ministry of Education, 2004, p.27, based on Brookfield, 1995, and Smyth, 1992).

Source: <http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Teaching-and-learning-approaches/Engaging-students-in-critical-thinking>

Responding to these questions requires additional understanding of the attitudes and values as an underlying concept of HPE.

What is respect?

- **Respect is how you feel about someone.** Having respect for someone means you think good things about who a person is or how they act. You can have respect for others, and you can have respect for yourself.
- **Respect is how you treat someone.** Showing respect to someone means you act in a way that shows you care about their feelings and wellbeing.

Showing respect for others include things like not calling people names, treating people with courtesy, caring enough about yourself that you don't do things you know can hurt you.

Source: <http://talkingtreebooks.com/definition/what-is-respect.html>

What is social justice?

Social justice is found when a society enables all its members to participate in and have access to the social, cultural, political, and economic resources that define a normative way of life for that society.

Social justice is absent when groups of people within a society are excluded from or have very limited access to social, cultural, political and economic resources, compared to the majority of that society.

Social justice is related to, but is wider than, human rights. People may have their human rights respected and upheld, but still be excluded from participating in or accessing the resources of their society.

Social justice is about fairness in the way we:

- Deal with other people.
- Share responsibilities
- Distribute income, wealth, and power in society
- Create social, economic, and political structures
- Put those structures into operation so that all members of society are able to be active and productive participants.

Source (adapted from): <http://www.salvationarmy.org.nz/about-us/position-statements/social-justice>

8. The ways understandings of health promotion feature in the HPE learning area are framed by the HPE strands and the achievement objectives

The HPE Achievement Objectives unpack health education into eight levels of learning spanning years 1-13. Achievement Objectives are organised under four strands, three of which have relevance for health education.

The description of each strand highlights aspects of individual or collective action to be included in learning programmes.

How is the learning area structured?

The learning activities in health and physical education arise from the **integration** of the underlying concepts, the strands and their achievement objectives, and the key areas of learning, which for health education is mainly mental health, sexuality education, and food and nutrition. The three strands most relevant to health education are:

(Strand A) Personal Health and Physical Development, in which students develop the knowledge, understandings, skills, and attitudes that they need in order to maintain and enhance their personal wellbeing and physical development;

(Strand C) Relationships with Other People, in which students develop understandings, skills, and attitudes that enhance their interactions and relationships with others;

(Strand D) Healthy Communities and Environments, in which students contribute to healthy communities and environments by taking responsible and critical action.

(Extract adapted from NZC p.22).

See the resource in Part B – PLD6 - for examples of the ways health promotion related AOs could be used in a range of learning contexts.

9. Formal assessment with NCEA health achievement standards at senior secondary level requires understanding of health promotion.

The three upper levels of the NZC (levels 6-8) map onto NCEA levels 1-3. Every achievement standard includes an aspect of health promotion. For achievement of all health standards, knowledge of actions or strategies (approaches) for achieving wellbeing are a requirement for learning success.

This table summarises the way ideas related to the underlying concept of health promotion are included in each of the health education achievement standards. [See also PLD7 in Part B of this resource.](#)

AS #	Achievement standard title (and achievement criterion)		Health promotion focus in this standard – that is, knowledge (and in some cases demonstration) of strategies or actions to achieve wellbeing
Level 1			
AS90971 1.1	Take action to enhance an aspect of personal wellbeing.	3 credits Internal	Personal goal setting in relation to enhancing an identified area of wellbeing need. Developing a SMART goal and action plan, implementing and evaluating the plan in relation to wellbeing.
AS90972 1.2	Demonstrate understanding of influences on adolescent eating patterns to make health-enhancing recommendations.	4 credits External	Designing a basic action plan to improve an aspect of food and nutrition for a school or community setting (based on a scenario). OR Demonstrating understanding of personal, interpersonal and community/societal actions to bring about change and/or enhance wellbeing in relation to food and nutrition.
AS91097 1.3	Demonstrate understanding of ways in which wellbeing can change and strategies to support wellbeing.	4 credits Internal	Demonstrating understanding of personal, interpersonal and community/societal actions needed to support a person in a situation where their wellbeing has changed.
AS90973 1.4	Demonstrate understanding of interpersonal skills used to enhance relationships.	5 credits Internal	Demonstrating knowledge of own and joint problem solving, and knowledge and application of interpersonal communication skills including effective listening and assertiveness skills (through rehearsal, or role play).
AS90974 1.5	Demonstrate understanding of strategies for promoting positive sexuality.	4 credits Internal	Knowledge of strategies for promoting sexual health at personal and community level (preventing STIs and unplanned pregnancy), exercising rights and responsibilities in romantic/sexual relationships, and promoting positive sexuality/inclusiveness of diversity.
AS90975 1.6	Demonstrate understanding of issues to make health-enhancing decisions in drug-related situations.	4 credits External	Demonstrating the use of a decision making model.

Level 2			Health promotion focus in this standard
AS91235 2.1	Analyse an adolescent health issue.	5 credits External	Knowledge of personal, interpersonal and community/societal strategies (and actions) needed to achieve healthy outcomes in relation to a selected adolescent wellbeing issue.
AS91236 2.2	Evaluate factors that influence people's ability to manage change.	5 credits Internal	Knowledge of personal, interpersonal and community/societal strategies (and actions) needed to build resilience by developing, enhancing, or emphasising the protective factors and reducing or mitigating the risk factors.
AS91237 2.3	Take action to enhance an aspect of people's wellbeing within the school or wider community.	5 credits Internal	A group/collective process to plan a goal related to an aspect of school/community wellbeing, plan and implement actions, and evaluate the process and impact of the actions in relation to the goal and its impact on people's wellbeing.
AS91238 2.4	Analyse an interpersonal issue(s) that places personal safety at risk.	4 credits External	Knowledge of personal, interpersonal and community/societal strategies (and actions) including the use of laws and policies needed to reduce the impact on wellbeing when there are power imbalances in relationships (bullying, harassment, intimidation, discrimination).
AS91239 2.5	Analyse issues related to sexuality and gender to develop strategies for addressing the issues.	5 credits Internal	Knowledge of personal, interpersonal and community/societal strategies (and actions), that contribute to social justice in gender and/or sexuality situations. The strategies need to show understanding of the values of social justice.
Level 3			
AS91461 3.1	Analyse a New Zealand health issue.	5 credits Internal	Knowledge of community/societal strategies (and actions) - which may still include aspects of personal and interpersonal actions (depending of the issue) needed to achieve equitable health outcomes in relation to a selected health or wellbeing issue. For the most part the strategies need to link to the determinants of health that contributed to the issue in the first place.
AS91462 3.2	Analyse an international health issue.	5 credits External	
AS91463 3.3	Evaluate health practices currently used in New Zealand.	5 credits Internal	Evaluation of health practices includes consideration of whether or not the health practices are holistic or treat only one dimension of health or wellbeing, how effective the practices are – as relevant to the health or wellbeing situation selected for the investigation.
AS91464 3.4	Analyse a contemporary ethical issue in relation to wellbeing.	4 credits Internal	Analysis of the ethical dilemma includes consideration of whether or not the different perspectives provide opportunity for health promotion in relation to the issue.
AS91465 3.5	Evaluate models for health promotion.	5 credits External	Knowledge of the way different models of health promotion can be applied to situations and to evaluate the likely success of these based on what theory says about the effectiveness of models.

Source of standards titles and registration numbers: Health Education Achievement Standards matrix
<http://ncea.tki.org.nz/Resources-for-Internally-Assessed-Achievement-Standards/Health-and-physical-education/Health-education>

10. When a whole school approach is taken to promote student wellbeing, these actions are the responsibility of all leaders and teachers, working with students and community.

Education Council - Our Code Our Standards: Code of Professional Responsibility and Standards for the Teaching Profession (2017). Source: <https://educationcouncil.org.nz/content/our-code-our-standards>

Based on the Education Council (2017) Code of Professional Responsibility, and regardless of the subject, topic or content knowledge they teach, *all teachers* are required to *promote the wellbeing of learners and protect them from harm* (from part 2 of the code 'commitment to learners'). Promoting student wellbeing is the responsibility of all teachers at all times, not specially the teachers teaching health education.

Similarly, all teachers, regardless of the subject material they are teaching, are required to comply with the Education Council Teacher Standards. A selection of the Standards (with elaborations) are noted below. That is, the promotion of student wellbeing (as an educational outcome) is the collective responsibility of all teachers, not just the teacher teaching health education.

Teacher Standards	Elaboration of the standard
Learning-focused culture <i>Develop a culture that is focused on learning, and is characterised by respect, inclusion, empathy, collaboration and safety.</i>	<ul style="list-style-type: none"> • Develop learning-focused relationships with learners, enabling them to be active participants in the process of learning, sharing ownership and responsibility for learning.
Design for learning <i>Design learning based on curriculum and pedagogical knowledge, assessment information and an understanding of each learner's strengths, interests, needs, identity, language and cultures.</i>	<ul style="list-style-type: none"> • Select teaching approaches, resources, and learning and assessment activities based on a thorough knowledge of curriculum content, pedagogy, progressions in learning and the learners. • Harness the rich capital that learners bring by providing culturally responsive and engaging contexts for learners.
Teaching <i>Teach and respond to learners in a knowledgeable and adaptive way to progress their learning at an appropriate depth and pace.</i>	<ul style="list-style-type: none"> • Teach in ways that ensure all learners are making sufficient progress, and monitor the extent and pace of learning, focusing on equity and excellence for all. • Use an increasing repertoire of teaching strategies, approaches, learning activities, technologies and assessment for learning strategies and modify these in response to the needs of individuals and groups of learners. • Provide opportunities and support for learners to engage with, practise and apply learning to different contexts and make connections with prior learning. • Teach in ways that enable learners to learn from one another, to collaborate, to self-regulate and to develop agency over their learning. • Ensure learners receive ongoing feedback and assessment information and support them to use this information to guide further learning.

All teachers are expected to create safe supportive environments conducive to learning. Features of these environments include respectful communication and respect for culture and diversity, shared decision making, and a culture of care and concern. Many of these principles are captured in *Tātaiako: Cultural Competencies for Teachers of Māori Learners* (Education Council, 2011). Source this document at <https://educationcouncil.org.nz/content/t%C4%81taiako-cultural-competencies-teachers-m%C4%81ori-learners-0>

The Education Review Office (ERO)

The Education Review Office (ERO) evaluation of whole school approaches to promoting student wellbeing resulted in two reports being published:

- *Wellbeing for Children's Success at Primary School* (ERO, 2015a)
- *Wellbeing for Young People's Success at Secondary School* (ERO, 2015b).

Since then, further ERO reports have included:

- *Wellbeing for success: effective practice* (ERO, 2016a)
<http://www.ero.govt.nz/publications/wellbeing-for-success-effective-practice/>
- *Wellbeing for success: a resource for schools* (ERO, 2016b)
<http://www.ero.govt.nz/publications/wellbeing-for-success-a-resource-for-schools/>

The 'resource' document includes a series of evaluation indicators to guide school practices for carrying out their own evaluation of actions to promote student wellbeing.

These ERO documents make it clear that promoting student wellbeing is a collective responsibility of the whole school community. **Promoting student wellbeing is not solely the responsibility of teaching and learning programmes in health education.** Wellbeing in this context refers more to mental and emotional wellbeing and social wellbeing, although inclusion of spiritual wellbeing and can be interpreted from this literature.

ERO - Guiding principles for student wellbeing

The principles are strongly tied to a holistic approach to student wellbeing and acknowledge student wellbeing as multi-dimensional. Each principle needs to be enacted in balance with each of the others for student wellbeing to be properly promoted.

- Positive and trusting **relationships** are at the centre of effective efforts to promote student wellbeing, creating a sense of connection and belonging within the school community.
- The **strengths** of students and their whānau are valued and used as the basis for promoting and responding to student wellbeing.
- **Cohesion** across policies, practices, interventions and initiatives contributes to an integrated, joined up, well 'glued' and seamless approach to promoting student wellbeing.
- **Inquiry** is dynamic, considers the school context, uses a wide range of information sources and acts upon findings to improve student wellbeing, driving improvements in both learning and teaching contexts.
- **Collaboration** enables the inclusion and involvement of students, teachers, leaders, parents, whānau and community in promoting student wellbeing.

Source: <http://www.ero.govt.nz/publications/wellbeing-for-success-effective-practice/appendix-2-guiding-principles-for-student-wellbeing/>

See also the NZCER report *Finding a balance – fostering student wellbeing, positive behaviour, and learning: Findings from the NZCER national survey of primary and intermediate schools* (NZCER, 2016) and the useful infographic *Making a difference to student wellbeing*.

<http://www.nzcer.org.nz/infographic-making-difference-student-wellbeing>

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Part B. Resources for professional learning and development

This section aims to provide a selection of materials to support middle leader and teacher professional learning and development (PLD) and future resource development in health education.

Each section is designed to be a stand-alone reading accompanied by a suggested group discussion/PLD activity that a middle leader could facilitate with teachers in a department or syndicate meeting, or the section could be used by individual teachers as part of their self-directed professional learning.

This section contains the following PLD activities:

1. Deepening teacher understanding of health promotion in health education through models of health promotion
2. The action competence learning cycle – *revisited and re-emphasised*
3. Is health education ‘for’ or ‘about’ health (promotion)?
4. The role of health education and whole school approaches
5. The role of external providers for supporting health education approaches to health or wellbeing promotion
6. Health promotion and the HPE achievement objectives
7. Developing understanding of health promotion actions and strategies across NCEA L1 – L3 Health Achievement Standards

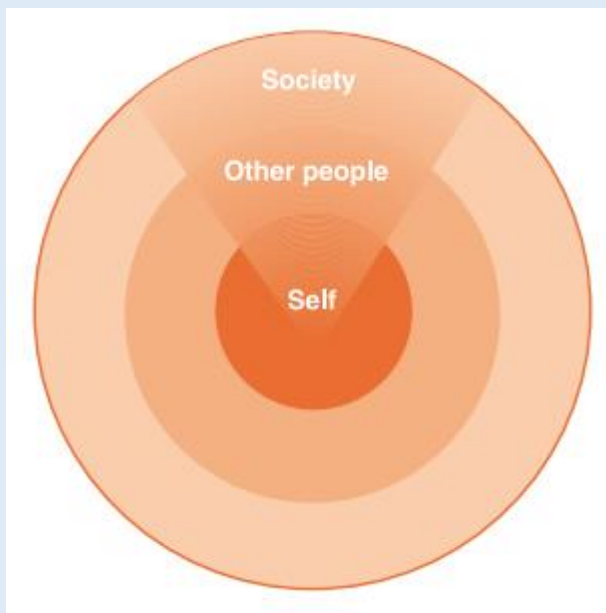
PLD1. Deepening teacher understanding of health promotion in health education through models of health promotion

1. Socio-ecological perspective understandings – the personal, interpersonal and societal

Extract from: *Health and Physical Education in the New Zealand Curriculum* (Ministry of Education, 1999, p. 33).

The Socio-ecological Perspective

People can take part in the health promotion process effectively only when they have a clear view of the social and environmental factors that affect health and wellbeing. Through learning experiences that reflect the socio-ecological perspective, students can seek to remove barriers to healthy choices. They can help to create the conditions that promote their own wellbeing and that of other people and society as a whole. Through this perspective, students will also come to a better appreciation of how and why individuals differ.



The socio-ecological perspective will be evident when students:

- identify and reflect on factors that influence people's choices and behaviours relating to health and physical activity (including social, economic, environmental, cultural, and behavioural factors and their interactions);
- recognise the need for mutual care and shared responsibility **between themselves, other people, and society;**
- **actively contribute to their own wellbeing, to that of other people and society, and to the health of the environment that they live in.**

Through the socio-ecological perspective, students will learn to take into account the considerations that affect society as a whole as well as individual considerations and will discover the need to integrate these.

Source: <http://health.tki.org.nz/Teaching-in-HPE/Health-and-PE-in-the-NZC/Health-and-PE-in-the-NZC-1999>. Note that although the 1999 HPE document has no policy status as a curriculum document, it remains a useful resource to explain the underlying concepts and key areas of learning.

PLD activity for HPE middle leaders and teachers

Resources:

- The extract above on the socio-ecological perspective.
- Position statement #6 listing a range of skills needed for taking action.
- Your own health education teaching and learning programme – junior and senior levels.

Task:

- Review your junior programme to identify where a range of personal, interpersonal and community/societal skills (and associated knowledge about the use of these skills) are included across your junior health education programme. Which aspects of the junior programme could be strengthened to give more learning focus to the knowledge and skills needed for the *process* of taking individual and collective action?
- What skills can you add to the list in Position statement #6? Where do you (or could you) include these skills in your programme?
- How are these skills referred back to and/or developed further when considering personal, interpersonal and community/societal actions and strategies for learning leading to Level 1&2 NCEA achievement?
- What opportunities are there for students to use these skills as part of a whole school approach to promote student wellbeing at school?

2. Ottawa Charter, Bangkok Charter and Te Pae Mahutonga AND the ‘Health education models for health promotion’ (behaviour change, self-empowerment and collective action)

Although these models do not become a required feature in student learning until Level 8 (NCEA Level 3), it is recommended that all teachers have a basic understanding of the principles of a range of health promotion models. This recommendation is to ensure that health education programmes across NZC level 1-7 are providing opportunity for the development of sufficient knowledge (as a succession of ‘building blocks’) leading to the theoretical and research-based understandings of the principles of effective health promotion. See also the illustration of progression in PLD6.

PLD activity for HPE middle leaders and teachers

Resources:

- Position statement #5 listing the models of health promotion that have relevance for health education.
- Your own senior health education teaching and learning programme.
- Past examples of examinations for AS91465 (Health 3.5).

Task:

- Locate online and bookmark sources of the Ottawa and Bangkok Charters (WHO website) and Te Pae Mahutonga.
- Locate the Information about the behaviour change, self-empowerment and collective action models in the *Curriculum in Action: Making Meaning Making a Difference* (print copy or online).
- Compare and contrast these models to identify what is similar and different, what contexts are the most appropriately applied to and why – this includes identifying the strengths and limitations of each.
- Select one or two past examination papers for Health 3.5 and work your way through these to ‘test’ your knowledge of the way health promotion models are applied to a range of health promotion contexts.
- Review your senior health education programme planning to identify where some early ‘building blocks’ leading to learning about these models might be included in Year 11 and 12 leading to assessment with Level 1 and 2 Achievement Standards. In year 13, or when students are working towards NCEA Level 3, how are ideas about health promoting models being incorporated across the learning programme to ensure depth of understanding about the strategies needed to bring about equitable outcomes for groups and at whole population level?

Note that even if students are not completing Health 3.5 as an assessment, the knowledge of the behaviour change, self-empowerment and collective action models is still required for 3.1 and 3.2, and the Ottawa or Bangkok Charter, or Te Pae Mahutonga (depending on the health or wellbeing issue and context) may be useful for identifying strategies to bring about more equitable outcomes. It may also be helpful to introduce the basics of the health education models at year 12 (NZC Level 7/NCEA Level 2), for example for students to be able to critique the strengths and limitations of their action taken as part of AS 91237 (Health 2.3) .

PLD2. The action competence learning cycle – *revisited and re-emphasised*

PLD activity for HPE middle leaders and teachers

Resources:

- Position statement #2.
- An original source of the ACLP such as *The Curriculum in Action: Making Meaning Making a Difference Years 11-13* (Ministry of Education, 2004, p.28) or online at <http://health.tki.org.nz/Key-collections/Curriculum-in-action/Making-Meaning/Teaching-and-learning-approaches/Action-competence-learning-process>
- Your own health education teaching and learning programme.

Task:

- Review your junior and senior (primary or secondary) programmes to identify where students have opportunity to develop knowledge and skills related to each (individual) stage of the ACLP – as developmentally appropriate for the level of achievement (and irrespective of whether or not this learning is coherently joined together to fulfil the intent of the ACLP).
- Is there at least ONE place in your learning programme for each year level where the students have opportunity to purposefully and deliberately engage in a complete cycle of the ACLP? If so, what learning context? What evidence do you collect to show that learning about the health promotion process has occurred?
- What types of activities have you found help your students to think critically to ‘develop knowledge and insight’ and to respond to questions such as: *How did the issue arise (history, values, beliefs)? What is its importance now and in the future? Who benefits? Who is disadvantaged? Why and how?*
- Similarly, what activities have you found help your students to navigate their way through and around the other stages of the ACLP cycle?
- What aspects of your programme could be strengthened to develop student capabilities and understandings for approaching individual and collection health promoting action *as a process*? For example, explicit teaching of the stages of an action cycle, including setting SMART goals, aligning actions with goals, evaluating actions, and so on.
- How would you apply the teaching as inquiry approach (NZC p.35) to decide what students know about the ACLP, what needs to be focused on to deepen their understanding of the process, what teaching strategies will be used to develop knowledge and associated skills for working through an ACLP cycle, and what evidence you would collect to show this learning had occurred?

PLD3. Q. Is health education ‘for’ or ‘about’ health (promotion)?

A. As a matter of *educational* outcomes, health education is ‘about’ wellbeing and the process of health promotion.

Reading – to use as the basis for discussion

What is ‘effective’ health education in the NZC?

When taken in its curriculum context, effective health education is measured or assessed in terms of learning outcomes for students – have students achieved the intended learning and achieving at or beyond the expected level of the curriculum, and have they made progress over time? Teacher effectiveness is ‘measured’ in relation to the Standards for the Teaching Profession (Education Council, 2017).

Arguments in defence of what health education is (and isn’t) and what it can (and cannot) do:

Given the complex interplay of factors that determine the health of populations, why would education (alone) result in measurable health improvements? Why would it be assumed that the number of young people binge drinking, drinking and driving, catching STIs, having an unplanned pregnancy (etc) can be measured as the result of an education programme based on *learning*? It’s not what health education learning intentions say the outcomes will be. Research leading to understanding the determinants of health indicate that the most significant predictor of health status in this country (and any other developed nation) is poverty – or in other words, economic determinants. When the significant impact of the political, cultural and social determinants of health are also considered, the influence on population health of health education *alone*, is highly problematic to measure and likely negligible.

Consider these statements:

- As an NZC learning area, HPE is founded on a concept of holistic wellbeing (hauora) not intended to be measured by medicalised individual and population health outcomes; the socio-ecological perspective requires consideration and developing understanding of the complex interplay between individuals, learning about the process of taking action to promote wellbeing.
- Plenty of young people have perfectly fine health behaviours. A premise of curriculum learning is that students must be able to progress in their learning over time – where do they progress to if there’s nothing ‘wrong’ with them? How can their health statistics improve when there’s nowhere to improve to?
- Health education in the NZC is for all students regardless of any (perceived) current health or wellbeing status. It’s not about fixing sick or dysfunctional children and young people. Health education in the NZC is not a form of therapy or intervention ‘for those that need it’.
- It would be unethical and untenable for a school to establish a learning programme, designed to be measured/assessed by curriculum learning outcomes, to instead require a change in students’ health behaviours and health status for as the measure of learning success, not only, but especially when poverty is a key reason for poorer health status.
- The nature of health education knowledge makes students’ use of this knowledge in their personal lives highly desirable, but teachers and schools have no authority and control over students’ health behaviours beyond the school context (again go back to the determinants of health as to ‘who’ or what is most influential of young people’s wellbeing).

- To a teacher, students are learners, not clients or patients. As a matter of professional practice (requiring qualifications, professional registration and up to date certification), teachers are *teachers*, not social workers, counsellors, nurses, doctors, or health promoters delivering services to meet health sector outcomes.
- If behavioural interventions are required for a targeted group of students with behavioural or wellbeing issues, what teachers need to know is how their school systems work and what their professional responsibility is when accessing or using these systems to support students. Interventions for students experiencing wellbeing related issues often require support from an external provider – a professional with expertise in their field to respond to the situation ethically and knowledgeably. Health education that meets the learning needs of all students is not a health or behavioural intervention. (*An educational intervention is one that seeks to improve an aspect of a child's learning when it is identified they need additional support to develop knowledge and skills in a particular area.*)
- At best, health education can claim to make a contribution of knowledge, skills, and perhaps attitudes, to the 'prevention' of health related harms in contexts such as drug and alcohol education, safer sex practices, and food and nutrition. However, measuring 'prevented' behaviours is highly problematic and contentious given the complexity of health issues (the political, economic, cultural and social factors that influence health issues). It is very difficult to defend claims that a reduction in the incidence of a particular health behaviour, or a drop in population statistics showing improved health outcomes for a population group, is from education alone when the multiple other factors implicated in the issue cannot be accounted for.
- Health education can make a contribution to the promotion of wellbeing through the development of knowledge about the process of health promotion, and skills to act in ways that promote wellbeing. The educational outcome of this knowledge and skill development, and where engaging in a health or wellbeing promotion process, is still assessed as a learning outcome.
- Health education is a body of knowledge, skills and understandings to be learned as part of a learning pathway leading possibly to further study and work. Senior health education provides a qualification pathway that contributes to students having choices beyond school. Teachers of health education use the teaching as inquiry approach (NZC p.35) to establish student learning needs, decide strategies that helps students learn, to monitor student learning progress and achievement, and to help students track and monitor their progress toward their learning and qualifications goals.

1. Health education teacher practice and the Education Council *Code of Professional Responsibility and Standards for the Teaching Profession*

PLD activity for HPE middle leaders and teachers

Resources:

- Position statement #10.
- Locate a copy of **Our Code Our Standards: Code of Professional Responsibility and Standards for the Teaching Profession** (Education Council, 2017). See also the support materials in **The**

Code of professional responsibility: Examples in Practice

<https://educationcouncil.org.nz/content/our-code-our-standards>

- *Wellbeing for success: a resource for schools* (ERO, 2016)
<http://www.ero.govt.nz/publications/wellbeing-for-success-a-resource-for-schools/> - see the indicators listed in this document.

Task - Group discussion and/or individual reflection:

- Select some of these bulleted statements and see if you can defend them in context of either the teacher standards, the Code of Professional Responsibility, and/or the ERO evaluation indicators for promoting student wellbeing.
- For which statements do you want to take a different position? Why is this? What NZ education document(s) would you refer to in order to defend and support this alternative position?
- Do any of these statements have implications for your current teaching (or middle leadership) practice? If so, which statement(s), what needs to change, and why?
- How clear are you about the extent of your health education teaching responsibilities specifically, and your teaching responsibilities in general (regardless of the topic or subject material you are teaching), for promoting the wellbeing of students? How clear are you about your responsibilities to wider school systems that support student wellbeing? Not sure – see PLD4 activities.

2. Effective pedagogy, the key competencies, and health education

PLD activity for HPE middle leaders and teachers

Resources:

- Position statements #1, 3 & 8.
- Locate a copy of the effective NZC pedagogy statement (p.34-36) and the key competencies (p.12-13), assessment (p.39-41), as well as the learning area statement p.22-23, and the HPE achievement objectives.
- The section on TKI that considers the key competencies in conjunction with the effective pedagogy statement may also be useful. Source this at: <http://nzcurriculum.tki.org.nz/Key-competencies/Key-competencies-and-effective-pedagogy>

Task - Group discussion and/or individual reflection:

- Select some of these bulleted statements and see if you can defend them in context of the NZC.
- Do any of these statements have implications for your current health education teaching (or middle leadership) practice – when considered in context of the NZC effective pedagogy, key competencies, and assessment statements? If so, which statement(s), what needs to change, and why?

PLD 4. The role of health education in whole school approaches to promoting student wellbeing

A whole school approach (WSA) to promoting wellbeing requires people at all levels or layers of school organisation to work in collaboration, and for meaningful and productive partnerships to be developed with key stakeholders, including parents and whānau, in the school community.

The details of a WSA will be dependent on the specific nature of the wellbeing context, however it will typically include the following features.

High quality curriculum teaching and learning for all students. This includes:

- Teaching and learning programmes across all learning areas that are developed in accordance with the NZC vision, principles, values, effective pedagogy and key competencies.
- Dedicated teaching and learning programmes in health education which are grounded in the underlying concepts of the HPE learning area.
- Learning programmes that teach students how to engage in a process of health promotion and learning knowledge and skills to act individually and collectively in relation to an issue.

Leadership of school policy, procedures and practices that give priority to:

- Whole school curriculum design that provides health education opportunities for all students;
- Establishing clear expectations of practice and behaviour (or conduct) for all staff and students;
- Systems for referral procedures for students requiring specialist health and wellbeing support.
- Rigorous procedures for selecting and using community-based providers and resources to support curriculum and early intervention practices;
- A fair (preferably restorative) system for managing behavioural misdemeanours;
- Ongoing review and evaluation of all relevant school systems and procedures to ensure the promotion of wellbeing is embedded in school practices and sustained over time, and is not simply 'yet another project' with a beginning and an end run for a fixed period. Also, evaluation considers the impact of the actions to promote wellbeing, not just self-reported satisfaction of participants and stakeholders with the process.

Teachers and educational leaders who:

- Engage in rigorous staff appraisal processes and evidence gathering to show that they meet the teacher standards and are engaged in ongoing PLD – which may include PLD related to promoting student wellbeing
- Act as role models and mentors and consistently promote wellbeing messages
- Create and maintain safe supportive learning environments;
- Are appropriately trained teachers who can deliver quality health education teaching and learning programmes.

Student action groups, youth councils or youth health councils for:

- Student-led health promotion;
- Peer support or peer mentoring.

Early intervention support that:

- Identifies students at risk of not achieving because of wellbeing related issues;
- Is managed by effective pastoral systems in the school, including guidance counsellors (or social workers) to ethically and professionally provide or supervise intervention procedures and processes;
- Provides students with access to culturally-responsive, early-intervention providers in the community who can make a difference.

Community – parents and whānau who have:

- Opportunities to be consulted and share in the decision-making processes for school policies and procedures that have relevance for the promotion of student wellbeing;
- Access to information to help them to connect with community-based providers that support parents to help their children (and themselves or each other) in wellbeing related situations;
- Opportunities for engaging in school events that aim to promote wellbeing.

Other stakeholders in the community who can support the school in actions to promote student wellbeing include:

- Agencies, organisations, and service providers in the community which support young people's health and wellbeing in ethical and culturally responsive ways;
- Role models in the community who exemplify what it means to promote wellbeing.

The contribution of health education to whole school approaches to promoting student wellbeing

PLD activity for HPE middle leaders and teachers

Resources:

- Position statement #10 on whole school approaches to promoting student wellbeing.
- Locate a copies of the ERO documents with a focus on wellbeing – in particular the resource titled *Wellbeing for success: a resource for schools* (ERO, 2016).
<http://www.ero.govt.nz/publications/wellbeing-for-success-a-resource-for-schools/> - see the indicators listed in this document (p.9-16).

Task:

- Read through the evaluation indicators listed in the ERO resource. Make an initial note of any indicators that appear to have particular relevance for your health education teaching and learning programme.
- When ERO talk about 'wellbeing', what are they referring to? Does this understanding of wellbeing reflect the HPE concept of hauora? Why or why not?
- With further consideration, which indicators do you think your health education teaching and learning programme contributes to in some way?
- Which indicators do you contribute to as a teacher in your current practice – regardless of the subject or topic you are teaching (ie they are not health education specific)?
- Of those indicators that you make a direct contribution to, what evidence would show you are being effective in this aspect of wellbeing promotion?
- What opportunities can you see where health education could make a more deliberate and visible (or recognised) contribution to the promotion of student wellbeing? What do you need to do to make effective use of these opportunities?

PLD5. The role of external providers for supporting health education approaches to health or wellbeing promotion

Adapted from the NZHEA '*Engaging with outside providers*' statement prepared to support the *Sexuality Education: A Guide for Principals, Boards of Trustees and Teachers* (Ministry of Education, 2015).

Engaging with members of the community who have particular knowledge and expertise to support teaching and learning about health promotion in health education can be a valid approach – e.g. external providers who are not employees of the school. However, for the provider to make meaningful and educationally valued contributions to the learning programmes requires careful consideration of what they can offer.

These questions need to be considered when planning to use the services of an external provider.

Why would we use an outside provider?

- For what aspects of the teaching and learning do we lack expertise and that we would consider engaging with an external provider? OR for what aspects of the teaching and learning programme would it be highly appropriate to engage with a provider because they are a key stakeholder in the local community who works in the field that is the focus for the health promoting actions being planned by students?
- How could this provider extend and add to learning opportunities for our students?

What do we know about the suitability of the provider?

- What does the provider state is their aim or purpose? What is their 'agenda'? How do we know this?
- What are the values of this organisation? Do they align with the values of *The New Zealand Curriculum* and the values of our school?
- Does this provider clearly and explicitly embrace the values of diversity? Are their practices culturally appropriate for our students? How do we know this?

How credible is the provider?

- What qualifications and expertise does the provider have?
- Does the provider organisation require police vetting of their employees/contractors? How could we find this out?
- Can I source feedback from others who have used this provider to help inform my decision about its place in our programme? What does this feedback say?

What does the provider actually offer?

- Is their focus and the service they offer about school wide promotion and/or, support for curriculum-based teaching and learning programmes? What are the implications of this if using teaching and learning time for delivering health promotion messages aimed at a general audience (rather than my students specifically)?
- What exactly is it that the organisation offers – a 'service' that responds to client (school/student) needs utilising a range of resource material, or an off-the-shelf, one-size-fits-all, pre-prepared 'programme' of activities developed and facilitated by the provider?
- If the provider offers a one-size-fits-all pre-planned 'programme' does their approach allow for the programme to be adapted to respond to the needs of students at our school, and their community?
- How consistent is the provider's service/resources with the NZC HPE learning area achievement

- objectives and underlying concepts?
- What pedagogical approaches will they use?
- How is this provider funded (do we have to pay and if so, is this a good use of our funds)?

How is the effectiveness of the provider's service evaluated?

- Does this provider have a formal evaluation or review of their programme and/or services? If so, what conclusions are drawn about the quality and effectiveness of their service, and therefore how suitable it might be for your school?
- What will successful outcomes 'look like' if the provider delivers their programme or service effectively? What does the organisation's programme or service aim to achieve?) What do we want it to achieve?

PLD activity for HPE middle leaders and teachers

Resources:

- Most of the position statements have some relevance for this section.

Task:

- Do you currently have a school or department/syndicate process and a checklist that all staff know to use when considering the use of an external provider in health education? If not, consider developing this as a department (see NZHEA's 'engaging with outside providers' for examples).
- List any providers you currently use for health education. Which would you say contribute to learning about health promotion in your teaching and learning programme? What's your evidence for this?
- How much do you know about your current external providers? Work through the list of questions above. Do any of your answers (or lack of answers) result in cause for concern? What could you, your department/syndicate or school do better in future when engaging external providers?

PLD6. Health promotion and the HPE achievement objectives

The table on the following pages lists a selection of the HPE AOs for each level of the NZC that could be used in learning about, and participating in, a health promoting process. These AOs cover personal (strand A), interpersonal (strand C), or community/societal (strand D) actions and strategies.

At each level, an illustration is provided to show how the selection of AOs is incorporated in a learning programme where individual and/or collective action is being taken to promote an aspect of personal or group/whole school wellbeing.

PLD activity for HPE middle leaders and teachers

Resources:

- The NZC HPE AOs at the levels relevant for your class(es).
- The examples of the way a selection of the AOs could be incorporated in a health education programme (select those level(s) from the following pages that are relevant for your class(es)). Also select the example(s) at the next level(s) to see how the learning could develop at subsequent levels.
- Your current health education programme.

Task:

- On reviewing your current health education programme for each year level, can you extract from the learning within units, across units, and/or across the whole programme, a combination of teaching and learning activities that show the ways students are developing knowledge of health promotion as a process? As part of annual reporting to the board, middle leaders might consider writing a summary statement (similar to those illustrated) about the contribution health education is making to whole school approaches – where this is applicable.
- Where in your programme is the learning of knowledge and skills that will enable students to engage and participate in the design and implementation of a health promotion process, and evaluate their actions?
- If these aspects of learning about health promotion are absent or not as strong as they could be, where could you strengthen your programme to include this learning?

Health promotion and the HPE achievement objectives

Combinations of HPE Achievement Objectives that could be included in an Action Competence Learning Process	Example of a learning situation where the learning leads to and incorporates an example of individual or collective action
NZC Level 1	
<p>Students will:</p> <p>A1 Personal growth and development: Describe feelings and ask questions about their health, growth, development, and personal needs and wants.</p> <p>A3 Safety management: Describe and use safe practices in a range of contexts and identify people who can help.</p> <p>A4 Personal identity: Describe themselves in relation to a range of contexts.</p> <p>C1 Relationships: Explore and share ideas about relationships with other people.</p> <p>C2 Identity, sensitivity, and respect: Demonstrate respect through sharing and cooperation in groups.</p> <p>C3 Interpersonal skills: Express their own ideas, needs, wants, and feelings clearly and listen to those of other people.</p> <p>D2 Community resources: Identify and discuss obvious hazards in their home, school, and local environment and adopt simple safety practices.</p> <p>D3 Rights, responsibilities, and laws; D4 People and the environment: Take</p>	<p>A suburban primary school near a commercial and industrial area of the city includes a 'safety' theme in its year 1 and 2 programme. The school is surrounded by busy streets, has a stream along one border of the school as well as a local park (where the members of the community walk their dogs and many students from the secondary school congregate after school). The school has a swimming pool as well as an extensive playground area with a range of equipment (as does the neighbouring park). After a recent fire at a local industry, the school is also being conscientious about fire drills, and evacuation procedures, as well as the expected earthquake procedures.</p> <p>As a consequence of the previous year's safety drills (some of which included the use of an external provider), the teachers had become aware of the substantial negative, risk and fear-based focus of their safety education. Many students would talk about the safety procedures they had learned using language that related to feelings of fear and anxiety. The teachers acknowledged that learning safety procedures was necessary but they need to include learning opportunities that enabled the students to talk more about the purpose of these for wellbeing.</p> <p>A revision of the learning programme associated with the various safety events included the use of stories with themes related to aspects of safety. These provided students with ideas and language that meant they could ask questions and describe aspects of each safety training, drill or event (1D3/4) in terms of their personal safety needs (1A1, 1A3), and describe their personal responsibilities in each situation and why they needed to do this for their wellbeing (1A3, 1A4). They also drew pictures of actions they take to stay safe, and talked about their picture with the class while the teacher also added annotations from their description (where students were unable to do this themselves). These (annotated) pictures were included in their learning portfolio and were later discussed at the 3-way conferencing with parents (1D2).</p> <p>They also learned how to help and support others in situations where there were safety considerations. They rehearsed what they could say to a friend or classmate if they thought the person was about to do something unsafe, or to check the person knew what to do to stay safe. They learned where to find a trusted adult (at</p>

individual and collective action to contribute to environments that can be enjoyed by all.	school, at home, or if they were at the shopping mall, or park), if they or a friend needed help, as well as rehearse what they needed to say (1C2, 1C3).
NZC Level 2	
<p>Students will:</p> <p>A1 Personal growth and development: Describe their stages of growth and their development needs and demonstrate increasing responsibility for self-care.</p> <p>A4 Personal identity: Identify personal qualities that contribute to a sense of self-worth.</p> <p>C1 Relationships: Identify and demonstrate ways of maintaining and enhancing relationships between individuals and within groups.</p> <p>C2 Identity, sensitivity, and respect: Describe how individuals and groups share characteristics and are also unique.</p> <p>C3 Interpersonal skills: Express their ideas, needs, wants, and feelings appropriately and listen sensitively to other people and affirm them.</p> <p>D1 Societal attitudes and values: Explore how people's attitudes, values, and actions contribute to healthy physical and social environments.</p> <p>D3 Rights, responsibilities, and laws; D4 People and the environment: Contribute to and use simple guidelines and practices</p>	<p>As part of whole school approach to supporting student wellbeing, teachers are required to guide their students through a range of learning activities to establish their classrooms as communities. The teachers of students in year 3 and 4 decided, based on what they were observing among their students, that there needed to be balance of learning activities. Firstly the learning supported students to recognise positive aspects of their individual identity (what was unique to them and what they shared in common with others), and why this is important for a feeling of wellbeing (2A4. 2C2). This also included developing understanding about 'wellbeing' and what this meant to them (at 7-8 years), as well as identify aspects of wellbeing they could do something about themselves, and what help and support they needed from others (2A1).</p> <p>Secondly, the students needed to develop understanding and learn skills for taking personal responsibility for aspects of their own wellbeing (2A1), while at the same time developing the skills needed to work as a community, especially skills to do with respectful communication and working cooperatively and collaboratively in all aspects of their school work (2C1, 2C3). The students developed understanding of what it looked, felt, and sounded like when they worked cooperatively and collaboratively and how this supported the wellbeing of themselves and others. After one of the activities, a student one of the classes asked 'was it fair that they had to work with people they weren't friends with or didn't really like, and especially when someone had been mean to them in the past and then we are told we still have to work with that person'. The teacher used this opportunity to engage students in developing understanding of 'fairness' and the implications for personal wellbeing, and the ability for the class to work as a community if situations that had happened in the past were not dealt with in a suitable way (2D1).</p> <p>In further learning across science (living world), social studies, and health education, the students developed a range of understandings about the idea of a 'community' and the need for connections between all the people (or organisms) living in community, and if a human community is to function, then everyone needs to contribute in a way that considers both themselves and others. To summarise their ideas about communities, the students prepared a class charter with statements and illustrations to explain how their class would operate as a community – they used some of the words and ideas from the school motto /vision/ values statement which the students came to realise the meaning of by creating their own charter (2D3/4).</p>

<p>that promote physically and socially healthy classrooms, schools, and local environments.</p>	<p>Some weeks later, the teacher suggested that the students review their charter to see if it was 'working'. To do this the students decided they would use a bus stop-type activity to anonymously answer questions they designed (based on statements in their charter). The questions asked students to rate (on a scale) how well they thought the class was doing in relation to each charter statement. The class summarised these statements and found that there was one area that most students rated low – it was around the issue of fairness that the students had raised earlier. The teacher is planning to incorporate further learning about this idea in the learning programme during the coming weeks.</p>
<h2>NZC Level 3</h2>	
<p>Students will:</p> <p>A1 Personal growth and development: Identify factors that affect personal, physical, social, and emotional growth and develop skills to manage changes.</p> <p>A3 Safety management: Identify risks and their causes and describe safe practices to manage these.</p> <p>A4 Personal identity: Describe how their own feelings, beliefs, and actions, and those of other people, contribute to their personal sense of self-worth.</p> <p>C1 Relationships: Identify and compare ways of establishing relationships and managing changing relationships.</p> <p>C2 Identity, sensitivity, and respect: Identify ways in which people discriminate and ways to act responsibly to support themselves and other people.</p> <p>C3 Interpersonal skills: Identify the pressures that can influence interactions with other people and demonstrate basic assertiveness strategies to manage these.</p>	<p>A large primary school was aware of the separation of the junior (year 1-2) and senior (year 5-6) students at the school. The structure and organisation of the school, and the large numbers of students, meant that practical considerations often got in the way of providing opportunities for students, across the year levels, to engage meaningfully with each other.</p> <p>A recent unfortunate incident in the playground resulted in a group of year 2 students being upset after they were intimidated by some year 6 students because the younger children wanted to play in the space that had been taken over and 'laid claim to' by the senior students. There had been some similar incidents in recent months.</p> <p>Unsure of how to approach the situation the principal suggested to the year 5 and 6 teachers that the students be given opportunity to come up with a solution to the issue. To understand the nature and extent of the situation, the teachers guided the students on a 'fact finding mission' – each class chose their approach (mini surveys, playground interviews, visiting one of the junior classes and asking questions – in conjunction with related learning in the junior school). Results from the students' investigation showed the problem was widespread and many of the young students were scared to go into parts of the playground where the older children played, or were under the impression they were 'not allowed to' go into some parts of the school where the senior classes were held and they would be punished by the teachers if they were caught in the wrong part of the school. It was apparent the younger children got these ideas from the older students.</p> <p>The students were then asked by the teachers to come up with a list of possible ways they could remedy this problem and help create an environment where all of the younger students felt safe at school and realised they wouldn't 'be in trouble' for being in certain parts of the playground or school buildings. With some negotiation between the year 5 and 6 classes, each class took responsibility for one type of action. These included providing different sorts of activities for the junior students at lunchtime – physical outdoor (fun)</p>

<p>D1 Societal attitudes and values: Identify how health care and physical activity practices are influenced by community and environmental factors.</p> <p>D2 Community resources: Participate in communal events and describe how such events enhance the wellbeing of the community.</p> <p>D3 Rights, responsibilities, and laws: Research and describe current health and safety guidelines and practices in their school and take action to enhance their effectiveness.</p> <p>D4 People and the environment: Plan and implement a programme to enhance an identified social or physical aspect of their classroom or school environment.</p>	<p>activities as well as organised games, as well as quieter indoor games, sitting with and talking with some of the quieter students at play time (one class had commented on the number of students they saw sitting by themselves, or pairs of students trying to stay well out of the way of other students), one class realised they had many students in the class with younger brothers and sisters in the junior school so they connected with their younger siblings at lunchtime and showed them around their classroom and introduced them to their other friends, and so on.</p> <p>The following term the principal asked the teachers and students to follow up on their actions to see if the junior students thought it had made a difference (there had been no more incidents of intimidation reported). Each class decided how they would do this (most chose ways similar to the method used for finding about the problem in the first place). Once each class had compiled a report of their findings, representatives from each class were invited to share their results directly with the teachers at a staff meeting. Their reports were made available on the school intranet for parents to read, along with some information from the principal for parents about ways to have a conversation with their children to keep checking that they are feeling safe and cared for at school, and at home.</p>
<h2>NZC Level 4</h2>	
<p>Students will:</p> <p>A1 Personal growth and development: Describe the characteristics of pubertal change and discuss positive adjustment strategies.</p> <p>A4 Personal identity: Describe how social messages and stereotypes, including those in the media, can affect feelings of self-worth.</p> <p>C1 Relationships: Identify the effects of changing situations, roles, and</p>	<p>Year 7 and 8 students at an intermediate school were highly enthusiastic about an upcoming school social. This was coinciding with a series of health education lessons on puberty and how to help themselves and others manage these changes in a way that supported wellbeing.</p> <p>During their lessons on physical, emotional, social, and other pubertal changes (4A1) it became apparent to the students in a year 8 class that the girls and boys in the class had quite different views and expectations about themselves, and of each other. These differences were in relation to what they thought about, what concerned them about the changes going on, what upset them, and what got in the way of maintaining a sense of wellbeing – ideas related to the appearance of body parts, issues around body size, developing romantic feelings and being attracted to another person (or not), and having a boy/girlfriend (or not). The students agreed that this was causing some conflict especially between girls, and to some degree between boys and girls (4C1). Through a bus stop-type activity the teacher gathered a wide range of information from all of the students that showed them the many negative feelings (and not many positive feelings), as well as some of the differences between boys and girls, related to the concerns they had earlier expressed.</p>

<p>responsibilities on relationships and describe appropriate responses.</p> <p>C3 Interpersonal skills: Describe and demonstrate a range of assertive communication skills and processes that enable them to interact appropriately with other people.</p> <p>D1 Societal attitudes and values: Investigate and describe lifestyle factors and media influences that contribute to the wellbeing of people in New Zealand.</p> <p>D3 Rights, responsibilities, and laws; D4 People and the environment: Specify individual responsibilities and take collective action for the care and safety of other people in their school and in the wider community.</p>	<p>The teacher decided to focus a lesson on where the students thought they got these ideas from with music videos and performers, along with other TV, movie, and media personalities being a main source of ideas about appearance and social behaviour (4D1). Other influences came from each other and sometimes their families (4A4). The teacher challenged the students to come up with ideas as to what they thought they could do about it and reduce the negative feelings about themselves and improve the quality of their interactions with friends and classmates. The class seemed to think they couldn't do much and you just had to accept 'that's the way it is' but they did think they could be nicer to each other and not tease others about the way they looked, and if someone did say something negative to stand up to them using the assertiveness skills they had learned previously (4C3).</p> <p>To help the students to see they could do something about it, in the next lesson the teacher drew attention to the advertising material that had been prepared for advertising the social. The principal and board of trustees had decided on a dress code for the social that read '<i>girls dresses should be appropriate for their age</i>' and '<i>boys should wear smart casual trousers and a tidy shirt</i>' (the last school social had resulted in negative feedback from some parents about the highly sexualised adult-like dresses of some girls and the scruffy street clothes of some boys). Before the teacher could ask what they thought might be wrong with that dress code, several students – boys and girls asked 'what if girls don't want to wear a dress?', and 'what if a boy wants to wear a dress?' - the class had recently read the David Walliams story and seen the film <i>The Boy in the Dress</i> as a way to look at gender stereotypes and as an introduction to gender diversity (4A4).</p> <p>The class decided that they wanted to take action and with guidance from the teacher, they surveyed most of the students in the school about their views around the dress code for the social. The results showed that the year 7 and 8 students didn't think boys should 'have to' wear trousers or that girls 'have to' wear dresses. They generally agreed the clothing should be age appropriate and had a list of ideas about what they thought this meant. On the basis of the results the class wrote a letter to the principal and the board stating their case and invited the principal to their class to discuss this. The principal was receptive and suggested that the students come up with some rewording for the advertising, and also write a statement that could be included in the newsletter for parents stating what the dress code would be and why.</p> <p>On the evening of the social the year 8 class surprised everyone as (unknown to the teacher) they had all agreed among themselves that the boys would wear dresses and the girls would wear trousers (one of the class had seen something similar on an overseas website). The rest of the students were suitably dressed,</p>
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	<p>some girls wore trousers, and some of the boys wore traditional cultural dress where formal clothes were a type of skirt (4D3/4).</p> <p>The students evaluated their actions after the social by interviewing a range of students across the school about the social – the revised dress code and how they thought people enjoyed the evening as a result of this. The results were overwhelmingly positive. With permission, some of the quotes were added to the school intranet for everyone to read (4D3/4). As a result of the year 8 class actions, other classes are now looking at ways they can challenge gender stereotypes and gender norms and take action to change the way things are done at their school.</p>
NZC Level 5	
<p>Students will:</p> <p>A1 Personal growth and development: Describe physical, social, emotional, and intellectual processes of growth and relate these to features of adolescent development and effective self-management strategies.</p> <p>A4 Personal identity: Investigate and describe the ways in which individuals define their own identity and sense of self-worth and how this influences the ways in which they describe other people.</p> <p>C1 Relationships: Identify issues associated with relationships and describe options to achieve positive outcomes.</p> <p>C2 Identity, sensitivity, and respect: Demonstrate an understanding of how attitudes and values relating to difference influence their own safety and that of other people.</p>	<p>Staff at the local secondary school are aware of the stress and anxiety experienced by many students entering year 9. As the only secondary school in the town, they draw from a wide rural area with many small primary schools. The new students arrive knowing only a few others from their previous school. The school has a peer support-type system where seniors support the juniors, but the brief weekly sessions do not appear to be sufficient early in the year. As part of a review of the systems supporting the transition to secondary school, the principal has asked the health education teachers if they could facilitate some form of review to gain a year 9 and 10 student perspective on the matter. The year 9 students were about to start a unit on friendships and the year 10 a unit on resilience and dealing with change and the teachers thought it could naturally form a part of the learning programme.</p> <p>After introductory lessons in year 9 about the role and nature of friendships for young teenagers' wellbeing (5A1), and in year 10 the ways young people are becoming increasingly aware of their own identity and what is important to them for wellbeing (5A4), the teachers posed the situation to the students in each class about the school wide review of the peer support system and about the transitions to secondary school. They were being invited to give feedback about their experiences – and how would they like to do this? In negotiation with the teacher, each class came up with a slightly different focus and groups within classes took responsibility for different aspects of the process. Once each class had completed its review process, the principal was invited to each class to receive the feedback, which was collected together and a summary was provided for the teachers at a staff meeting.</p> <p>This resulted in some changes being made to school systems related to the way students are introduced to the school before they start in year 9, as well as a more concentrated induction programme at the start of year 9, and a brief support programme for year 10 as the students thought that because so many friendship</p>

<p>C3 Interpersonal skills: Demonstrate a range of interpersonal skills and processes that help them to make safe choices for themselves and other people in a variety of settings.</p> <p>D1 Societal attitudes and values: Investigate societal influences on the wellbeing of student communities.</p> <p>D2 Community resources: Investigate community services that support and promote people's wellbeing and take action to promote personal and group involvement.</p> <p>D4 People and the environment: Investigate and evaluate aspects of the school environment that affect people's wellbeing and take action to enhance these aspects.</p>	<p>groups change during year 9, it was important to revisit some of the peer support activities – this also gave more of the year 13 students leadership roles.</p> <p>What came out of the review for health education teachers was a need for year 9 to understand changes to friendships and the impact of these on wellbeing, as well as how to manage these changes. Lessons included learning skills for positive self-talk (rational thinking), self-nurturing strategies and doing things that they enjoyed and helped them to feel positive, as well as identifying a circle of support and who they could trust to talk to, and some strategies for destressing when they felt upset (5A1, 5C1).</p> <p>For the year 10 students the focus on learning was to develop students' understanding of diversity and difference as a lot of the teasing and name calling, put downs etc were in reference to (perceived) difference, or using language that was variously sexist, racist, homophobic, and generally offensive – without necessarily understanding what some of the language meant. The students acknowledged they knew it was wrong and it made them feel bad but 'everyone says it' so 'everyone does it', 'it's just something you learn to do when you come to high school', and no one tells us not to. Students (re)learned skills for using "I" statements and expressing feelings, assertiveness and giving constructive feedback, and problem solving (5C2, 5C3)</p>
<h2>NZC Level 6</h2>	
<p>Students will:</p> <p>A1 Personal growth and development: Investigate and understand reasons for the choices people make that affect their wellbeing and explore and evaluate options and consequences.</p> <p>A3 Safety management: Demonstrate understanding of responsible behaviours required to ensure that challenges and risks are managed safely in physical and social environments.</p>	<p>The year 11 health class were using the context of adolescent alcohol use as part of the learning leading to several of their assessments. They had spent time investigating patterns of alcohol use among NZ teenagers using the Youth/12 data, read recent HPA articles and viewed a recent documentary to identify reasons why teenagers drink alcohol, and in particular why some binge drink (6A1). This included consideration of the many ways excessive alcohol use affected wellbeing – physical, mental and emotional, social, and spiritual. They had also spent time unpacking scenarios to determine what was risky about drinking in a range of situations (6A3), as well as exploring the impact of peer pressure on teenage drinking (6C1). They also investigated a range of laws that related to teenage alcohol use and how these could contribute to wellbeing (6D3).</p> <p>As part of the learning programme the students had learned how to make decisions (using a decision making grid which they had applied to a range of alcohol and other drug situations), worked through a problem</p>

<p>C1 Relationships: Demonstrate an understanding of how individuals and groups affect relationships by influencing people's behaviour, beliefs, decisions, and sense of self-worth.</p> <p>C2 Identity, sensitivity, and respect: Plan and evaluate strategies recognising their own and other people's rights and responsibilities to avoid or minimise risks in social situations.</p> <p>C3 Interpersonal skills: Plan strategies and demonstrate interpersonal skills to respond to challenging situations appropriately.</p> <p>D3 Rights, responsibilities, and laws: Compare and contrast personal values and practices with policies, rules, and laws and investigate how the latter contribute to safety in the school and community.</p>	<p>solving process that focused on peer pressure to drink alcohol, and rehearsed assertiveness skills in alcohol and other situations (6C1, 6C3).</p> <p>When the students were ready to start their individual goal setting and action planning (for AS Health 1.1), they were able to identify an interpersonal skill that they needed to focus on. This didn't have to be specifically related to alcohol use – as not everyone drinks – but a skill that could be developed further which could be used in an alcohol situation, or used in a completely different social situation. Ideas suggested were being assertive, joint problem solving, and managing stress (6C2, 6A3).</p> <p>With support the students each identified a wellbeing goal, mapped out the activities they would need to complete to achieve the goal (and the timeframe in which they would complete the activities), identified what they thought successful completion of the goal would look/sound/feel like in that amount of time, set up a logbook to record regular entries about the completion of their actions, along with any notes about barriers and enablers to achieving their goal, and what they noticed about the various dimensions of their wellbeing in relation to these actions (6C2).</p> <p>At the end of the allocated time, students were supported to evaluate the implementation of their planned actions and to reflect upon the impact of their actions on their wellbeing. Their evaluation also included what worked and what didn't with consideration of why, and what they could do next time (6C2).</p>
<h2>NZC Level 7</h2>	
<p>Students will:</p> <p>A4 Personal identity: Critically evaluate societal attitudes, values, and expectations that affect people's awareness of their personal identity and sense of self-worth in a range of life situations.</p>	<p>While learning about sexual and gender diversity, the year 12 health education students commented on how there seemed to be no connection between the newly formed group supporting students with diverse sexual and gender (SDSG) identities, and the rest of the school. The students appreciated that it was often helpful to be able to talk with others from similar circumstances as yourself (whatever that meant), but to deal with some of the issues like the bullying and intimidation of this group of students – which was still happening in the school – there needed to be actions everyone took responsibility for. They grappled with the idea that to separate the SDSG from the (assumed) heterosexual and cisgender students risked marginalising and making the SDSG students 'the other', but then they also decided that they needed to take personal and collective responsibility for contributing to a school community that was inclusive of and fair for all students (7A4).</p>

<p>C1 Relationships: Analyse the nature and benefits of meaningful interpersonal relationships.</p> <p>C2 Identity, sensitivity, and respect: Analyse the beliefs, attitudes, and practices that reinforce stereotypes and role expectations, identifying ways in which these shape people's choices at individual, group, and societal levels.</p> <p>C3 Interpersonal skills: Evaluate information, make informed decisions, and use interpersonal skills effectively to manage conflict, competition, and change in relationships.</p> <p>D1 Societal attitudes and values: Analyse ways in which events and social organisations promote healthy communities and evaluate the effects they have.</p> <p>D2 Community resources: Evaluate school and community initiatives that promote young people's well-being and develop an action plan to instigate or support these.</p> <p>D3 Rights, responsibilities, and laws: Evaluate laws, policies, practices, and regulations in terms of their contribution to social justice at school and in the wider community.</p>	<p>Unsure of how to proceed, the health education students decided they wanted to find out from the students in the SDSG support group about sorts of negative comments they received from other students (and teachers) at school, as well as information about what was helpful to feel included, so that they could target their actions to particular behaviours (7C1). The health teacher suggested that to protect the privacy of individual students in the group – and given how new the group was - that the information they sought could be obtained via the group's liaison teacher (which was done). The class also used data and ideas from the Youth'12 study and ideas from the Rainbow Youth website. They also decided to invite a Rainbow Youth facilitator/advocate into the class to discuss the sorts of actions that might be appropriate to take that wouldn't draw undue attention to the SDSG group, and didn't keep positioning them as 'the other' group in the school (7D2). In other words, actions that were relevant and meaningful and showed respect (7C2, 7D1).</p> <p>With support from Rainbow Youth the students designed a plan of action based on developing respectful communication, and valuing the diversity of people – and not limited to SDSG. Before the action was undertaken, the SDSG group were consulted about the plan's suitability and if they felt it was an appropriate course of action. The plan was in effect a series of smaller actions whereby the year 12 students worked with the year 9 students around not using derogatory or put down language (it was noted that many year 9 students used put-down and non-inclusive language without realising what it meant) (7C3). The year 10 classes were doing a unit on reducing bullying as part of their health programme – the year 12 students asked if this year level could produce posters, blogs, Facebook or other social media statements, with messages about inclusiveness that taught them something about respectful communication and being inclusive of diversity as well as being messages that could be seen by the whole school (7D2). The year 12 class selected some of these for the school intranet and links were provided along with the information for parents to help them better understand issues faced by SDSG.</p> <p>As only a minority of senior students took health education, the focus for the senior school was more problematic as there were few ways to directly access all students. Although the Year 12 class agreed it wasn't the best idea for what they wanted to achieve, they opted for a senior assembly presentation from an advocacy group who provided a multimedia presentation delivering inclusive messages about diversity and the sorts of behaviours and language that supported inclusiveness in schools.</p> <p>The year 12 class decided to evaluate all of the actions by waiting a fortnight and then over the course of a week, used their break times to carry out snapshot interviews (2 questions in two minutes) with as many students as possible. Their two questions were, 'what do you remember from (based on a student's year level)?' and 'what is one positive thing you have done since then to treat people more fairly or inclusively?'</p>
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	<p>OR or something positive you have seen or heard someone else say or do to treat people more fairly or inclusively?'. A summary of this data was given to the SDSG group as well as the principal who responded very favourably about the work the class had done and said he would include this in the next board report (7D3).</p> <p>The feedback to the year 12 class from the SDSG liaison teacher suggested that the students were not aware of any negative backlash from the various actions, but there was still some name calling and non-inclusive language being used around the school. The SDSG group said that their peers and friends who knew about their sexual or gender identity had been highly supportive, to the point of being overly protective as they tried to ensure that the increased school wide focus did not draw unwanted attention from other students. The SDSG group are now discussing how they might contribute to school wide approaches to support student diversity – based on sexuality and gender, and also cultural diversity and physical abilities.</p>
NZC Level 8	
<p>Students will:</p> <p>A1 Personal growth and development: Critically evaluate a range of qualitative and quantitative data to devise strategies to meet their current and future needs for wellbeing.</p> <p>A4 Personal identity: Critically analyse the impacts that conceptions of personal, cultural, and national identity have on people's wellbeing.</p> <p>C1 Relationships: Critically analyse the dynamics of effective relationships in a range of social contexts.</p> <p>C2 Identity, sensitivity, and respect: Critically analyse attitudes, values, and behaviours that contribute to conflict and identify and describe ways of creating more harmonious relationships.</p>	<p>The year 13 health education students were considering ways they could 'test' what the health promotion models they were studying as theory meant in practice – they were finding it difficult to apply the ideas from the theory to real life situations. The teacher suggested they look at contributing something to the school wide focus on wellbeing – the teachers were considering ways they needed to change their practice to better support the wellbeing of students, so was there something the students could do to help the teachers understand what needed to change?</p> <p>The students invited the deputy principal leading and coordinating the promotion of student wellbeing activities to one of their lessons to investigate the possibilities of what the class could do to support these changes. The DP shared with them some of the results from the NZCER 'Me and My School Survey' which showed which aspects of teacher practice some teachers needed to change (8A1).</p> <p>Several of the students reported that one of the most memorable things they did in year 12 health was to interview a person who had experienced a major change in their lives and to find out what helped, and what got in the way, for managing the situation. One of the things many of the students found was important was that people needed to feel a part of something, to feel a sense of connection and belonging. They recalled that this was all part of building resilience and having the capacity to cope in times of adversity.</p> <p>As their ideas were taking shape, the students thought the collective action model was probably the most appropriate model for their school situation, although they like some of the ideas from Te Pae Mahutonga but</p>

<p>C3 Interpersonal skills: Analyse and evaluate attitudes and interpersonal skills that enable people to participate fully and effectively as community members in various situations.</p> <p>D1 Societal attitudes and values: Critically analyse societal attitudes and practices and legislation influencing contemporary health and sporting issues, in relation to the need to promote mentally healthy and physically safe communities.</p> <p>D3 Rights, responsibilities, and laws: Demonstrate the use of health promotion strategies by implementing a plan of action to enhance the wellbeing of the school, community, or environment.</p>	<p>couldn't see that the model would work as a whole. The teacher introduced them to <i>Tātaiako: Cultural Competencies for Teachers of Māori Learners</i> (explaining this was a resource for teachers but it also lists examples of what students say about their teachers when they use responsive ways of working and create a sense of belonging and being valued).</p> <p>They students decided they needed some additional information and designed a short 5 minute interview that they could carry out with several students each lunchtime over the course of a week. They used ideas from the student voice section of <i>Tātaiako</i> to design their survey (8A1, 8A4). Once the results were compiled they found some major themes in the students answers, in particular, the need for all teachers to show that they care about the students' learning, make the learning relevant, and know who they are – not just their name but also know something about them, and that they feel valued as people. Also they wanted their teachers to communicate respectfully at all times (aspects of 8C1, 8C2, 8 C3).</p> <p>The students needed to decide what action to take. In a follow up session reporting back to the DP it was suggested that the class design a workshop for the teachers, and that groups of students from the class could work with groups of teachers. They would get support to design and plan the workshop but it would be over to them to lead the discussion activities with groups of teachers using the findings from the surveys (8D3).</p> <p>After the workshop was completed, the students collected individual feedback from each teacher to evaluate what they had done. A summary of this feedback was presented and discussed with the DP who is using some of the ideas for further work with the teachers. The DP has said they will also follow up later in the year to find out what changes the teachers have made.</p> <p>When the students returned to looking at the models of health promotion they realised that the actions they had taken fitted with parts of most of the models, but it was the collective action model was still the best fit for what they had planned, how they were able to work, and what they were able to achieve.</p>
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PLD 7. Developing understanding of health promotion actions and strategies across NCEA L1 – L3 health education achievement standards

The following information provides guidance for teachers as they support students to develop understanding of the actions and strategies aspects of the NCEA Level 1 - 3 health education achievement standards.

Terminology:

- **An action:** the act of doing something that makes a positive difference for people's wellbeing (doing something that is intended to have health-enhancing outcomes).
- **A strategy:** A plan, approach, tactic, a way to go about doing something to achieve an intended (health-enhancing) outcome. A strategy may be made up of a number of actions.
- **Wellbeing:** relates to the four **inter-related** dimensions of hauora as described by the whare tapa whā model.
 - At NCEA **Level 1**, students may need to respond to each dimension separately to demonstrate they understand the scope and intent of each dimension, and then explain how their proposed actions can enhance specific aspects of wellbeing. They also need to show understanding of how the dimensions interconnect and are interdependent, and to talk holistically about wellbeing.
 - At NCEA **Level 2 and Level 3** the concept of hauora is dealt with more implicitly. As students explain and justify their selected actions or strategy for enhancing the wellbeing of individual people and society overall, it is unlikely that reference to wellbeing will refer to specific dimension(s) of wellbeing.

PLD activity for middle leaders and teachers

Resources

- Position statements #6 & #9.

Task:

- Discuss and review your department's health education programme in relation to the way the health promotion 'knowledge building blocks' are developed across the levels of learning e.g. What health promotion knowledge and skills are developed in your year 9 and 10 health education programme to prepare students for learning leading to NCEA Level 1 and beyond? (See *position statement #6*). How well is knowledge of health promotion scaffolded and development across NZC Levels 6-8 (years 11-13/NCEA Levels 1-3)?
- How well does your learning programme enable students to develop understanding that the actions to promote and *sustain* wellbeing, need to change the factors that caused or contributed the situation (the wellbeing need) in the first place?

The following tables summarise the way the HPE underlying concept of health promotion develops in complexity of understanding and application across the NCEA Level 1-3 health education achievement standards.

Table 1. Summary of how the breadth and depth of the conceptual understanding of health promotion develops across NCEA Levels 1-3

NCEA Level 1	NCEA Level 2	NCEA Level 3
<p>Identify a personal, interpersonal or societal (P, IP or S) action.</p> <p>Describe what this action involves and who might carry it out.</p> <p>Explain or justify how/why this action would enhance wellbeing (specific to the context). Depending on the standard this may also include consideration of short-term (ST) and/or long-term outcomes (LT) and how wellbeing is enhanced now and in the future.</p>	<p>Identify an action that links back to the factor(s) influencing the issue (P, IP or S)</p> <p>Describe in detail what this action involves and who carries out the action.</p> <p>Explain/justify how/why these actions or strategies would enhance wellbeing in the ST and/or LT (as specific to the context) and address the influencing factor(s).</p> <p>The inter-relationships between strategies may also need to show how P, IP and S actions work in combination to have a greater positive effect.</p>	<p>Recommend a strategy that links back to the determinant(s) of health influencing the issue.</p> <p>Describe in detail what these strategies involve and who is responsible for carrying out the actions that put the strategy into place.</p> <p>Justify how/why this strategy addresses the relevant determinants of health and therefore why it was chosen (<i>e.g. it been used successfully elsewhere, or recommended by an organisation, or it links to national/ international priorities</i>).</p> <p>Also required is explanation of how this strategy could lead to equitable health outcomes.</p> <p>The selection of strategies shows understanding of effective health promotion theory or models.</p>

Table 2. Developmental progression of the concept of health promotion across related NCEA Level 1-3 health education achievement standards

The achievement standards in this table are arranged in rows of Level 1-3 to show how the health promotion aspect of the standard builds on the previous level (which is why the numbers of each level of standards are not in numerical order). *Note that this is not the only way the standards could be arranged to illustrate this knowledge progression.*

NCEA Level 1	NCEA Level 2	NCEA Level 3
Goal setting, action planning, and theoretical/researched models for health promotion		
1.1: Personal goal-setting plan Students individually identify a personal wellbeing need and frame this as a SMART goal to be achieved. They then plan action(s) to meet this goal. The actions include consideration of possible barriers and enablers. The plan is then implemented, a log of progress maintained, and the impact or outcome of the action is evaluated. <i>Was it a SMART goal? Why/why not? To what extent did the specific actions enhance wellbeing? Was there more impact on some dimensions of wellbeing than others? Why was this?</i>	2.3: Health promotion actions (collective action) Students in groups identify a wellbeing need for their school/community and frame this as a SMART goal to be achieved. They then plan action to meet this goal. The actions include consideration of possible barriers and enablers. The plan is then implemented, a log of progress maintained, and the impact or outcome of the action is evaluated. <i>Was it a SMART goal? Why/why not? Were the possible barriers anticipated and addressed? To what extent did the specific actions enhance wellbeing for the target group? Why was this?</i>	3.5: Health promotion models The focus is on how the strategies and actions typical of the principles (or action areas or other features) of selected health promotion models are incorporated (or not) into health promotion campaign(s), and the likely effectiveness of the models for enhancing the wellbeing of people and communities e.g. Ottawa Charter, Te Pae Mahutonga, Bangkok Charter, and the features of collective action (in comparison with the behaviour change and self-empowerment models).
The socio-ecological perspective - personal, interpersonal and societal considerations for health promotion		
1.2: Action planning that supports the wellbeing of others (other than, or as well as, self) in a food related context The proposed actions relate to addressing the influences on eating patterns at P, IP and S levels – only a basic understanding of the SEP is required. The actions need respond to the food	2.1: Address an adolescent health issue The actions relate to addressing the influences on an adolescent health issue at P, IP and S levels – a more comprehensive understanding of the SEP is required including the inter-relatedness of P-IP-S factors. <i>What action can be taken that relates to the influencing factor(s)? What does</i>	3.1 and 3.2: Recommend strategies to address a (NZ or international) health issue The strategies must align with the major determinants of health influencing the issue. It is important that the recommended strategies seek to address the factors that contributed to the issue in the first place. <i>What strategies (or</i>

<p>related situation presented. <i>What does this action involve? Who carries out these actions? How would this address the influence on eating patterns and enhance overall wellbeing?</i></p> <p>1.6: Decision-making in drug-related situations</p> <p>The actions focus on the use of the decision-making process (what choices could be made in this situation, and to choose and justify the most health-enhancing decision). <i>What are the possible choices that could be made in this situation? Evaluate ('weigh up') the choices by considering feelings involved and possible consequences (as guided by the questions). Justify why this was the most health-enhancing choice, using references to aspects of wellbeing (now and in the future).</i></p>	<p><i>this action involve? Who carries out these actions? How would this address the influence(s) on the issue and enhance wellbeing – now and in the future?</i></p>	<p><i>approaches) need to be implemented to change aspects of the political, economic, cultural (and social) determinant(s) contributing to the issue? What needs to happen to put these strategies into action? Who carries out these actions? How do these strategies reflect the principles of an effective health promotion model? Why was this approach chosen – has it been successfully used (support with evidence), or linked to known policies/priorities? How will this action address the contributing factor(s)? How will this action lead to more equitable outcomes and reflect the values of social justice)? How will this approach enhance the wellbeing of individuals and groups, communities and society, now and in the future?</i></p>
<p>Skills, actions and strategies for managing change</p>		
<p>1.3: Strategies for managing change</p> <p>The actions relate to managing the change situation at P, IP and S levels – only a basic understanding of the SEP is required. <i>What action can be taken that relates specifically to the change situation in the scenario? What does this action involve, and who carries it out? How would this help the person in the scenario manage change and enhance wellbeing (or be used for others experiencing change, and to enhance the wellbeing of communities)?</i></p>	<p>2.2: Strategies for building resilience and managing significant life changes</p> <p>The actions relate to reducing or mitigating the risk factors and enhancing the protective factors at each of P, IP and S levels. <i>What action can be taken that relates specifically to the significant change situation in the scenario and the risk and protective factors implicated in the situation? What does this action involve, and who carries out these actions? How would these actions minimise the risk factors and/or enhance the protective factors for a person, so that they may</i></p>	<p>3.3 Contemporary practices (western alternative and traditional) for managing health situations</p> <p>Contemporary health practices are linked to a health condition or situation which implies that a change in health status has occurred. Investigation into different health practices could consider whether or not individual or collective health promotion-type strategies and actions are a feature of the practice e.g. 'green' prescriptions (individual healthy lifestyle choices) or traditional medicine that involves a community (collective) approach.</p>

	<i>have the capacity (the resilience) and the supportive environment to manage the change situation in a way that supports their wellbeing?</i>	
Skills and actions to maintain and enhance interpersonal relationships		
1.4: Interpersonal skills used to enhance relationships The actions focus on developing knowledge, and the demonstration (through rehearsal/ 'roleplay') of a growing repertoire of interpersonal communication skills – the actions and techniques used when interacting with others to support the wellbeing of self, the other person in the relationship, and the relationship between people. <i>What skill is most appropriate to use in a given situation and why? What is involved in the use of this skills? How will use of these skills support wellbeing?</i>	2.4: Strategies to manage unsafe situations where there is a power imbalance in relationships The actions relate to addressing the unsafe situation at P, IP and S levels. <i>What action can be taken that relates specifically to the situation in a given scenario (bullying, intimidation, discrimination or harassment)? What does this action involve, and who is responsible for carrying it out? What is the policy (or legal) situation related to this scenario and how can policy be used to support the action? How would this manage the situation and enhance wellbeing for individuals and for communities? How does this action redress the power imbalance and support wellbeing?</i>	
Skills, actions and strategies for social justice		
1.5: Strategies for promoting positive sexuality The actions focus on personal skills for managing self, and interpersonal skills and strategies for promoting positive sexuality e.g. enhancing wellbeing in romantic/sexual relationships, as well as 'societal' actions in the form of knowing about agencies that support sexual health. <i>What skills/action can be used in this situation (as guided by the question/appropriate to the</i>	2.5: Strategies for achieving social justice in sexuality and gender situations These strategies and actions relate to achieving outcomes that are fair, inclusive and non-discriminatory – in other words actions that reflect the values of social justice. Although the wellbeing of individuals is enhanced by actions that are fair (etc), achieving social justice (by its nature) requires actions to be carried out by	3.4 Ethical dilemmas and social justice Not all ethical dilemmas selected in health education will be sexuality or gender related. However, the connection here is that the values of social justice feature when developing understanding about ethical thinking. <i>In relation to a selected ethical dilemma, does the current legal situation around the issue allow for any health promotion approaches – and what is 'fair'</i>

<p><i>scenario)? What does using this skill/action involve and who carries it out? How can use of this skill/action in this situation promote positive sexuality and enhance overall wellbeing – now and in the future?</i></p>	<p><i>other individuals, and collectively by groups, or all members of a community/society. What actions can be taken that relate specifically to the issue/inequality caused by the factor(s) impacting on sexual or gender identity or expression? What does this action involve and who carries out the action? How does this action promote the values of social justice and change the factor(s) influencing the situation in the first place, and lead to enhanced wellbeing).</i></p>	<p><i>and ‘inclusive’ in this situation – who gets to decide this? Health promotion in ethical situations can be highly problematic – and that’s the point e.g. euthanasia is not legal in NZ which makes it legally problematic to promote in any circumstances, and although an abortion can be obtained legally, the sensitivity around the issue in culturally diverse communities means widespread public attention is not usually drawn to such services. However, there may be other ethical situations where the nature of public opinion makes it more acceptable to ‘promote’ the situation for health or wellbeing purposes.</i></p>
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Part C. Revisiting the curriculum project paper

‘Making sense of health promotion in context of health and physical education curriculum learning’

Locate this paper in the NZC archives references section at:
<http://nzcurriculum.tki.org.nz/Archives/Curriculum-project-archives/References>
(Scroll down the alphabetised list.)

‘Making sense of health promotion in context of health and physical education curriculum learning’ (Robertson, 2005) was one of a series of papers prepared by initial teacher educators and teachers associated with the HPE (1999) and/or NZC (2007) curriculum developments. Much of the document still has relevance but the passage of twelve years since, and the release of the NZC in 2007, means that aspects of this document need to be revised.

Rather than rewrite the article, substantial passages of which remain relevant, we have instead asked and responded to a succession of questions:

- What is new (since the 2005 paper)?
- What do we need to update and change?
- What do we want to retain and re-emphasise?

And on reflection:

- What do we continue to try and strengthen?

What is new (since the 2005 paper)?

- **The New Zealand Curriculum** (MoE, 2007) is now the current curriculum policy document.
- As a feature of the NZC, **effective pedagogy** leading to the development of student **key competencies**, including **critical thinking**, is expected of all teachers, it is not specific to HPE. Similarly, the **teaching as inquiry** approach, as a feature of effective pedagogy which requires teachers to focus on learning based on ‘where students are at’ and select evidence-based teaching and learning strategies that help their students learn, is the expected practice of all teachers. (See Aitken, Sinnema & Meyer, 2013.)
- The school wide emphasis on **promoting student wellbeing** is now a feature of schooling improvement. See the various NZCER and ERO reports on promoting student wellbeing (Section A). It is also the professional expectation of all teachers that they will promote student wellbeing (Education Council, 2017).
- There is far greater emphasis and resourcing to support **Māori learners** e.g. *Tātaiako Cultural Competencies for Teachers of Māori Learners* (Education Council, 2011)
- The **Te Pae Mahutonga** model for health promotion (from Durie, 2003) is more widely known and used.

- The WHO **Bangkok Charter** added to the Ottawa charter to give global focus to promoting health by addressing the determinants of health.
- There are many more health education specific **teaching and learning resources** (see for example NZHEA <https://healtheducation.org.nz/>)
- The **internet and digital technologies** have opened up so many more opportunities to access knowledge and teaching resources – but at the same time presented challenges in the way this is undermining wellbeing – especially social media and cyberbullying, and students’ access to pornography.

What do we need to update and change?

Related to many of these new(er) considerations, a number of changes or alteration could be made to the 2005 paper. These changes include the following.

- As the current curriculum policy document is ***The New Zealand Curriculum (MoE, 2007)*** all references describing teaching and learning expectations now need to be to this document.
- We need to be more appropriate with the way we use the term ‘**hauora**’. On the recommendation of the writing team for the Hauora learning area for Te Marautanga o Aotearoa (MoE, 2007), we need to avoid personalising the use of ‘hauora’. Hauora as doesn’t change, nor is it ‘affected’, harmed or enhanced. Hauora names a concept and it doesn’t change. What changes is our wellbeing (or state of health) and the various dimension of wellbeing considered in a holistic understanding of wellbeing.
- There is now more emphasis on **school wide promotion of student wellbeing** and that this is the responsibility of all teachers. (See the range of ERO and NZCER reports focused on student wellbeing, and Education Council *Our Code Our Standards* document.)
- With far more experience unpacking the learning intent of the **achievement objectives**, and **models of health promotion** (as well as the addition of further models of health promotion), we can refine our understandings of the way teaching and learning about the process of health promotion is a feature of health education programmes, and learning and qualification pathways.
- The role of Health Promoting Schools (HPS) has changed over time, and other **external providers** have emerged. Partnering with external agencies in ways that support teaching and learning in health education (or to support school wide approaches to promoting student wellbeing) is still a problematic space.

What do we want to retain and re-emphasise?

This is not an exhaustive list of possibilities, however, these aspects of the 2005 paper remain paramount.

- **Health promotion in health education is a learning process.** The **action competence learning process** is the recommended model to guide the approach to individual and collective action in health education.
- The HPE **underlying concepts**: hauora, the socio-ecological perspective, health promotion and attitudes and values, in combination are all-important for shaping health education knowledge across the key areas of learning.

- Effective **teacher pedagogy** is an integral part of the student learning process. Deliberate acts of teaching support students to develop the key competencies, including **critical thinking**, in health education contexts.
- The outcomes of health promoting actions in health education are **learning outcomes as a result of working through the process**, not health or behavioural outcomes.

What do we continue to try and strengthen?

Ongoing development of teachers' knowledge and understanding of:

- The various models of health promotion, including those don't teach senior secondary health education. Deeper understanding of health promotion models, as well as the actions needed for implementing health promotion planning, would benefit health education programme planning across all levels of the NZC, as well as improve NCEA achievement.
- The way the underlying concepts relate to and mutually define each other e.g. how health promotion as an underlying concept is shaped by understanding of hauora and wellbeing, the socio-ecological perspective, and attitudes and values.
- The progression of learning (the building blocks of health education knowledge) and what achievement of students in health education 'looks like' during the compulsory years of learning across the NZC (years 1-10).
- Teacher pedagogy that meets all professional expectations (effective pedagogy in the NZC, the Standards for the Teaching Profession and the cultural competencies in Tātaiako).
- The use of the action competence cycle as the learning process for health promotion and how the teaching as inquiry approach could support the selection and use of this process.

Additional references

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