Secondary school health education:
An analysis of the underlying processes

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Abstract

Health education is the setting where the majority of teaching and learning about health takes place in New Zealand secondary schools. This subject is incorporated within the learning area of Health and Physical Education, which is founded upon a socio-critical approach and is compulsory to Year 10. The 2007 New Zealand Curriculum guides teaching and learning within New Zealand schools and has established a strategic framework that focuses on student competencies, the local context, and meeting the diverse learning needs of students. Available health education research offers insights into the national curriculum, the challenges of implementing the learning area of Health and Physical Education, teachers’ professionalism and the influence of the school environment.

This qualitative study aimed to investigate health education in New Zealand secondary schools. Eight health education teachers, purposefully selected from secondary schools in New Zealand, participated in semi-structured interviews. Thematic analysis, grounded by a dual theoretical approach using social realism and Bernstein’s theory of education systems, generated seven main themes located within three thematic levels: wider school community relations, teaching as inquiry, and classroom delivery.

Themes in the first level reflected the marginalisation of health education and health education teachers’ relationships with parents, caregivers, and external agencies. The second level highlighted the reflexive role of health education teachers in establishing a student-centred health education. The last level reflected a contextual orientation to teaching practices, classroom health education content, and student assessment.

This thesis provides evidence of some of the teaching and knowledge processes underpinning health education in New Zealand secondary schools. It highlights teachers’ passion and investment in this subject, despite the challenges that arise. Understanding the experiences of health education teachers builds on the best-practice evidence base of school health education. This evidence base is vital in supporting health education to reach a level of subject maturity, establishing its value and need within New Zealand secondary schools.
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<td>BOT</td>
<td>Board of Trustees</td>
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<tr>
<td>ERO</td>
<td>Education Review Office</td>
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<td>HOD</td>
<td>Head of Department</td>
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<td>HPE</td>
<td>Learning area of Health and Physical Education</td>
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<td>HPENZC</td>
<td>Health and Physical Education in the New Zealand Curriculum</td>
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<td>HPS</td>
<td>Health Promoting Schools</td>
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<td>MOE</td>
<td>Ministry of Education</td>
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<td>NCEA</td>
<td>National Certificate of Educational Achievement</td>
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<td>NMSSA</td>
<td>National Monitoring Study of Student Achievement</td>
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<td>NZC</td>
<td>New Zealand Curriculum</td>
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<td>NZ</td>
<td>New Zealand</td>
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<td>NZHPCF</td>
<td>New Zealand Health Promotion Competencies Framework</td>
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<td>PLD</td>
<td>Professional Learning and Development</td>
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<td>RE</td>
<td>Religious Education</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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Chapter 1 School Health Education in New Zealand.

1.1 Introduction

In New Zealand (NZ), student health maintains a relatively high profile in media and research [1, 2]. Health education is the school subject that is largely responsible for educating young people about health and wellbeing [3]. This makes the school environment a potential setting where health education work can take place. State mandated guidelines for NZ schools set the direction for school management and health education curriculum. The 2007 New Zealand Curriculum (NZC) [4] currently guides how health education is taught in schools. The following chapter will provide a contextual backdrop to the teaching and learning environment in NZ schools, with specific reference to health education. The current management structure of the NZ school system, key national curriculum transitions, and students’ understandings of health will be discussed.

1.2 School structure

In NZ, it is compulsory for children aged six to sixteen to attend school [5, 6]. Most students start at age five, which corresponds to Year 1 of the school system [5]. Year levels correspond to the particular level of learning and age range of students [7]. Secondary schools will be the focus of this study; they teach students from Year 9–13 or Year 7–13 who are aged between eleven and nineteen years [7]. This study will specifically focus on the subject health education, which is taught in Years 9–13. For this study, Years 9–10 will be referred to as junior school, and Years 11–13 as senior school. Secondary schools are also generally grouped according to single sex, such as boys or girls only, or co-educational [7].

The New Zealand Curriculum (NZC) is the current state mandated school curriculum in NZ [4]. It guides the implementation of eight different curriculum learning areas [4]. The learning area of Health and Physical Education (HPE) is the focus of this study. HPE incorporates three distinct, but interrelated, subjects; health education, physical
education, and home economics [4]. At most secondary schools in NZ these subjects are taught separately [8, 9]. This subject separation has enabled this study to focus on the subject health education, rather than the overall learning area of HPE. In Years 11–13, learning is also guided by the national standardised assessment framework called the National Certificate of Educational Achievement (NCEA) [10]. NCEA has three levels of qualification (NCEA levels 1, 2 and 3); completion of each level is not constrained by a one year time-frame [10]. Each subject in NCEA has different achievement standards with the associated credits students can earn [5, 10]. This allows schools to offer a series of standards endorsed for specific subjects (e.g. health education), or develop individualised courses suited to the learning needs of the student [5, 10]. This study will also explore the subject health education within the NCEA framework.

1.3 School governance

School education in NZ has been managed under a neoliberal political ideology since the early 1990s [11]. Macdonald and Hay [11] described this neoliberal ideology as an approach to governing society in such a way as to reconfigure people as productive, economic entrepreneurs, who are responsible for making sound choices in their education, work, health, and lifestyle. Underpinning neoliberalism is a core belief that free marketing (of schools, educational services, employment etc.) will result in more efficient and effective outcomes. (p.6)

This ideology promotes individual autonomy and responsibility, which are situated within an economic framework [12]. In schools within NZ, this has led to a focus on the standardisation of learning outcomes and core subjects, a search for low risk ways to reach learning goals, and a corporate management model of school governance [12]. This ideology transformed schooling in NZ during the Tomorrow’s Schools reforms [12] and the introduction of the Education Act 1989 [13]; shifting school governance to the local school community [14, 15]. Schools financial, policy, and daily management are now overseen by a locally appointed Board of Trustees (BOT), which is often composed of the parents and caregivers of students at the school [4, 5]. The Ministry of
Education, the government appointed educational body, maintains strategic oversight of school management and school performance through a nationally mandated school curriculum and surveillance strategies [16]. These surveillance strategies include Educational Review Office school performance reviews, national standardised testing of students’ numeracy and literacy in Years 1–8, and publicly available reports of school and student performance [5, 14, 17, 18].

In NZ, state and state-integrated schools teach the national curriculum and receive operational grants from the Ministry of Education [16]. State-integrated schools also have a special character, which reflects their own specific philosophy or religion [18]. Schools are ranked according to a decile value from 1–10 [16]. Deciles are determined through a series of socio-economic indicators, providing an overall “measure of the socio-economic position of a school’s student community relative to other schools throughout the country” ([19], p.1). Decile 1 schools reflect the 10% of schools with students from low socio-economic communities [19]. The government provides a greater allocation of resources to low decile schools, compared to high decile schools [18].

In NZ, parents and caregivers have a degree of choice in determining which school their child attends. School zoning ensures that students living within the geographical region of a state school are given priority when enrolling [20]. However, students from outside this zone can also be enrolled, but places may be limited [20]. State-integrated schools allow any child to attend, although there are compulsory fees [20]. Competition for the preferred school of choice can also be influenced by parents’ and caregivers’ access to school performance reviews and indicators [18]. Some authors challenge the value of academic performance indicators [21, 22]. These indicators do not measure aspects of the school environment and relationships, which are key structures for supporting students’ learning [21, 22]. Schools in NZ are beginning to identify the importance of the whole school approach and are establishing school wide initiatives that enhance students’ wellbeing [3]. This change seems to be working. In 2012, NZ secondary school students reported small improvements in liking school, teachers’ fairness, and that they felt adults at school cared about them [23].
1.4 National Curriculum

Health education has undergone considerable change over the last 30 years in NZ schools. National curriculum guidelines set the direction for the pedagogic approaches and content taught in schools. Pedagogy refers to the theory and practice of teaching, whereas curriculum refers to the pedagogy and content taught [16]. Prior to 1985, health education focused on the narrow body/mind binary with health interventions focusing on prevention and changing risky health behaviours [14, 24]. In 1985, health education became an official subject, which integrated wider interpersonal and societal understandings of health [14]. In 1993 the entire school system was revamped under a government, which viewed education as a means to the economic and social security of NZ [15, 24]. The national curriculum took on a strategic framework that described an overall vision, principles, values, and competencies [15, 25]. Existing subjects were redefined into seven learning areas [25]. This new curriculum was oriented towards the specific learning needs of students and the integration of knowledge [25] (refer to Chapter 4.4). Learning objectives were outlined in terms of the knowledge and skills required for success within the economy; with English, maths, and science becoming core subjects [24]. During the 1990s new national curriculum statements were developed for each of the seven learning areas [24]; leading to the release of the 1999 Health and Physical Education in the New Zealand Curriculum (HPENZC) statement in 1999 [25].

The curriculum statement HPENZC was written by two government appointed curriculum writers; Tasker and Culpan [24]. Curriculum pedagogy and content were outlined as achievement objectives; skills students should develop across Years 1–10 [15, 21, 24, 25]. Four interdependent concepts drawn from the field of health promotion underpinned HPE [25]. These concepts were hauora (a Māori philosophy of wellbeing), attitudes and values (having a positive and respectful attitude to self, others and the environment), the socio-ecological perspective (a broad systems approach to health), and health promotion (the process of creating healthy environments) [25] (refer to Chapter 4.3). This curriculum statement also informed the curriculum direction of Health, when it became an NCEA subject in 2002 [9]. However, Robertson stated that NCEA achievement standards in Health “quickly became the default curriculum and
teachers tended to plan learning programmes primarily to the standards, and less to the overall intent of NZC” ([26], p.87) [9, 21].

Tasker, one of the principle HPE curriculum writers, argued this new curriculum direction supported a socio-critical approach to health education [27]. It also presupposed a philosophy of local experiential learning [12, 14] and legitimised community health knowledge [9, 25]. For Tasker this new direction offered a way to challenge those teachers who “have not seen health education as a legitimate component of the curriculum, and have little sense of content issues, responsibility for it, or ownership of it” ([27], p. 3). A socio-critical approach was linked to a pedagogic direction that taught students to think beyond the self; gaining a socio-critical awareness of others and the community [24]. Several authors argued the HPENZC also contained individualism rhetoric, which juxtaposed the socio-critical approach [12, 14, 15, 24]. Sinkinson [24] argued statements throughout the HPENZC contextualised learning in terms of “individualistic notions of self-mastery: confidence in one’s own abilities; responsibility for one’s own health and fitness; development of healthy living patterns; and constructively coping with challenges, personal stress, peer pressure and social conflict” (p. 52). Government youth health priorities were also evident with key areas of learning such as mental health, sexuality, and physical safety [25], closely reflecting the state’s priorities of reducing youth suicide, sexually transmitted disease, and alcohol misuse [9, 14].

Various groups in response to this document expressed criticism and concern. Literature highlighted the silencing of voices in the curriculum writing and submission processes, particularly those of Māori and teachers [15, 28]. Some Māori advocates argued that the definition of hauora, a Māori view of wellbeing, was misrepresented in the curriculum [29] (refer to Chapter 4.3.1). Although many teachers supported a local context approach to curriculum development, some raised concerns that the achievement objectives in health education were difficult to convert into content and student learning outcomes [12, 15]. There was also a decline over time in state funded professional development and HPE advisors initially provided support for schools to implement this new approach to health education, however this service declined over time [15, 30].

During the early 2000s, the government began revising the national curriculum direction, and merged all the curriculum statements into one document [14]. This led to
the introduction of the New Zealand Curriculum (NZC) in 2007 [4], which remains the current NZ-wide national curriculum. This new document maintained the same strategic framework, with the addition of a new learning area ‘learning languages’ [4]. All the learning area curriculum statements were condensed into this forty-five page document [4], which was seen to offer “a more manageable solution to issues associated with expectations of teaching, and too many achievement objectives across seven separate curriculum documents” ([21], p.329). Changes to the learning area of HPE consisted of a reduction in achievement objectives, and the original sixty-four page curriculum statement was reduced “to a single paragraph description and a series of achievement objectives” ([14], p.323). Initially, teachers continued to use the 1999 HPENZC curriculum statement as a support document [31]; however, these statements are now out of print and are only available online [7]. With time, fewer health education teachers may access the HPENZC statement, potentially leading to the loss of some valuable health education understandings

1.5 Students’ Health Views

The NZC clearly establishes the importance of students’ health and wellbeing, which is also an important public health priority. The compulsory nature of HPE until Year 10 suggests all school students should be receiving some form of health education during their school life [4]. How students talk about health can influence teachers’ selection of health information and teaching strategies employed in health education. The following section discusses NZ students’ self-reports of health and wellbeing and health views.

Most NZ secondary school students report having good health [1]. The 2012 National Youth 2000 Health survey [1] reported 90% of NZ secondary school students reported good, very good or excellent health. This randomly sampled survey of over 10,000 students, repeated in 2001, 2007 and 2012, is the only national cross sectional study that has explored NZ secondary school students’ self-reports of health [1]. There are several study design limitations. The study represented only 3% of the national school role, and did not include alternative education schools, which have a higher percentage of Māori and transgender youth [1].

The following paragraph summarises some of the findings from various Youth 2000 reports published to date [1, 2, 23, 32, 33]. These reports indicate a decrease in students’
self-reports over time in substance use, risky driving behaviours, violence, and teen-pregnancy. Several health areas remain unchanged, as shown through students’ self-reports of inconsistent condom and contraception use, being bullied, being overweight, experiencing significant depressive symptoms, a lack of time with at least one parent, parents’ concerns about finances, and access to a family doctor. Disparities also exist among students. Females reported poorer mental health outcomes than males; Māori and transgender students reported poorer health outcomes in mental health, bullying and school/home connectedness. The health disparities observed amongst student’s maybe a result of the inequity in household income reflected across NZ [34]. A disproportionate number of Maori and Pasifika families live in poverty, alongside experiencing structural discrimination and inequitable access to various social service such as health, employment, justice and schools [34]. This consequentially often leads to poorer social and health outcomes for these groups of people.

Students’ awareness and understanding of health is influential in enabling them to make healthy decisions. Burrows [35] study explored NZ primary and secondary school students’ understanding of health. Findings showed that students generally had a narrow view of health [35]. Health was often defined as health practices students engaged in, such as healthy eating and exercise, alongside corporeal characteristics of body size, shape, and weight. Other primary school studies have also reported similar findings, alongside students’ use of descriptive binary concepts to evaluate health practices, such as healthy/unhealthy and good/bad [35-37].

Students’ health views may be slowly changing. The 2015 National Monitoring Study of Student Achievement (NMSSA) reported on students’ achievement in the learning area of HPE [38]. This nationally representative sample of Year 4 and Year 8 students [38] showed an awareness of the holistic nature of health through the reporting of mental, physical and social aspects of health. However, students’ lack of criticality (particularly in Year 8), awareness of spirituality, and males’ under reporting of social aspects compared to females highlight gaps remaining in primary school students’ health knowledge [38]. Robertson expressed concern about this trend in health education stating, “students are arriving at secondary school (Year 9) without the depth of HPE understandings that would signal that they are on the right track for NCEA [referring to health education] success at secondary school” (p.86).
Students’ narrow understandings of health may be a reflection of the pervasive ‘healthism’ view, expressed in western society. Healthism represents a particular way of viewing the health problem, with health remaining rooted in medical notions of disease at the level of the individual [39]. This means that diseases, such as obesity, are often read off the physical appearance of the body and health is seen as the responsibility of the individual to maintain an ideal weight [40, 41]. By elevating “healthy lifestyles to a high moral calling” ([41], p.160), people who do not meet normative body types or markers of health maybe stereotypically seen as irresponsible [42]. Hokowhitu [43] argued this tendency reinforces ethnic, class and gender discrimination, perpetuating the stratification of health outcomes within NZ [40]. Health education can challenge these views by building students’ capacity to be resilient critical thinkers. It appears that many NZ students in Year 8 struggle with critical thinking, particularly Māori, Pasifika and low decile school students [38]. Students’ critical thinking does begin to improve as they move into secondary school, through their increased capacity to challenge normative judgements [35]. The differences in students’ health views and critical thinking is concerning. Students’ capacity to think critically enables them to reflect on how society constructs health meanings. Students who perceive they do not have an ‘ideal’ healthy body may be internalising this as a personal failing [44]. This negative internalisation may be contributing to the poorer mental health outcomes of Māori, Pasifika, and queer students in NZ secondary schools [2, 23, 45]. According to Dagkas [40] the perpetuation of ‘healthism’ and students’ lack of critical thinking may promote a sense of entitlement to bemoan rather than understand the health practices of others, judgementally evaluating not only themselves, but others in their families and communities for their failure to engage in healthy behaviours. (p.167)

The small changes in students’ health understandings over time [38, 46] highlight the challenges of shifting this strong ideology. Health education is one setting where a critical and holistic approach to health education can begin to challenge individualistic notions of health.
1.6 Summary

The NZC outlines a socio-critical approach to health education [47]. It orients health education towards the learning needs of students, the local health context and the development of health skills. This socio-critical curriculum direction appears to be making small changes in students’ understandings of health [38]. However, some groups of students continue to experience inequities in health outcomes and health knowledge [23, 38].
Chapter 2 Thesis Aim and Overview

This thesis attempts to build on NZ evidence, regarding school health education. The aim is to explore health education teachers’ experiences of planning and delivering health education, within the secondary school environment. Health education teachers’ experiences will provide the foundation for exploring the underlying processes involved in secondary school health education. This chapter provides an overview of the research objectives and methods, alongside outlining a thesis guide.

Objectives

In this thesis, four main research objectives are investigated, as reported below:

Objective One: To critically explore the knowledge foundations and knowledge practices underpinning health education.

Objective Two: To critically explore the social processes underlying the relations between health education teachers and school community members, within the wider secondary school environment.

Objective Three: To critically explore the social processes underpinning health education.

Objective Four: To critically explore the role of the health education teacher in guiding how health education is taught in secondary schools.

The aim of Objective One is to investigate the underlying knowledge processes involved in guiding the overall instructional approach to health education and classroom health education content. The interaction between different health and pedagogic concepts will be explored, alongside their influence on teachers’ practices. Objective Two investigates the social interactions between health education teachers and school community members, such as parents, caregivers and school management, and how their socio-political and economic views influence health education. Objective Three explores the social processes that guide how health education teachers communicate health education content to students. The final objective investigates the role of the
health education teacher in mediating the knowledge and social processes within the health education classroom and school environment.

Thesis overview

The participants in this study were purposefully selected from secondary schools in New Zealand and participated in semi-structured interviews (refer to Chapter 5.2). The nature of the interviews means data relates to how teachers taught health education to students, within the secondary school environment.

This study employs a dual theoretical approach (refer to Chapter 3). It draws on social realism’s concerns with the underlying teacher and knowledge processes involved in health education [48, 49]. Bernstein’s theory of educational systems offers insights into the social processes underpinning health education [50, 51]. Methodological tools from each theory, alongside literature, informed the thematic analysis of interview transcripts [52].

Researcher subjectivity can influence the direction of qualitative research [53]. Although a social realism attempts to minimise researcher subjectivity [54], it is important to acknowledge the role it has played in this study. The researcher’s privileged positioning as a NZ European, who attended a high decile state school, influenced their initial perceptions of secondary school health education. The researcher’s experience of school health education was limited, due to the prioritisation of traditional academic subjects within their school and family life; which relegated health education to the occasional class. Professional training as a mental health nurse was the researcher’s first in-depth foray into learning about health. After working in a mental health inpatient unit, the researcher developed a passion for the field of youth mental health. This project grew from a frustration with the lack of support in this field.

Given that health education is compulsory to Year 10 [4], this researcher wanted to understand what schools were currently doing to support young people’s health and wellbeing.

It is hoped that the short-term outcomes of this study will build on existing NZ health education evidence, further support health education teachers’ planning, and teaching processes, and raise stakeholder awareness of how the wider school environment influences how health education is taught in schools. The long-term anticipated outcome
is to further support teachers and students to have relevant and meaningful experiences within health education. However, measuring this outcome is beyond the scope of this thesis.

Thesis Guide

In this thesis, ‘Chapter 1: School Health Education in New Zealand’, outlines the management and national curriculum environment in NZ schools, alongside students’ health views. ‘Chapter 2: Thesis Guide’, offers a general overview of chapters in this thesis and a reading guide. In ‘Chapter 3: Research Approach’, the dual theoretical approach that guided this thesis is discussed. ‘Chapter 4: Literature Review’, offers a comparative critique of the national curriculum and health promotion, alongside a discussion of best-practice pedagogical approaches, the role of the health education teacher, and how health education is being taught within NZ schools.

Chapters 5 to 8 discuss the research methods that guided this study, alongside the thematic analysis findings and conclusions drawn. ‘Chapter 5: Research Methods’, describes the research methods used in this study; followed by ‘Chapter 6: Thematic Analysis Findings’, where the themes generated from the interview transcripts are analysed and conclusions drawn. ‘Chapter 7: Discussion’, draws on theory and literature to analyse the most likely processes underpinning health education in NZ secondary schools. This thesis finishes with ‘Chapter 8: Conclusions’, which summarise the results and implications for school health education.
Chapter 3 Research Approach

3.1 Introduction

This chapter outlines the dual theoretical and methodological approach taken in this study. A social realist philosophy [48, 55] and Bernstein’s structuration theory of education systems [51] are drawn on to explore both curriculum content and the social relations within health education. These theories are complementary as they are both founded upon the identification of “causal mechanisms or principles that contribute to the social structuring of society” ([55], p.3). Bernstein’s sociology theory, and associated methodological tools, will enable the exploration of the social processes involved in the communication of health education. Social realism theory and Archer’s methodological approach [48] will provide insights into the internal knowledge relations within the classroom health curriculum. This chapter discusses both theories (refer to Chapter 3.2) before providing an in-depth description of the methodological tools from each theory (refer to Chapters 3.3–3.5), which will guide the analysis of data obtained from teachers’ interviews.

3.2 Theoretical Foundations: A Dual Approach

The theoretical approach taken in this study will combine a social realist analytical approach with Bernstein’s theory of school education systems. Over the last fifteen years an educational realist tradition has begun to emerge which often draws on the work of Bernstein [56-59]. These mutually supportive theories offer a way to build a broader understanding of both school educational systems and curriculum knowledge, with Wheelahan [58] stating that

Bernsteinian theory and critical realism constitutecomplementary approaches that together provide insights into the structures of knowledge, the content of knowledge and the relationship between knowers and knowledge. (p. 638)
The commonalities between these theories enable a dual approach. It is also important to make the differences transparent. The social realist views the world as existing independent of our knowledge of it, whereas Bernstein views our knowledge as constructing the social objects in the world [55, 56, 60]. The theoretical commonalities are based on the view that the world is stratified [55] and both theories seek to discover how different objects interact in a specific historical timeframe [49, 55].

The literature review in this study highlighted a lack of social realist educational research. Most educational research is positioned within a critical or constructivist theoretical view point. A constructivist views knowledge as relative and explores the power relations between educational agents and the legitimisation of particular ways of knowing [53]. It is not my intention to undermine the wealth of knowledge and educational change that constructivist research has attained. The social realist agrees with many of the constructivist’s approaches. The social realist also views knowledge as relative and supports a social justice approach, which highlights the power of agents and ensures silenced voices are heard [55, 61]. Where social realism differs, is its concern with the form of health education curriculum that is communicated. The health education curriculum has the power to condition teachers’ and students’ knowledge practices, regardless of who is speaking about the knowledge [56, 60]. In this sense, knowledge has power and this needs to be considered separately from the specialised people and social structures involved in communicating knowledge [48, 49].

Bernstein and the social realist are epistemologically compatible as they view knowledge as being derived from two basic knowledge forms [50, 51, 56, 57, 62]. Bernstein identifies the structures of knowledge as vertical or horizontal [63]. Hordern [64] stated that “Bernstein’s (1999) vertical and horizontal discourse distinction provides a useful means for delineating between types of knowledge prioritised in education” (p. 432). Horizontal discourse is locally circulated via tacit learning in a particular context [63], whereas vertical discourse is explicit and has coherent internal logics, where conceptual learning occurs in a signposted sequence [50, 63].

The social realist offers more depth to understanding the internal knowledge relations of these two knowledge structures [55, 56]. The internal knowledge relations of the horizontal discourse, or everyday knowledge, involves the interaction of concepts as they become useful and relevant to a particular situation [56, 57, 62]. Muller refers to
the work of Chisholm et al. (2000) to describe the internal relations of a horizontal curriculum as ‘contextual coherence’ [62]. Vertical discourse, or theoretical knowledge, links concepts and models through a presumed “hierarchy of abstraction and conceptual difficulty” ([62], p.216) [55, 58, 65]. Again Muller cites Chisholm et al. (2000), referring to the internal relations of a vertical curriculum as ‘conceptual coherence’ [62].

Some social realists argue that theoretical knowledge is powerful [55, 56, 62]. It enables teachers to apply the most appropriate teaching practice to a particular situation. Theoretical knowledge, such as the chemical construction, manufacturing process, and instructional use of whiteboards, provides teachers with the knowledge to think about the best or most creative way to use whiteboards in a given situation. Horizontal or local knowledge is said to be less powerful as its usefulness is only located to a particular situational context [55, 56, 62]. The teacher may know that a white board marker leaves words on a white board, but they remain unaware of the chemical processes involved in the manufacturing and use of white boards and markers. Knowledge in today’s society rarely exists in either of these two forms. Constructivism and globalisation have both contributed to the integration and diversification of knowledge [56, 60]. Knowledge from different disciplines is drawn on when it becomes relevant in addressing particular societal concerns.

Archer, a social realist, provides a methodological approach that enables the knowledge and knowers debate to be less polarised. Archer states that humans have the capacity to engage in reflexive self-talk [66]. This enables humans to mediate the social and knowledge conditions in which they work and live [48, 49, 66, 67]. Reflexive agency enables teachers to align their personal concerns with how they personify their social roles and the associated practices [49, 68]. If teachers sit within a moral position of ensuring health education supports students’ educational outcomes, then this influences how they engage in teaching practices [48, 49, 69]. In this sense, a purpose or meaning underpins teachers’ practices and school curriculum.

In remaining focused on reflexive agency, educational debates may slowly begin to shift their focus to teachers’ and students’ meaningful engagement with different forms of knowledge, alongside meaningful access to society’s conversations and practices. The meaningfulness of health education in students’ lives closely aligns with the public
health imperative, of the usefulness of knowledge. Archer’s social realist methodology also suggests that knowledge should

demonstrably give us a greater or lesser capacity to negotiate the real constraints and affordances of our world, including our social world, and allow us to pursue a more fruitful and satisfying condition. ([70], p. 58)

By using a dual theoretical approach, a more thorough analysis of health education teachers’ experiences will occur. Together, these theories will help explore the content of health education, teachers’ agency, and the social processes that shape how health education is taught within the secondary school environment.

3.3 Social Realism: Identifying the Underlying Processes

Social realism is predicated upon Bhasker’s [54, 71] critical realism philosophy, which is concerned with the scientific relations between material objects. Bhasker [71] argued the natural world is composed of three overlapping domains of reality. The first domain consist of our experiences of material objects in the world [71]. An experience most teachers have had is smelling the pungent odour of a white board marker.

The second or actual domain is the level where events occur, which lead to our experiences [71]. To understand why this pungent odour occurs, scientists engage in particular research practices and draw on different knowledge sources. The social practices of science occur in a controlled environment where the conditions in which objects interact are carefully managed [71]. Science attempts to isolate and prove the different processes causing the pungent odour. However, as the world is an open system, science cannot always fully account for every interaction involved in an event. This means our knowledge of the odour (or world) is fallible, and science needs to be open to critique and building deeper understandings [55, 71].

The final level or ‘real’ domain involves the real structures and processes that have created the odorous compound [71]. Objects such as chemical compounds have a specific chemical composition. Each compound is composed of specific electron, neutron, and protons. These are the chemical properties of that object. The properties of
different objects interact in uncertain ways leading to a new odorous compound emerging or leading to no change [48, 49, 71-73]. This means objects can be both transformed or reproduced. Science is concerned with identifying the chemical processes between the different properties of objects. As these material objects are not dependent on human activity, scientific theory has a greater capacity to be predictive about the processes involved [73].

The natural sciences, as previously discussed, cannot be directly transposed on to the social sciences, as societies are open systems. Society conditions the social practices of humans, just as society is transformed through human activity [49, 74, 75]. Although there is a dependent relationship between society and humans, the objects within society such as social structures, human agents, and knowledge, have relatively independent properties [48, 49]. Therefore, the existence of objects cannot solely be explained through society or human action [73]. The interactions between different objects are also situated within a specific historical timeframe. This means theory can only ever be explanatory, as society undergoes constant transformation and reproduction [73].

Archer, a social realist, created a methodological approach founded upon Bhasker’s critical realism [48, 49]. The essence of Archer’s methodology requires the researcher to analyse if health education teachers “have an adequate understanding of their world, and if not, to explain why not” ([74], p.315). The researcher uses a process of analytical abstraction. This involves using theory and data to explore the different levels of interaction within society. The analysis moves backwards from teachers’ experiences, to the social practices of teachers, and then to the social and cultural objects that initially conditioned teachers’ activity [48, 49, 72]. At each stage, the researcher makes a rational judgement about the relations between different objects in each of these domains.

In the domain of experience, humans have a particular perception of society, although this experience may be fallible [49, 55]. A key knowledge experience of teachers may be the belief that ‘writing on the whiteboard enables the sharing of curriculum knowledge with students’. From the level of teachers’ experience, we can analyse the knowledge practices involved in this experience.
Within the domain of knowledge practices [48] teachers have knowledge of the different ways whiteboards can be used within the classroom. Some teachers may believe it is useful for writing curriculum content, others may find it useful for interactive classroom brainstorming sessions. From these knowledge practices a new section of the ‘teaching pedagogy’ view emerges which believes ‘whiteboards are an effective tool for classroom content transmission’.

The social realist is concerned with finding the underlying knowledge processes that condition the knowledge practices of teachers. Archer suggested knowledge objects such as the ‘whiteboard marker’ exist within society and act independently of human action [49]. These knowledge objects have emerged out of the previous knowledge practices of humans and condition future practice [48, 49]. Knowledge of the ‘whiteboard marker’ has properties that relate to the chemical manufacturing and instructional use of the whiteboard and pen. The knowledge of ‘teaching pedagogy’ has the knowledge property of providing different ways of communicating curriculum content to students. These knowledge properties come into relation through a process of ‘external and contingent complementary relations’ [48]. The property that emerges is the ‘specialised use of whiteboards as a pedagogic tool’. This emergent property goes on to condition teachers’ knowledge practices.

The above discussion describes only one process in Archer’s social realism methodological approach. Other underlying knowledge processes linked to her methodology are summarised in Appendix B. Archer’s methodology will enable the researcher to analyse the knowledge processes underlying the instructional approach to health education.

### 3.4 Reflexive Agency

The social realist believes the transformation of social and knowledge objects, such as ‘teachers’ or ‘curriculum’, is dependent on human activity. This activity is always conditioned by the prior interactions between structural and knowledge objects [48]. As humans engage in social and knowledge practices, they are themselves transformed with new agential properties emerging [48, 49, 55, 72].
According to Archer [48] human activity occurs in several interrelated domains. In the domain of society, people may experience life as a primary agent [48, 68]. A primary agent acts on their own; their particular life chances will determine the power and influence they have [68]. Primary agents can form corporate groups, such as the Health and Physical Education department. These collectives have a common purpose, are involved in organised action, and have shared resources [49]. From this corporate activity, power emerges [48, 49, 66, 67]. This power enables corporate groups to have the greatest influence over change in society.

The next domain is the social actor. Human agents take on particular social actor identities, such as the health education teacher. Teachers are required to perform generic teaching practices [48, 49, 66, 67], such as marking assessments, curriculum planning, and building relationships. Each health education teacher performs these practices in different ways, as they negotiate the constraints and enablements of the school environment [48, 49, 66, 67].

The final domain is human agency, where each teacher’s subjectivity enables them to personify the social actor role of the health education teacher. Archer identified reflexive agency or the capacity to self-talk, as the underlying process involved in conditioning a person’s actions [48, 49, 67, 69]. Reflexive agency enables a person to marry their concerns and projects to “a way of life that allows their realisation, a way of life about which we can be wholehearted, investing ourselves in it with each personifying its requirements in our own unique manner” [67, p.15] [68].

Archer identified that an individual generally performs one dominant style of reflexivity. There are four dominant styles reported in her methodology [48, 49, 67-69]. Communicative reflexive relates to the capacity to be internally reflexive, but with the need to talk to another person before making important decisions. Autonomous reflexive is described as the capacity to engage in internal conversation with a focus on practical matters. Engagement in internal dialogue and decision-making that is based on a moral purpose is described as Meta-reflexive. Fractured reflexive relates to a person having difficulty with any form of self-reflection. Although Archer believes one reflexive style dominates, other authors challenge this idea. Some social realist educational studies have reported individuals engage in more than one reflexive style,
and communicative reflexive is a more advanced skill than meta reflexive [66, 68, 69]. This study supports a broader approach to reflexive agency.

Archer’s methodological approach to human agency will enable the exploration of health education teachers’ position and power within schools, how teachers personify different teaching practices, and the reflexive self-talk that conditions these practices.

### 3.5 Bernstein: Transmitting the Health Education Curriculum

Bernstein’s theory offers several methodological tools for exploring the social processes within school communities, and the transmission of the health education curriculum within the classroom. These tools are useful in determining the underlying processes that condition health education teachers’ teaching practices.

Bernstein’s principle of classification refers to the process underlying the interaction between agents and discourses within the wider school community [51]. Discourses refer to the ideas, beliefs and practices that underpin the subject being studied, such as a teacher, student or the subject health education [76]. School discourses, such as health education, contain specialised content and agents who can speak about this content [50, 51]. Bernstein refers to agents as any person who performs a particular role, such as the teacher, parent or student [50]. The boundaries around school discourses are created through “specialised rules of access and specialised power controls” ([77], p.45). This means particular agents, such as the health education teacher, may have more power to speak about the subject health education than students. Bernstein refers to the strength of the boundaries around different school discourses or agents as classification [51]. Weak classification infers the boundaries around a school discourse are flexible or permeable, enabling different agents to access and communicate this discourse. Strong classification limits an agent’s access to a discourse and only specialised agents can speak about this discourse [50, 51]. This principle will enable the exploration of the interactions between the subject health education, health education teachers, and wider school community agents, such as external agencies, family, school personnel, and their associated discourses.

Bernstein’s principle of framing is the process underlying the communication of curriculum content between teachers and students [51]. Bernstein refers to the three
rules that underpin this interaction as the ‘pedagogic device’ [51]. These rules are recontextualisation rules, distributive rules, and evaluation rules. These rules describe the processes of power distribution within the relationship, communication of the curriculum, and evaluation of what knowledge has been acquired [50, 51, 55, 77, 78].

The recontextualisation rule in Bernstein’s theory guides the overarching approach to curriculum communication. This rule determines how teachers are “appropriating other discourse and bringing them into a special relation with each other for the purpose of selection, transmission and acquisition” of the health education curriculum ([51], pp.183-184). The recontextualisation rule governs the instructional approach to health education. The structure of this approach embeds an instructional discourse within a privileged regulative discourse [77]. An instructional discourse, such as constructivism (refer to Chapter 4.4.1), governs the selection of content, the sequence that knowledge is communicated, and the pace at which students learn this knowledge [51]. A regulative discourse such as neoliberalism (refer to Chapter 1.3) or a student-centred ideology (refer to Chapter 4.4.2) governs the purpose and behavioural relations within the classroom [50, 51, 55, 77]. Social realism will enable the exploration of how these different discursive concepts come together and influence teachers’ practices.

Distributive rules in Bernstein’s theory control the relationships and behaviour within the classroom by determining who has the power to “transmit what to whom and under what conditions” ([50], p.46). This rule will determine the power struggles that may occur within school wide and classroom relationships. An example of weak framing over the teacher-student relationship involves teachers facilitating classroom activities so students can share their experiences in discussions. Strong framing would involve a teacher standing at the front of the classroom talking to students who sit quietly and listen.

Evaluative rules in Bernstein’s theory provide a symbolic measure of what knowledge a student has recognised and been able to apply to a given context [50, 51]. Teachers can use different assessment strategies to determine students’ knowledge acquisition, such as exams, projects, or classroom observations. Evaluation can be strongly framed through formal assessment procedures. In this situation teachers outline what knowledge students should have acquired and they assess this through what is missing from students’ work [50, 51]. Weak framing over evaluation occurs when teachers
allow students to produce their own texts. Teachers then use their expert knowledge to evaluate what skills and knowledge students have shown in producing this text [50, 51, 79]. This rule will enable the exploration of how teachers plan to assess students’ health education learning, and their perception of how successful students are in acquiring health knowledge.

3.6 Summary

Social realism and Bernstein provide a dual theoretical approach that is concerned with analysing the underlying processes involved in health education. These processes influence both the content taught and pedagogic approaches used in health education. Methodological tools from social realism will enable the analysis of knowledge processes and teacher agency. Bernstein provides insight into the social processes between different school agents and their associated discourses. This dual theoretical approach enables a comprehensive analysis of school relationships, classroom health education content and pedagogy.
Chapter 4 Literature Review

4.1 Introduction

This chapter will discuss relevant NZ and international health education literature, which was identified through the literature review strategy. A comparative analysis of health promotion and health education is documented. This is followed by an analysis of health education pedagogies and the role of the health education teacher.

4.2 Literature Review Strategy

The dual review of educational policy and literature began in November and December of 2014. A range of public health and educational databases were searched – EBSCO Host, ProQuest, Ovid, Web of Science, Informit, Scopus, ERIC, Academic One File, Science Direct, Index NZ, NZCER, and Education Counts. Databases were searched for the following key words: “health education”; school*; ("high school*" or "secondary school*"); teach*; student*; health*; and "New Zealand". Searches were limited to articles that were peer reviewed, English language, and from 1990 onwards.

To obtain national curriculum and national reports, the following national educational websites were searched: Ministry of Education (www.education.govt.nz); Education Review Office (www.ero.govt.nz); New Zealand Council for Educational Research (www.nzcer.org.nz); and Te Kete Ipurangi: The New Zealand Curriculum Online (www.tki.org.nz). The University of Otago Library catalogue was also searched for books and ebooks.

Key article reference lists were searched for relevant texts; these were obtained where possible. Subscriptions were made to the above databases where possible, so new articles could be reviewed. Where this was not possible, the above search was performed again in January of 2016, but was limited to the Year 2015–2016.

A separate search, related to the theoretical lens of this study, was also conducted in Google Scholar and the University of Otago Library catalogue. The following key
words were searched for: school*; education; curriculum; pedagogy; “social realism”; “critical realism”; and Bernstein.

Literature in this study remained located to the general field of health education and teaching. The large amount of literature identified in the above search and the limited timeframe of this research, meant physical education or specific health education topics were not included in this search strategy. The literature discussed in this thesis supports the positioning of this educational study within a public health perspective. It does not provide a systematic analysis of selected studies. All NZ related literature identified in the search was included in the review.

The review of literature also deductively sensitised the researcher to important theoretical understandings, which informed the semi-structured interview design [80-82]. Some authors claim this approach narrows the analysis of data [82]. It was a necessary step in this study, due to the researchers naïve 'outsider’ view of health education [53].

4.3 Curriculum Insights: Drawing on Health Promotion

Two key national curriculum documents guide health education in New Zealand (NZ) secondary schools. These are the 2007 New Zealand Curriculum (NZC) [4], and the 1999 Health and Physical Education in the New Zealand Curriculum statement (HPENZC) [25]. Underpinning these documents are the four key underlying concepts outlined in the NZC: hauora, the socio-ecological model, attitudes and values, and health promotion [4]. These concepts are also important within the practice of health promotion, as outlined within the New Zealand Health Promotion Competency Framework (NZHPCF) [83].

The following sections will provide a comparative discussion of the four concepts underpinning the learning area of HPE and their relationship to health promotion frameworks. The scope of this comparative review does not allow for the historical analysis of the field of health promotion. For a fuller discussion, see Signal and Ratima’s book ‘Promoting Health in Aotearoa New Zealand’ [84]. Therefore, the New Zealand Health Promotion Competency Framework (NZHPCF) [83] will be used as a starting point for this comparative discussion.
The NZHPCF (see Appendix 1) was developed in 2011 through a lengthy consultation process between health agencies and cultural representatives [83]. The framework reflects

the unique context of Aotearoa New Zealand, which recognises our special relationship with Te Tiriti o Waitangi, values the diversity of all people and acknowledges our place in the global health promotion community. ([83], p.6)

This framework provides an accountability tool for those involved in the shared practices of health promotion. These practices are founded upon bicultural relations, values and ethics, health promotion knowledge, and practical competencies [83]. The knowledge foundations of health promotion can offer some insights into the teaching of health education in schools. Health education is often described in terms of the teaching and learning experiences associated with individuals or groups, as they develop the knowledge and skills to support health behaviours [85]. According to Green and Tones [47] health promotion includes the processes of health education, alongside creating healthy public policy [85]. This means health promotion is also concerned with health action at a societal, environmental and policy level; with the aim of empowering individuals and communities to increase control over the health and wellbeing of themselves and communities [47, 85].

The comparative discussion will also highlight the close alignment of the NZC and NZHPCF. Embracing the true essence of health promotion in schools can be achieved through the Health Promoting Schools (HPS) settings framework [86]. HPS can empower schools to make students’ health a priority across the settings of the community, school environment, and health education classroom. Discussion about HPS will establish the background for exploring how schools in this study utilise aspects of the HPS framework.

4.3.1 Hauora

The term hauora defines the Māori notion of wellbeing [25]. Hauroa was defined in the 1999 HPENZC [25] as an adaption of Mason Durie’s (1994) Whare Tapa Wha model,
which is a model widely referred to in health promotion. The HPE support document compared

hauora to the four walls of a whare (house), each wall representing a different dimension: Taha wairua (the spiritual side), Taha hinengaro (thoughts and feelings), Taha tinana (the physical side) and Taha whanau (family). (Adapted from Durie 1994, as cited in [25], p.31)

In support of a bicultural approach, within the learning area of Health and Physical Education (HPE), an English definition was also provided that stated, “Wellbeing encompasses the physical, mental and emotional, social and spiritual dimensions of health” ([25], p.31). This closely aligns with the World Health Organisation (WHO) definition of wellbeing (WHO 1946, as cited in [47]) where “Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity” (p.9).

Some Māori advocates challenged the use of hauora in the 1999 HPENZC. Literature highlights the essence of this debate as another expression of colonial power [28, 29, 40, 43, 87, 88]. ‘Māori’ and ‘hauora’ were actively dislocated from their contextual and genealogical foundations, and subsumed within a privileged European interpretation of wellbeing [28, 29, 40, 43, 87, 88]. The 2007 NZC did little to address these concerns, condensing hauora into one line describing it as a “Māori philosophy of wellbeing that includes the dimensions taha wairua, taha hinengaro, taha tinana, and taha whanau, each one influencing and supporting the others” ([4], p. 22).

The narrowing of hauora to one line, arguably, further undermines this definition. How Māori interpret this definition is linked to their cultural identity and is “informed by a Māori epistemology and ontology” which speaks of such things as the “physical, spiritual and symbolic connectedness to the land” and a “direct link with the tipuna (ancestors)” ([87], p.8). According to Larson [89] misrepresentation of this definition is also expressed through the delineation of hauora into separate operational aspects, which can ignore the holistic complexity of this term. Robertson [26] also suggests that the concept hauora is often personalised, where ‘my hauora’ is talked about, rather than using hauora as a model to explore wellbeing. The 2015 Sexuality Guidelines [90] offer
more space for exploring hauora than previous curriculum guidelines, through the explicit and detailed reporting of Māori, and Pasifika models of health. Although this is positive progress, it may be partially reactionary, due to the high profile of continuing disparities in health outcomes amongst Māori, Pasifika and transgender students in schools (refer to Chapter 1.5).

A health promotion approach to wellbeing also aligns with hauora and the WHO definition. It further extends these models by including spirituality, alongside viewing health and disease on a continuum, where the overall goal is to draw on personal and societal resources to empower people towards better health [47]. In this sense, learning how to manage and feel empowered to cope with disease becomes the focus [47]. The learning area of HPE also takes this approach, focusing on building students resilience, health understandings and skills to “take critical action to promote personal, interpersonal, and societal well-being” ([4], p.23). Empowering students towards health through education, needs to remain firmly rooted in the notion that there are varied understandings of health; often embedded in cultural, personal, or collective perceptions. Green and Tones [47] suggest it is difficult to define health

largely because health is one of those abstract words, like love and beauty, that mean different things to different people. However, we can confidently say that health is, and apparently always has been, a significant value in people’s lives. If we do not acknowledge the contentious nature of health and have a sound understanding of the determinants of our preferred conceptualisations, it is unlikely that we will be able to develop inclusive strategies for promoting it. (p. 8)

It is essential in both health education and health promotion that students are empowered to define their personal health concerns, goals, and strategies. When the value-laden nature of ‘health’ is embraced, different models of health and personal understandings become legitimised. This may support health education to remain relevant and meaningful for students.
4.3.2 Socio-ecological Model

Students’ health is intricately linked with the social worlds in which they live [91]. The 2007 NZC curriculum acknowledges this by including the socio-ecological model of health as an underlying concept. The NZC summarises this model as “a way of viewing and understanding the interrelationships that exist between the individual, others, and society” ([4], p.22). This model is one of many health promotion models that frame the interrelations between society and health. These interrelations occur at different levels within society. Dahlgren and Whitehead’s ‘Determinants of Health Model’ (1991, as cited in [47]) describe these levels as political, economic, cultural, psychosocial, and individual. Although the NZC is not explicit in its reference to this model, it is implied through students developing the capacity to discuss “factors that influence the health of individuals, groups, and society: lifestyle, economic, social, cultural, political, and environmental factors” ([4], p.22).

It is interesting that the elaborated 1999 HPENZC, in comparison to the later 2007 NZC, omitted political factors from the socio-ecological definition. Although the national curriculum supports a socio-critical approach the omission of political critique suggests teachers and students should not critique the very educational systems that influence their wellbeing. What this highlights is the power of the government over the national curriculum. Some authors argue there is an implicit undertone of the neoliberal self-responsible individual in the national curriculum [12, 21], and alternative voices, such as Māori, are often silenced [28, 29, 40, 43, 87, 88]. This could, arguably, be influencing teachers’ and students’ capacity to fully embrace a socio-critical curriculum [92]. It may also lead teachers to narrow the socio-ecological model to “discrete, identifiable determinants, the effects of which rational, informed young people could negate if they just made the ‘right’ choice” ([93], p.370). An approach that does not invest in discussing action strategies may lead to students’ feelings of powerlessness to effect change in their lives [94]. This approach often locates health to the responsibility of the individual through behaviour change. Sinkinson and Burrows [24] expressed concern that

in many schools the teaching and learning in health education remains under developed in socio-ecological perspectives,
and student learning in health education often fails to foster criticality. (p.56)

Health education in schools can start reversing this trend. Developing students’ capacity to engage in critical thinking increases their awareness that health decisions are largely context specific [92, 93]. This may empower them to view health knowledge and practices as changeable and contestable [92, 93]. Health education teachers can role model and provide learning opportunities that engage students in socio-critical thinking and action. The first step might involve conducting a socio-critical analysis of the very subject that advocates this approach. This study begins to explore these issues by asking teachers how social and political factors within the school and community environment influence their practices.

### 4.3.3 Attitudes and Values

Both the national curriculum [4, 25] and health promotion competencies [83] refer to the ethical principles of equity, social justice, integrity, cultural diversity, and bicultural relations. The 2007 NZC outlines these values as foundational for students’ developing “a positive, responsible attitude… to their own well-being; respect, care, and concern for other people and the environment; and a sense of social justice” ([4], p.22). Green and Raeburn [95] impress that ethics in health promotion enables the formation of trusting relationships, where diverse viewpoints are valued. Campbell and Gillett [96] further support this by highlighting the need for “some fair mechanism for resolving conflicts between different interests” (p.12).

Taking an ethical approach creates a health education classroom that is a physically, psychologically, and culturally safe place for fostering interdependent relationships. Equitable learning opportunities ensure everyone has the same opportunity to move toward self-efficacy in their learning, regardless of their abilities or life characteristics [97, 98]. Health education teachers can engage in advocacy work to ensure resource allocation supports an effective health education programme [99]. School management and national curriculum writers need to act with integrity, prioritising students’ learning rather than school and state economic performance in the market place [26]. Developing an explicit ethical framework for school-wide health and health education, may make inroads into pursuing equitable health education learning outcomes for students.
4.3.4 Health Promotion

Health promotion action, as outlined in the 2007 NZC, seeks “to develop and maintain supportive physical and emotional environments” and to involve “students in personal and collective action” ([4], p.22). This narrow definition does not articulate the broad essence of this professional discipline. However, as previously discussed, many of the principles and values underlying the national curriculum are grounded in a health promotion framework. Robertson [26] outlines that some educational research confuses “health promotion as a practice… as distinct from the models of health promotion for health education used in conceptual teaching and learning” (p. 83). Achievement objectives outlined in the learning area of HPE relate to students learning ‘about’ health promotion understandings which also include learning about taking health promotion action. This is distinct from the health promotion practices that occur across the wider school to support students’ health and wellbeing, which is the “collective responsibility of all members of the school community” ([26], p. 84).

Health education literature advocates for a critical approach to health education [27, 100, 101]. The 2007 NZC outlines a critical approach to all learning areas through its explicit referencing to the ‘thinking competency’ [4]. Students use “creative, critical, and metacognitive processes to make sense of information, experiences, and ideas” ([4], p.12). This definition highlights students’ involvement in critical thinking and reflection. Health promotion takes the next step, which involves students taking critical health promotion action [100-103].

In the learning area of HPE, the ‘action competence learning process’ is advocated for as an approach for taking critical action [26, 104]. This critical inquiry cycle enables teachers to integrate into one learning activity the four underlying concepts in the 2007 NZC, as well as critical thinking, reflection and action [104]. In this process, groups of students critically think about a health issue related to their hauora. Nutbeam identified three levels of health literacy skills that students might develop as they learn about health; these are functional, interactive and critical literacy [105]. When thinking about a health issue, students can develop their functional literacy through developing the skills to understand health risks and how to access health services [105].

The next level of learning would involve engaging in critical reflection; which shifts people from understanding “the construction of their positioned practices” to “begin to
engage in counterhegemonic practice” ([103], p.163). It is at this point students engage in ethical and ideological reflection about how to address the health issue [47, 104, 106-108]. At an individual level students can develop interactive literacy skills, such as health and social skills, that support personal health [105]. Part of this might be using the socio-ecological model to explore how the health issue occurs in society, and how power relations form, legitimatise, and shape the issue [47, 100, 104, 106, 109].

If health action is to be truly transformative then it builds students critical literacy, which are the health skills that enable groups of students to take social and political collective action [105]. Building these skills requires learning opportunities that address community wide health issues. Students can be involved in the planning, implementation and evaluation of health promotion actions, that take place outside of the classroom contexts [104].

The 1999 HPENZC achievement objectives do not outline students’ engagement in taking critical action until Year 8, when students will demonstrate ‘the use of health promotion strategies by implementing a plan of action to enhance the well-being of the school, community or environment” ([25], p.29). This is quite late in the learning sequencing given HPS literature identifies that students younger than this are capable of taking action [110] (refer to Chapter 4.3.5).

Critical health promotion action also needs to involve groups of students working together to take action within their communities. This collegial approach is supported by a Māori worldview [111]. This world view positions health and health promotion action as an interdependent relationship between people through the recognition that “autonomy is relative, not absolute; that it is self-determination in relation to others” ([112], p.7). Critical health promotion action involves health education teachers empowering groups of students to build on their strengths, resources, opportunities, and authority, to support both advocacy and action for health [98, 113, 114]. This form of pedagogy can be difficult to implement as it may be time and resources intensive [115, 116], and can challenge teachers’ and students’ subjective positioning [106]. This approach does not need to be implemented at every year level [104]. Providing students with at least one opportunity to engage in collective health promotion action during their secondary school years might support students to develop the awareness that effecting change in society is possible [104].
Health Promoting Schools (HPS) is a settings approach that addresses students’ health by taking critical health promotion action across the wider school community [86, 110, 117]. In NZ, there is an increasing number of schools taking up this approach [118]. In 2009, “approximately 67% of schools in New Zealand were considered HPS schools” (Ministry of Education, 2008 as cited in [119], p.5).

HPS is founded upon the 1986 Ottawa Charter [47], and the 1999 HPENZC document explicitly recognises HPS as a way of supporting health across the school setting [25]. HPS is a socio-ecological settings approach, where the school’s students and teachers are not treated in isolation from the larger social networks in which they live, work and play, and the creation of supportive health environments and community action are central to achieving the desired health outcomes. ([120], p.72)

HPS sets out three levels of health promotion action in schools. These levels correspond to the school organisation and ethos, curriculum teaching and learning, and community links and partnerships [110]. These three strategic actions involve staff, student, and community involvement in policy development and environmental change, alongside the teaching and learning of health education [121, 122].

HPS is generally used to address school-wide health issues such as nutrition, pastoral care services, school environment, and health education [117, 118, 122-124]. Studies and reviews of HPE have shown mixed levels of effectiveness in regards to students’ health outcomes [117, 121, 125, 126]. Initiatives that were more effective involved family, and theoretical approaches [125], alongside long time frames [126, 127]. Inadequate evaluation processes were a common contributor to the challenge of determining effectiveness [119, 121].

Barriers to successful implementation of HPS are often related to a lack of institutional support and time, privileging of academic subjects, and staff motivation and turnover [121, 127, 128]. Building a school’s capacity to engage in HPS can be supported by:
establishing collaborative leadership and management structures [86, 119, 120, 122, 129-132]; creating policy directives that integrate health and educational goals in the local context [119, 120, 128, 131, 132]; ensuring Kaupapa Māori is embedded [119]; building school and community ownership [120, 128, 133]; providing financial and human resources [86, 119, 128, 130]; providing professional development opportunities [86, 120, 130]; developing inquiry-based exemplars of HPS approaches and a national database of expertise [119]; and supporting evaluation and sustainability practices [119, 122, 129].

4.3.6 Summary

The national curriculum and the discipline of health promotion draw on similar health and pedagogic understandings to inform practice. Teachers and health promoters are working towards the same equitable and socially just health and learning outcomes for school communities. The socio-critical paradigm that underpins health education can be challenging to implement. Drawing on health promotion research and literature may provide further insights into supporting this health education approach. A settings approach that addresses students’ health across the wider school community, such as HPS, can further support the effectiveness of health education. Establishing links between health education, school-wide health initiatives and healthy school policy enables a more coherent and supportive approach to how students learn ‘about’ health.

4.4 Health Education

This section will form the theoretical foundation for a best-practice approach to health education. It will also establish why educational research needs to investigate the social relations between health education teachers and wider school community members, alongside teachers’ communication of health education content to students. Both of these questions are objectives for this study (refer to Chapter 2).

4.4.1 Teaching Approaches

Health education teachers can employ a variety of pedagogical approaches. These approaches are grounded in an overarching instructional approach. The national curriculum in New Zealand (NZ) has largely made the transition from a traditionalist
teacher led approach, to the current constructivist student-centred approach in the 2007 New Zealand Curriculum (NZC) [14, 24]. This section will provide a historical overview of the dominant pedagogical approaches observed in NZ, before specific pedagogical issues are discussed, such as a student-centred curriculum, school relations with the community and external agencies, and student performance.

School education in NZ, until the 1990s, largely followed a traditionalist instructional approach. School subjects often focused on a singular subject, such as English, mathematics, or science [51]. Teachers acted as experts who shared their specialised knowledge; students passively acquired then reproduced this knowledge through performing in different situations [47, 51, 55]. Health education often focused on students’ health deficits through teaching preventive health strategies [134]. Green and Tones [47] highlighted the paternalistic nature of this approach that involved “coercing people into adopting approved behaviours to prevent disease and improve health” (p. 303).

In the early 1990s, a constructivist approach to school education emerged within the education sector in NZ. This approach grew from the psychology and sociology movements in the 1960s and 1970s, which developed contextually situated theories of child development [51, 55]. These theories recognised the inherent capacity of humans to effect change, the relationship between individuals and their environments, and the diversity of individual’s competency development [50, 135, 136]. Young people were no longer seen as needing protection, but as having the agentic capacity to act upon the world and be involved in the learning process [47, 134, 136]. The direction of the curriculum moved from providing students with knowledge “to acknowledging and building on their prior learning experiences” ([47], p.314). The teacher became the facilitator of students’ active learning [47], and curriculum content was orientated to students’ development of skills and competencies in particular real life contexts [4, 14, 15, 21]. Bishop [111] stated that “the closer the classroom experiences and home experiences are for students the more likely it will be that students will be able to participate in the educational experiences designed at school” (p.12).

In NZ, the 1999 Health and Physical Education in the New Zealand Curriculum (HPENZC) statement reflected a constructivist approach [25]. Teachers (primary and secondary) involved in delivering aspects of the learning area of Health and Physical
Education (HPE), generally used aspects of a student-centred teaching approach [8, 9]. These aspects generally remained located to classroom activities, where teachers facilitated group work that supported students to share their diverse experiences [8, 9]. Some teachers who taught health education, at an NCEA level, found that they were less likely to use a student-centred approach due to the specific learning requirements of achievement standards and assessment practices [9, 21, 26]. This meant health education teachers used a more expert driven approach, and there was less opportunity for students’ active learning [9].

From the mid-1990s, a neoliberal government focus on economic productivity oriented the competencies within the school curriculum to the instrumentalities of the workplace [50, 51, 55]. This meant that curriculum was orientated towards preparing students to “seize the opportunities offered by new knowledge and technologies to secure a sustainable social, cultural, economic, and environmental future for our country” ([4], p8). Competencies in the 2007 NZC focused on generic attributes, valued by employers such as “thinking, using language, symbols, and texts, managing self, relating to others, and participating and contributing” ([4], p12). Wheelahan [55] identified this new direction as ‘Instrumentalism’. Elements of constructivism such as a student-centred approach and contextual learning, were blended with the generic competencies of the workplace [55, 58]. The current 2007 NZC largely follows a constructivist approach, but does blend aspects of instrumentalism.

4.4.2 Classroom Relationships

At the core of a student-centred approach is the establishment of democratic relationships between teachers and students [94, 111, 137, 138]. Bolstad [102] suggested a pragmatic approach to democracy is required. She suggests it is not about teachers ceding all the power and responsibility to students, or students and teachers being ‘equal’ as learners. Rather, it is about structuring roles and relationships in ways that draw on the strengths and knowledge of each in order to best support learning. (p.89)
This classroom approach recognises the diverse strengths of both teachers and students. Allen [139] and Scratchley [140] both reported that students want to be engaged in curriculum design. Students often believe they “have something to contribute, and believe that student input can make a difference” ([137], p.33). Allen’s study was specifically related to sexuality education, exploring over 1000 NZ 16 to 19 year olds responses to an open-ended questionnaire, from 15 secondary schools [139]. Scratchley’s study was a participatory study in one primary school, exploring children’s understandings of health and health education [140]. The context of both studies qualifies their reflections on student engagement.

Although democracy is ideal, it is not always possible in schools, given the strong focus on assessment (refer to Chapter 4.4.3) and pressured curriculum timetables [93, 99, 141]. However, through the valuing of both teachers’ expertise and students’ local knowledge, classroom practices are more likely to become meaningful. Hipkins opinion piece exploring the process of authentic inquiry in school health education [142] alludes to this, through her reflection that teaching practices should focus on an ‘ontology of being’. This involves empowering students ‘to become themselves’ [142]. Bishop [111] supports this approach, particularly for Māori students, where “to be Māori is to be normal; where cultural identities are valued, valid and legitimate. In other words, where children can be themselves” (p.11). Bishops study implemented and evaluated teachers and students experiences of the effectiveness of a professional development model that focused around a culturally responsive teaching profile. Gains in both literacy and numeracy were attained by Māori students where culture was valued within teaching and learning.

To support students becoming themselves different local and expert views can be drawn on to explore issues that naturally emerge from the learning process [137]. The 2007 NZC advocates for the integration of subject knowledge [4], although this does not often occur in the secondary schools [17]. Knowledge integration can sometimes be challenging due to teacher subjectivity and the prioritisation of certain messages [143 ], alongside a lack of resources and time [144]. This can sometimes lead to a lack of coherence between the different types of knowledge and activities students are engaging with in the classroom [138, 145].
Health education can integrate both local and expert health knowledge as it becomes relevant to students’ health concerns. Drawing on expert knowledge ensures theoretical models inform the understandings gained in the learning processes. Actively drawing on the diverse strengths of classroom members can open up critical dialogue about health, and the meaningful application of health knowledge and skills in real life contexts.

4.4.3 Student Assessment

The 2007 NZC achievement objectives provide guidance on what content and skills students should be able to perform [4]. Different assessment strategies can be used to evaluate students’ knowledge. A traditionalist approach tends to employ teacher generated assessment procedures, where student performance is measured based on what is missing from the text they produce [50, 51]. A constructivist approach generally focuses on students’ creation of texts and prioritises internal assessments [50, 51, 56]. The teacher then interprets students’ competency development from these texts [51].

Teachers’ subjective views on student performance and the purpose of assessment can determine the pedagogical and assessment approaches implemented in class [93]. A socio-cultural study in two Australian schools drew on two teachers’ experiences, alongside classroom observations and student interviews, to determine how a sociocultural perspective was practiced in health education. This study reported that teachers may be less likely to engage with pedagogical approaches that carry an element of uncertainty, such as health promotion action, if they perceive student performance is unlikely to reflect the time and effort put into implementing the activity [93]. It is often these pedagogical approaches, which are relevant and meaningful for students [93].

A qualitative Doctoral thesis by Weir [9] (refer to Chapter 4.6.2) offered some insights into student assessment. This study analysed thirteen semi-structured interviews conducted with health education teachers in North Island secondary schools, 12 of which were female. Secondary school health education teachers placed little emphasis on summative assessment in junior secondary school health education. At an NCEA level, health education teachers were sometimes teaching to the health education achievement standards [9]. This is often a result of “greater prescription of content and assessment requirements” ([9], p. ii). Despite the prescription of content, health education teachers in Weir’s study often perceived that school community members
viewed health education as lacking conceptual difficulty and was more suited to low academic students [9].

4.4.4 Community Engagement

The 2007 NZC advocates for parents, caregivers and the community to have greater involvement in aspects of school life [25]. Schools are a common meeting place for parents and students, where relationships and reciprocity is built that supports learning and community wellbeing [146]. Community involvement is mandatory in health education. Schools are required to consult with the wider school community about health education, at least once every two years [25]. Consultation engages the community in curriculum review and planning, which ensures the curriculum reflects local health views [25]. NZ research suggests that most schools struggle with all forms of community engagement, including curriculum review [8, 147-149]. Secondary schools generally inform rather than consult parents about the curriculum [148] and involve the community less than primary schools [147].

Many parents and caregivers value the opportunity to be involved in school life. Engagement with schools offers a way to improve student achievement and wellbeing, influence curriculum, and to offer and receive support [150, 151]. Hornby offered an explanatory model of the challenges that may arise when engaging with schools, which sometimes relate to differing goals, attitudes, culture, policy and financial need [152]. Supporting Māori engagement should be a priority in NZ education. Several qualitative studies were identified that explored Māori families and students experiences of school education in NZ. These studies report collaborative partnerships between Māori families and schools offer a way to connect learning across settings [153], drawing on Māori family expertise through flexible, supportive, constructive, and respectful bidirectional relations [151]. It is suggested schools need to advocate for and value Māori cultural activities and provide culturally responsive learning solutions [151, 153]. A shift away from deficit thinking about Māori students’ performance is argued, moving towards high expectations, support, and care for students’ learning needs and wellbeing [153, 154].

Bull’s [149] opinion piece suggested community involvement in health education needs to focus on democracy. He refers to Gutmann and Thompson (2004) definition of
democracy which involves “co-operative action by citizens to address collective problems in ways that contribute to the common good but also allow for difference” ([149], p.5). Communities offer an untapped resource of different “kinds of expertise needed to develop 21st century learning experiences for their students” ([102], p.92). Community engagement can be challenging, but it does offer an avenue to enhance the relevance and meaningfulness of students’ educational experiences.

4.4.5 External Agencies

In NZ, external agency involvement in school health education has grown exponentially since the Tomorrow’s Schools reforms during the 1990s [11, 107, 155, 156] (refer to Chapter 1). Ball [157] suggests education has become an “object of profit, provided in a form which is contractible and saleable” (p.76). External agencies, such as profit or not-for-profit health or social organisations, are in a prime position to invest in school health education, developing and marketing programmes and resources to schools. Several authors contend the economic benefits largely remain located to external agencies [107, 155, 157]. This is often reflected through the prioritisation of corporate ideology in programmes [107, 157], and the attainment of a valuable purchasing population [107, 155].

Schools need to be discerning about their involvement with external agencies. Quality control processes, for working with agencies, should be established within school policy and include programme evaluation [11, 129, 155]. Two NZ studies outlined the poor quality of programmes delivered by external agencies, both in the learning area of HPE and the wider school environment [155, 156]. Richards [155] study explored sponsorship and fundraising by external agencies through a questionnaire in primary and secondary schools, across six geographical regions in NZ. Penney’s [156] study used publicly available information from the internet to examine the public and privately funded HPE initiatives, programmes and resources in NZ. Both of these studies reported the lack of pedagogical expertise of these providers. Penney also highlighted the poor alignment of programmes to the NZC achievement objectives and the privileging of a body/mind model of health [156]. Robertson [26] reflected that external agencies need to “partner with educational institutions to ensure they understand NZC and the teaching and learning environment in which they expect their resources or programmes to be used” (p.92).
4.4.6 Summary

School health education in NZ blends different instructional approaches. This means teachers’ pedagogical practices do not fall neatly into a specific approach. However, schools largely follow a constructivist approach placing the student at the centre of teaching and learning.

The wider school community provides a valuable resource to support students’ educational learning. School engagement with the community tends to be informative, rather than truly democratic. External agency involvement in health education may be fraught. Schools can develop quality control mechanisms for monitoring the effectiveness of programmes delivered by external agencies. This may support the delivery of appropriate health messages within schools. This is not easy, as free health education programmes may offer an inviting approach to manage limited resources and teachers’ workloads [9, 155].

Health education teachers are in a pivotal position for ensuring learning remains student-centred. Teachers’ capacity to form relationships with the community and external agencies can support this endeavour. This study will explore the relationships health education teachers have with parents, caregivers, and external agencies, which aligns with Objectives Two of this thesis (refer to Chapter 2).

4.5 The Health Education Teacher

Health education teachers’ personal and professional experiences, are influential in determining how health education occurs within the classroom context. The following chapter explores how health education teachers’ subjectivity, professionalism, and collegial experiences impact on their teaching practices. Professional development research will also be discussed as it provides a strategy to support teachers’ health education expertise.

4.5.1 Teacher Subjectivity

Health education teachers’ subjectivity influences how they negotiate a complex array of policy, curriculum, health, and pedagogic views in the school environment [158]. Martino and Beckett [159] insightfully recognised that teachers’ subjective knowledge
is the threshold point at which teaching is planned and enacted [93, 160]. Teachers beliefs about students and learning are influential in “determining how they operate in the classroom and are essential in changing teacher practice” [160, p.12]. A survey of seventy-five Australian high school health education teachers, reported teachers’ pedagogic approaches were largely influenced by their understandings about the purpose and pedagogy of learning and relationships with students [161]. Discourses that are shared in the public domain, such as gender and political ideology, can influence teachers’ beliefs and pedagogy. Several Australian ethnographic studies reported on the influence of the heteronormative discourse or the neoliberal political ideology on health education teachers’ pedagogy. In one study two male HPE teachers personal positioning to the heteronormativity discourse legitimised their use of active sports for boys and a more discussions based pedagogy for girls [159]. In the other study, alignment to a neoliberal political ideology for one male health education teacher led to a narrow socio-critical pedagogy, perpetuated by a desire to attain a higher professional status in the school. The female teacher valued the neoliberal ideology aspects of performativity and efficiency, which legitimised her belief that student directed pedagogies were risky and time consuming in health education [93].

Personal histories and personal experiences of what it means to be healthy also influence teachers’ pedagogies. A NZ based qualitative study by Burrows analysed the experiences of three HPE primary school teachers, alongside school polices, observations, and teaching resources [158]. School culture and teachers’ “lived history of ‘health’, their understandings of their own and others’ bodies, and their personal convictions about what, for them, constitutes a ‘good’ and/or ‘healthy’ life” ([158], p.729) were influential in guiding teaching practices.

Teachers’ confidence is part of this subjectivity. A range of both quantitative and qualitative studies report reported a lack of confidence can contribute to: teachers’ negative experiences of managing student-teacher relationships in the classroom [161]; a lack of familiarity with health content [8]; and pedagogic and content narrowing [8, 9, 160, 162].

Despite the subjective variation in how teachers communicate the health education curriculum to students, Burrows and McCormack [158] argue it is exactly this dissonance that provides the
rich diversity of perspective evidenced in teachers’ work that yields opportunities for students to think and do health otherwise – something 21st century teachers would undoubtedly embrace as a healthy outcome. (pp. 741-742)

Providing students with different health education experiences can open up discussion about the value-laden nature of health. Through critically reflecting on different health experiences, students can come to understand that health views can be challenged and changed. This opens up the space to learn about health in different and meaningful ways.

4.5.2 Professionalism

In NZ, secondary school teachers generally align to a particular subject specialisation [163]. Health education teachers are often professionally prepared through a Physical Education degree, followed by completing health education papers before or during the completion of a teaching qualification [8]. Physical education teachers, who also teach the subject health education, may firstly align with a physical activity pedagogy and struggle to implement a socio-critical perspective [101, 116, 162]. For some health education teachers, particular personal circumstances and personal dispositions influenced how they became a teacher, rather than an initial desire to teach health education [9].

Teachers allegiance to a particular subject specialisation, such as physical education or home economics, can also influence health education pedagogy. A qualitative case study of two sexuality education teachers in an Australian high school highlighted teachers’ responses to gender. The male physical education teacher responded in terms of a biological model. The home economics teacher, despite gender theory expertise, employed a narrow view due to her discomfort with this topic [162].

Professional development can influence teachers’ pedagogy. In NZ, middle school teachers’ confidence in teaching was strongly associated with both higher levels of tertiary level study in any subject and the number of years teaching [164]. An American survey of middle and secondary school sexuality educators who were professionally prepared, reported teachers had a greater awareness of content and pedagogic
knowledge than non-professionals, leading to a broader sexuality education programme [165]. However, one third of teachers struggled with participatory pedagogy [165].

Professionalism often entails the capacity to enact specific teaching competencies. An American qualitative study of school health education professionals reported technical skill and abilities, rather than human values and attitudes, are competencies which are often prioritised. These technical competencies related to relationship building, assessment, community engagement, and pedagogic proficiency in active student learning, positive classroom management, and continuing professional development [166]. Students perceptions also offer insights into important professional teacher qualities. New Zealand secondary school students aged 16-18 year olds from 15 schools reported on their experiences of sexuality education. They valued the qualities of the teacher rather than their professional background. They valued teachers that were knowledgeable, valued their role, could relate to students and were professional [139].

The teaching and learning inquiry cycle is one of the key professional pedagogic strategies outlined by the 2007 NZC [4, 108]. This enables teachers to identify students’ learning needs, which informs how programmes are planned, evaluated and revised [4, 108]. Health promotion also draws on a similar cyclic inquiry process [47]. A moderate portion of all NZ teachers struggle with the inquiry process, particularly planning how to respond to students’ needs and evaluating learner outcomes [108].

According to the Education Review Office [108] the inquiry cycle is a key professional competency and improves teachers’ practices by establishing “feedback loops …when teachers observe, respond, and evaluate in ‘real time’” (p.2). Teaching as inquiry is not just an individual exercise. Educational conversations with other school staff, such as teaching colleagues, guidance counsellors, and school management, can also support the inquiry process. Collegial inquiry may also support health education to move beyond the classroom to become a wider part of school life.

To support the teaching practices of all NZ teachers, professional and learning development (PLD) programmes are sometimes offered by the Ministry of Education, schools, and external agencies [8]. Avalos [167] outlined professional development as
a complex process, which requires cognitive and emotional involvement of teachers individually and collectively, the capacity and willingness to examine where each one stands in terms of convictions and beliefs, and the perusal and enactment of appropriate alternatives for improvement or change. (p.10)

Teachers who teach in the learning area of HPE in NZ generally prefer PLD opportunities that involved networking with community agencies, other school contacts, university staff, or teachers’ conferences [8, 9]. They also reported a lack of access to PLD [8, 9]. Barriers that can contribute to poor access relate to a lack of time and resources, teachers’ perceived lack of provider pedagogic expertise, and programmes that do not relate to the national curriculum [8, 147].

In 2015/16 the Ministry of Education began developing a school wide systems approach to PLD, which is being piloted in the learning area of HPE [168, 169]. This was in response to a Ministry of Education contracted literature review conducted by Timperley and Wilson exploring ‘Teachers professional and learning development’ [170]. From this literature review a PLD strategic direction for NZ was developed that involved targeting national priority areas through an equitable networking system [168]. This system is designed to: link internal and external expertise; develop effective leadership and profession led initiatives; strengthen school and subject networks through evidence-informed inquiry; and have a national system that evaluates and reports on expert providers [168, 169].

International PLD research also supports the approach taken by NZ [167, 170-172], alongside emphasising that programme content challenges problematic personal and professional views [167, 170, 173] and provides sufficient time, money and opportunities for extended learning [170, 172].

If this new PLD approach is effective, it will hopefully ensure NZ teachers experience the beneficial outcomes that PLD offers. These positive outcomes may relate to teachers having a shared purpose [8, 9], improvements in professional self-efficacy and confidence [8, 9, 167, 170, 172], greater satisfaction with teaching experiences [167, 170, 172], the development of trustworthy and non-judgmental relationships with
students [164, 174-176], maintenance of personal wellbeing [9], improved student learning outcomes [167, 170-172, 176], and a reduction in learning disparities within and across schools [172].

It appears the Ministry of Education is taking steps to provide a professional development approach which support teachers’ exploration of their subjective and professional experiences. This will empower health education teachers to access and evaluate different forms of health and pedagogic knowledge, develop creative programmes, and negotiate the constraints of the neoliberal school environment.

4.5.3 Summary

Teachers’ subjective and professional experiences play a role in structuring health education within schools. Teachers’ capacity to critically inquire into the effectiveness of school health initiatives and classroom programmes is essential. PLD can support this endeavour, alongside building students’ and schools’ self-efficacy to do health education in meaningful ways. This study will explore secondary school health education teachers’ perceptions of health education and their experiences of becoming a professional health education teacher. This will support the critical exploration of Objective Four of this study, which is to explore the role of the health education teacher in delivering health education.

4.6 Teaching Health Education in New Zealand Schools

This chapter explores the everyday challenges of health education teachers’ practice through acknowledging “the complexity of teachers’ work spaces and the way key ideas are enabled and constrained by key structures within those spaces” ([15], p.31). This chapter will establish the value inferred on the subject health education within the school environment. This will be followed by a discussion of selected articles identified in the literature review strategy that reflect how health education is delivered within both primary and secondary schools in NZ.

4.6.1 Valuing Health Education

Health education is the setting where the majority of deliberate teaching and learning about health takes place [3]. The school curriculum prioritises health education, as
exemplified through its compulsory status to Year 10, and the introduction of the subject health education as a National Certificate of Educational Achievement (NCEA) subject option in 2002 (refer to Chapters 1.2 and 1.3). It is through health education that the national curriculum often attempts to address the social and health issues of young people [107, 177].

Despite the national curriculum support for health education in NZ, schools appear to struggle to take up this imperative. Hargreaves [99] reported that health education is often undervalued within secondary schools [99]. This result was based on a small-scale questionnaire (n=25) completed by secondary school HPE teachers from ten regions in NZ, who attended a health education conference in 2009. School-wide curriculum crowding contributes to this, as schools are under increasing pressure to provide diverse learning opportunities within a limited timeframe [99, 141]. National and international literature suggest the undervaluing of health education is often displayed through a lack of collegial support, time and resource allocation [8, 99, 147, 178], low academic positioning [9], poor career progression and high staff turnover [178], untrained and low motivated health education staff [99], and high workload demands of assessment, planning and teaching [178, 179].

Advocacy work by organisations, such as the New Zealand Health Teachers Association, may support health education to have a stronger profile within schools. Many health education teachers already have a “committed belief in the role of their subject area, as well as their role as health educators” ([178], p.23). A collective commitment will support health education to have a profile within schools and ensure schools are working towards subject resource equity. Government and school advocacy for stronger curriculum content direction and resources may support this endeavour [26].

4.6.2 Teaching Health Education

This chapter discusses five studies that were identified from the literature review search strategy, which specifically explored the enactment of health education in NZ schools. These five studies were situated within two historical timeframes. The first timeframe was between 1999 and 2006. During this time the 1999 Health and Physical Education in the New Zealand Curriculum (HPENZC) document was introduced into schools,
alongside health education as a subject within the NCEA in 2002. The second timeframe occurred from 2007 onwards, after the release of the current 2007 New Zealand Curriculum (NZC). This section will discuss the strengths and limitations of each NZ study situated, alongside important understandings.

Three research studies were situated between 1999 and 2006. Studies by McGee [8] and the Education Review Office (ERO) [180] reported on HPE, with McGee reporting separately on health education. The ERO report [180] coincided with the 2006 National Education Monitoring Project [46]. This project explored primary school students’ understandings of health (refer to Chapter 1.5). Both studies were large nationally representative mixed methods studies, commissioned by departments within the Ministry of Education. They included both quantitative and qualitative research methods, alongside observations of teachers work. McGee’s study focused on primary and secondary schools; the ERO report focused only on primary schools (Years 4 and 8). The final study, a Doctoral thesis, was an interpretive study by Weir [9]. This study explored health education in secondary schools during 2003/04. There were several study limitations identified that were related to a poor response rate of thirteen teachers from thirty schools and a gender bias with twelve out of thirteen teachers being female.

Two studies in NZ primary schools occurred after the release of the 2007 NZC. Watanabe and Dickinson’s conducted a small scale qualitative study [181] in 2011. It compared the experiences of five primary school health education teachers in Auckland and five in Tokyo. In Japan, health education teachers are required to implement a government mandated health education textbook, whereas the NZC allows for a local content approach [181]. The other NZ study was part of a wider National Monitoring Study of Student Achievement (NMSSA) project [38] conducted in 2013. This study explored HPE teachers’ and students’ experiences of the learning area of HPE (student results: refer to Chapter 1.5). A non-representative national sample of Year 4 (176) and Year 8 (186) teachers completed a questionnaire.

The findings of these studies reported the enduring challenges of curriculum change during the transition to a new socio-critical approach under the 1999 HPENZC. The NZ studies conducted between 1999 and 2007 report many of the challenges and concerns associated with implementing the new learning area of HPE within schools.
Teachers who taught in the learning area of HPE or the subject health education during 1999–2006 reported that implementing the 1999 HPENZC curriculum was challenging. These challenges included: understanding the theoretical nature of the curriculum [8, 9, 180]; the curriculum was not always helpful for classroom planning and assessment [8, 9, 180]; qualitative achievement objectives were sometimes difficult to translate into student learning outcomes [8, 9, 180]; the curriculum did not always support the reporting of student achievement to parents [8, 9]; and the curriculum did not meet Māori students’ needs [8, 9]. External agencies (refer to Chapter 4.4.5) were used by some teachers to decrease their workload; however, teachers were concerned about their effectiveness [9].

Despite the curriculum challenges, health education teachers recognised this new direction legitimised a student needs approach at junior school, which enabled them to focus on learning rather than the assessment of learning [8, 9, 180]. Teachers were also generally able to integrate the four underlying curriculum concepts into classroom activities [8, 9, 180]. Teaching and learning prioritised the building of students’ interpersonal, communication, and problem solving skills [8].

The study by Weir [9] provided some insights into how health education teachers taught health education within the NCEA framework. Teachers reported that the content taught in health education focused on the requirements of the achievement standards, rather than addressing students’ health and social issues [9]. Teachers selected achievement standards based on the capabilities of their students; students who chose health education as an NCEA subject were predominantly low academic students [9].

The concerns teachers expressed in these early studies may have contributed to the government’s decision to simplify the national curriculum to the overarching 2007 NZC document. Two NZ studies are situated after the release of this curriculum.

The NMSSA [38] and Watanabe and Dickinson’s study [181] both shed light on how primary school health education teachers had embraced the learning area of HPE during 2014/2015. The NMSSA reported HPE teachers felt confident in drawing on local health views and facilitating group work for diverse learners. Teachers continued to face challenges when drawing on different cultural knowledge contexts and involving the wider school community in health education.
Watanabe and Dickinson’s [181] comparative study of primary school health education in Auckland and Japan highlighted several important findings. In Japan, which uses a mandated health education textbook, students gained greater health knowledge than students in NZ [181]. However, Japanese teachers reported textbooks did not cover all the local health issues and there was not enough time to cover all of the content [181]. Whereas the NZC allowed the exploration of local health issues.

Watanabe and Dickinson’s study [181] also showed there were school differences in how health education was taught in NZ schools [181]. Health education teachers in low decile schools, with students generally from disadvantaged neighbourhoods, often followed a traditional lecture style approach. This was largely due to a lack of finances, parental support, and limited access to external agencies’ programmes. Health education teachers from high decile schools, with students from generally advantaged neighbourhoods, had greater access to resources and were supported to engage in experiential learning [181]. The differences in teaching approaches were often related to time allocation, prioritisation of nationally standardised subjects, and the motivation of health education teachers [181].

The five NZ studies briefly discussed in this section highlight some of the views and approaches related to health education. Weir’s [9] and McGee’s studies explored health education in secondary schools; they were situated before the release of the current 2007 NZC. Watanabe and Dickinson [181] study explored health education, but at a primary school level. The other NZ studies explored the learning area of HPE. This qualitative study will attempt to build on existing health education evidence within the secondary school setting. It will provide insight into the teaching of health education under the 2007 NZC, through exploring NZ health education teachers’ experiences.
Chapter 5 Research Methods

5.1 Introduction

This research methods chapter outlines the social and ethical processes used to obtain and analyse data related to the experiences of secondary school health education teachers. The social realist describes these processes as a way “to understand how knowledge is produced, the internal relations of its process, and therefore scientific accountability that knows itself and troubles itself with critique” ([181], p.155). In pursuit of scientific accountability, this chapter provides in-depth detail of each research process involved in this study. These processes include qualitative interviewing, research validity, thematic analysis, and study limitations.

5.2 Qualitative Interviewing

A realist, according to Sayer (2000, as cited in [182]), believes

things exist and act independently of our descriptions; at the same time, human actions are concept-dependent, and human concepts make up a part of the reality of these facts. (p.19)

Gaining access to human experience can provide a starting point for understanding an objective reality [75, 182]. Human experience can be understood through interviewing, which is “a well-established research technique” ([183], p.43). Liamputtong [183] simply states interviews are “conversations with an agenda” where “information obtained through the conversation is then used to construct knowledge about the reality of the participants” (p.43). According to Barriball and While [184] semi-structured interviews are

well suited for the exploration of the perceptions and opinions of respondents regarding complex and sometimes sensitive issues and enables probing for more information and clarification of answers. (p.330)
A semi-structured interview approach was used in this study as it enabled the undervalued voice of New Zealand (NZ) health education teachers’ to be explored. Hesse-Biber and Leavy (2005, as cited in [53]) argue the interview provides an effective way of “accessing subjugated voices and getting at subjugated knowledge” (p.44). It also supported the development of the early career researcher’s interviewing skills [53].

A semi-structured interview guide with open-ended questions was developed; providing a neutral and sensitive starting point that defined some of the areas to explore in the interview [185]. Semi-structured questions “serve as touch stones that help to maintain some level of focus” ([53], p.54) in the interview, while at the same time allowing for the divergence of the conversation so new ideas and meanings can be explored [186]. These meanings often relate to both local knowledge and behaviour, alongside the social structures and rules that govern teachers activities [53]. This aligns with the methodological concerns of social realism and Bernstein, which guided this study.

Interview questions were collaboratively designed with the thesis supervisors, and piloted with two generalist teachers. This provided feedback on the style of interviewing, and the interview framework’s sensitivity and coherence for exploring teachers’ experiences. The interview schedule is reported below.

1) Please share with me your own personal experience of why you became a health education teacher. This may be your own experience of health education at school, your university experience, or your journey in this or other schools?

2) Could you share with me how health education is structured in your school?

3) Could you share with me your vision of what the purpose and value of health education is for young people?

4) Could you share with me what you see are the health issues for young people in New Zealand?

5) Could you share with me any concepts you consider important in the planning and delivery of teaching and learning in health education (junior and senior health education)?
6) I’m interested in what a typical health education lesson you would deliver would look like. Could you share with me some teaching and learning experiences that you thought were important and received well by your students?

7) Could you share with me your experience of engaging with parents and the wider community in health education?

8) Please share with me your experience of working with external agencies- who are they, what support do they offer school health education. Share with me your experience of the relationships you have with them?

9) Could you share with me your experience of the professional development that is offered for health education in New Zealand?

10) Could you share with me your experience of liaising or networking with other staff and schools to support your teaching and learning of health education?

11) Please share with me your thoughts about how policy influences your experience of being a health education teacher?

12) If we lived in an ideal world, share with me what you would like to add or be able to access to further develop health education in your school?

The Ministry of Education website Te Kete Ipurangi: The New Zealand Curriculum Online [16] was explored to identify secondary schools in NZ. School characteristics explored during the thematic analysis were obtained from this website. Eleven schools were purposefully selected based on the following school characteristics provided by this website (refer to Appendix I): geographical location, state, state integrated, girls only, boys only, coeducational, special character, and school decile. Purposeful sampling enabled a way to

select and study a small number of people or unique cases, whose study produces a wealth of detailed information and an in-depth understanding of the people, programmes, cases, and situations studied. ([187], p.212)
The time and funding constraints of this study also meant a small sample size was appropriate.

School principals were contacted via email in the first instance, to obtain permission to contact health education teachers at their school. Eleven school principals received a letter of introduction (refer to Appendix D) and participant information sheet (refer to Appendix E). Where school principals did not respond, follow-up occurred by a phone call, or visit in person. Three principals were unable to be contacted, seven gave permission, and one declined school involvement. Principals who gave consent were asked to provide contact details for health education teachers in their school, forward the email invitation on to health education teachers, or deliver the information sheet in person.

One health education teacher, at each of the selected schools, was contacted by the researcher. Health education teachers were emailed an introductory letter (refer to Appendix D), an information sheet (refer to Appendix E), and a copy of the interview schedule. If teachers did not reply to the email invitation or their email was not obtained, three phone calls one week apart were made to the Health and Physical Education (HPE) department. Only one teacher initially expressed an interest in taking part.

Relationships were built with two senior lecturers from the University in the region where this study was situated. These lecturers were currently working alongside secondary school HPE departments. The lecturers volunteered to discuss the research with health education teachers at the seven schools where the school principals agreed for teachers to participate. Where health education teachers expressed interest in participating, their contact details were forwarded to the researcher or they emailed the researcher directly. Initial contact occurred via phone or email. One health education teacher from seven participating schools agreed to be interviewed. One participant in the study recruited a health education teacher that had taught health education, but who was not currently teaching. This teacher had experience teaching under the 2007 New Zealand Curriculum. Six interviews involved one health education teacher, one interview involved two teachers. An interview appointment was scheduled at a day, time, and place that suited the teacher. Interviews were conducted in the school setting, except one, which was conducted in a University department.
The semi-structured interviews were audio recorded. The interview guide enabled specific questions to be asked, but allowed for flexibility to explore new fields of interest [53]. A flexible and reciprocal relationship also occurred between the researcher and the health education teacher. This enabled space to engage in dual reflection and meaning making, so new lines of inquiry were also explored [80, 81, 186]. Health education teachers were also provided with a koha (gift voucher) in appreciation for taking part in this study. Follow-up occurred via email one week after the interview, to support teachers if any adverse consequences or comments wanted to be shared.

It is important to note that the interviews were conducted over a five-month period during July to October of 2015. The researcher began transcribing and engaging in the early stages of thematic analysis before all the interviews were completed. This meant that new understandings were explored in subsequent interviews, however theoretical saturation of ideas was not obtained [80].

5.3 Research Validity

The social realist takes a critical approach to knowledge, recognising that its social construction is fallible [75]. Therefore, this researcher remains open to critique about the strategies and social practices used in the construction of this study. According to Moore [188] it is through ‘judgemental rationality’ that the researcher determines that some knowledge and ways of constructing knowledge, are better than others. This thesis will explicitly report the decision-making processes involved in the theoretical, methodological, and methods approaches utilised. This will ensure criteria are provided “whereby knowledge claims can be objectively evaluated” ([188], p.350).

The social realist also uses the principle of ‘reliabilism’, to determine the validity of the underlying social and knowledge processes identified within the interview data [70]. Hruby [70] stated that the reliability of theories is determined by “the degree to which they allow us to make accurate predictions” about the social world in which we live (p.56). Theory development needs to ensure that the outcome is useful; it has a pragmatic value in health education teachers’ lives [70].

Qualitative research refers to the use of two or more research approaches as triangulation [189]. This study utilised theory and methodological tools from both social
realism and Bernstein’s theory. Each different theory or tool is “sensitive to different real-world nuances” ([189], p.248). This enabled greater depth and reliability in understanding the processes underlying health education teachers’ practices [187, 189, 190].

Social realism attempts to minimise the influence of the researcher’s subjectivity within research [54]. In the natural sciences this is achieved through the explicit reporting of research processes [54]. However, in qualitative research, the researcher does need to engage in the process of interpretation “which is the first small step of abstraction” (Grant and Cocks, 1989 as cited in [191], p.16). Archer’s [48] methodological approach outlines how human reflexive agency mediates all social practices. Therefore, in this study the researcher’s subjective position (researcher’s subjective position, refer to Chapter 2) has influenced the selection of theory and methodology, alongside the methods used. The researcher’s concern was to discover how teachers were implementing health education, as this has implications for young people’s learning. The researcher remained conscious of their ‘naïve outside perspective’ of school health education, and wanted to explore the different constraints and enablement’s that support health education teachers in providing effective health education.

Throughout this study, research processes were guided by an ethical stance and health education teachers’ wellbeing was considered. In support of an ethical approach, the University of Otago category B ethics approval (refer to Appendix C), and informed participation consent (refer to Appendix F) was obtained. The researcher also engaged in critical communicative reflexivity with colleagues at every stage of the research. This “critical subjectivity based in cooperative conversations” (Fay, 1996 as cited in [188], p.348), enabled the researcher to be aware of their subjective effect on the research, and enabled theories and interpretations to be collaboratively tested [188, 192]. The personnel involved in collaboration were Masters’ supervisors, a senior lecturer who also offered a Māori perspective, and Public Health senior lecturers.

5.4 Thematic Analysis

Thematic analysis according to Crowe [193] is an effective
strategy for organising and interpreting qualitative data to create a narrative understanding that brings together the commonalities and differences in participants’ descriptions of their subjective experiences. (p.617)

This research aligns with several authors’ views that thematic analysis is a “method in its own right” ([52], p.78) ([193, 194]). This enables it to be aligned “to a range of theoretical interpretations” ([193], p.622), such as the dual theoretical approach used in this research. According to Braun and Clarke [52] a good thematic analysis will make the theoretical position transparent, as this “guides what you can say about your data and informs how you theorise meaning” (p.85). Aguinaldo [195] argued that methodological tools should not be used due to their “theoretical or epistemological superiority, but by their capacity to achieve the goals” (p.782) of the study. Thematic analysis was used in this study to condense, analyse, and theorise teachers’ interview data [52, 53].

This study employed Braun and Clarke’s [52] widely referenced thematic analysis, six staged approach (see Figure 5.4.1). This approach is iterative in nature, constantly “moving back and forward between the entire data set, the coded extracts of data that you are analysing and the analysis of the data you are producing” (p.86).

<table>
<thead>
<tr>
<th>Phase</th>
<th>Description of the process</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Familiarizing yourself with your data:</td>
<td>Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.</td>
</tr>
<tr>
<td>2. Generating initial codes:</td>
<td>Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.</td>
</tr>
<tr>
<td>3. Searching for themes:</td>
<td>Collating code into potential themes, gathering all data relevant to each potential theme.</td>
</tr>
<tr>
<td>4. Reviewing themes:</td>
<td>Checking if the themes work in relation to the coded extracts (Level 1) and the entire data set (Level 2), generating a thematic ‘map’ of the analysis.</td>
</tr>
<tr>
<td>5. Defining and naming themes:</td>
<td>Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.</td>
</tr>
<tr>
<td>6. Producing the report:</td>
<td>The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.</td>
</tr>
</tbody>
</table>

Figure 5.4.1 Phases of thematic analysis, original Braun and Clarke [52], p.87.

Thematic analysis is concerned with locating themes within the data set, which “captures something important about the data in relation to the research question and represents some level of patterned response or meaning within the data set” ([52], p. 82). There is a lot of critique about how themes are determined. This research used Ryan and Bernard’s (2003, as cited in [196]) recognition technique of repetition. This is
based on the “premise that if a concept reoccurs throughout and/or across transcripts, it is likely a theme” ([196], p.66). As this research is exploring an under-researched area, the researcher wanted to provide a rich description of the entire data set, rather than an in-depth analysis of specific themes [52].

Debate exists as to the value of exploring literature prior to the coding process, as it may influence researchers’ interpretation of the data [52, 53, 81, 82]. Due to the researcher’s naïve positioning to health education, an initial deductive review of literature was completed. This sensitised the researcher to specific issues that could be explored during analysis [53, 80, 81, 189]. To ensure the thematic analysis remained true to teachers experiences inductive analysis was the main process used for exploring data. This enabled themes and findings to “emerge out of the data, through the analyst interactions with the data” [189], p.453). These themes and patterns were then deductively compared with literature and theory to “hypothesise about the relationships between concepts” ([189], p.454) [80, 81]. Analysis of themes moved beyond semantic description to begin theorising about the social, knowledge, and agential practices involved in health education [52]. Due to this, “the development of the themes themselves” involved “interpretive work” and the analysis “produced is not just description, but is already theorised” ([52], p.84).

In following Braun and Clarke’s thematic analysis approach, the following phases were completed.

Phase One: Familiarising yourself with the data

In this initial phase interviews were self-transcribed verbatim, which enabled the researcher to become immersed in the data. According to Lapadat and Lindsay (1999, as cited in [197]) “the act of transcription is interpretive in that it is the process of formulating and producing a meaning unique to the situation or utterance” (p.230). To ensure this act of interpretation “remained true to its original nature” ([52], p.88), the transcripts of the interviews were member checked. This ensured the information teachers wanted to articulate was retained [189].

The combined interview, in this study, was transcribed as one transcript. However, the transcript was analysed twice to enable each teacher’s experience to be analysed separately, while retaining the context of the combined interview. A reflective diary also
enabled key thoughts and decisions to be monitored throughout the entire research process.

**Phases Two and Three: Coding and searching for themes**

This study used a recursive process in generating initial codes and searching for themes, due to the five-month interview completion period [52]. The qualitative data programme Nvivo provided tools for data and coding management. Transcripts were openly-coded line by line for any potential themes. Codes are conceptual or descriptive labels that give meaning to the selected data [198]. A hierarchal categorical codebook was created after the first coding of all the transcripts (refer to Appendix G). Although inter-rater coding supports coding validity, some authors are sceptical of its value as “the reliability check does not establish that codes are objective and merely that two people can apply the same subjective perspective to the text” (Loffe and Yardley, 2004 as cited in [194], p.402). Inter-rater coding was not used in this study, however collegial critique occurred with the researcher’s supervisors during the construction of codes and the thematic framework (refer to Appendix G and H).

**Phase Four: Reviewing themes**

This phase included refining themes [52]. Patton [189] describes this process as convergence, or “figuring out what things fit together… by looking for reoccurring regularities in the data” (p.465). Themes were refined through a two-step iterative exploration of their homogeneity (consistency within themes) and heterogeneity (comprehension across the data set) [52], and thematic maps were used to show this process (refer to Appendix H).

At each stage of thematic analysis, new patterns were coded for within the data set and themes were discarded, collapsed, or new themes created [52, 189, 198]. This study chose to reflect themes that were present within the entire data set. Therefore “some depth and complexity is necessarily lost, but a rich overall description is maintained” ([52], p.83). The matrix query tool in Nvivo was utilised to refine the data boundaries around each theme. This explored the relations between each theme at the level of the code and data. Gale [198] states the matrix can “facilitate recognition of patterns in the data by drawing attention to contradictory data, deviant cases or empty cells” (p.5). The
matrix also explored the relations between themes and school and teacher attributes (refer to Appendix H and I).

**Phases Five and Six: Defining themes and producing a report**

In this phase, data within each theme was “organised into a coherent and internally consistent account, with accompanying narrative” ([52], p.92). Themes were refined so they closely reflected theoretical understandings, and data extracts that fitted the essence of the themes were interpreted through narrative. To support the validity of the final thematic map (see Figure 6.3.1), a larger sample of exemplifying quotes is located in the appendix (refer to Appendix J).

The report writing phase attempted to create a rationally judged “analytic narrative” through vivid examples that provided “sufficient evidence of the themes” ([52], p.93). The researcher engaged in interpretation by “attaching significance to what was found” and “making sense of the findings” ([189], p.480) through a dual theoretical lens and literature.

**5.5 Limitations**

The purposeful sampling method used in this study has several limitations. Senior University lecturers recruited health education teachers in this study. These lecturers often liaised with schools when preservice teachers were completing their learning placements. Health education teachers’ previous relationships with these lecturers may have influenced their motivation to take part in this study.

The final sample for this study was small due to time and resource constraints. Schools were positioned within a moderate to high decile rating due to the geographical region of this study. Decile is a socioeconomic indicator, with low numerical values indicating the low socioeconomic position of the school community [16]. Only one school offered the subject health education within the National Certificate of Educational Achievement (NCEA) framework, and this teacher’s perspective was limited to NCEA level three. Despite these sample limitations, there was variation in teacher and school characteristics.
To ensure that teachers’ experiences were accurately transcribed, five out of eight teachers completed member checks at the level of the transcript. Member reflections did not occur at the level of analysing and report writing. However, the researcher does intend to disseminate these findings back to health education teachers and is open to critique.

Although theoretical and methodological triangulation did occur in this study, restricting the study to one data collection method (e.g. interviews) limited the depth of analysis generated. Analysis therefore remained located to interview data and the themes generated. These themes cannot be generalised to all health education teachers’ experiences. However, by providing a rich description of teachers’ experiences these results can be transferred to the reader as they recognise “the research overlaps with their own situation and they intuitively transfer the research to their own action” ([199], p.845).
Chapter 6 Thematic Analysis Findings

6.1 Introduction

The following chapter will report the characteristics of the schools and health education teachers in this study, alongside the thematic framework generated. Each theme will be discussed by providing a rich narrative, and exemplifying quotes. Theory and literature informs the framing of these themes. Throughout the interviews in this study, health education teachers generally referred to the subject health education as Health. This terminology has been left in teachers quotes to reflect the true essence of their experience. Further quotes that substantiate each theme can be located in Appendix J.

6.2 School and Teacher Characteristics

Teachers in this study taught at secondary schools with varying characteristics (see Appendix I). All schools were located in urban areas and situated within Years 10–13 (2/8) or Years 7–13 (6/8). Schools were either co-educational (2/8), girls only (3/8) or boys ‘only (2/8). All schools that were state-integrated (4/8) also had a religious affiliation. The remaining four schools were state schools. School decile rankings ranged from five to ten. The ethnicity of students at all schools was predominantly European. The proportion of students who identified as either Māori, Pasifika or Asian each represented less than 10% of the school population.

All schools offered the subject health education in junior school; it was incorporated within the broader learning area of Health and Physical Education (HPE). Only four schools offered some form of senior health education. Some schools (3/4) offered senior health education sporadically throughout the year. One school offered health education as blocks of learning in Years 11 and 12 that classes rotated through each year. Only one school offered health education as a subject option in NCEA.

Health education teachers had variable characteristics. Five teachers identified as male and three as female. There was ethnic diversity amongst the sample, with teachers identifying as NZ European (6/8), NZ Māori (1/8), or NZ Tongan (1/8). Most teachers were aged over forty years (6/8), and two were aged in their thirties. These teachers had
been taking health education for varied lengths of time, with the range falling between three to eighteen years.

Health education teachers in this study completed either a University Physical Education Degree with a Graduate Diploma in Education (4/8) or a Bachelor of Education Degree (4/8). Most teachers taught both physical education and health education (7/8). One teacher taught health education as a subject option at NCEA level 3, alongside having a role in pastoral care. Some teachers were also the head teacher of the Health and Physical Education department (5/8).

**6.3 Themes Overview**

The thematic analysis generated seven main themes and fifteen subthemes (see Figure 6.3.1). These themes were located to three relational levels. ‘Wider School Community Relations’ explores the relations between the subject health education and the school environment, alongside health education teachers’ relationships with the wider school community. The level of ‘Teaching as Inquiry’ locates themes to teachers’ personal and professional learning, alongside how teachers are reflexively inquiring about school community perspectives to inform health education. The final level is ‘Classroom Delivery’. This level locates themes to the classroom content of health education, teaching practices and student assessment. The following sections discuss the themes and the associated subthemes located to each level of the thematic map.
Figure 6.3.1 Final thematic map showing three levels of relations, seven main themes (blue rectangles), and fifteen subthemes (coloured ovals).
6.4 Health Education in Schools

This theme reflects the social processes that marginalise the subject health education and how schools are integrating health education within the school environment. Two subthemes capture this as reported in Figure 6.4.1.

![Diagram of Health Education in Schools]

*Figure 6.4.1 Map of the theme ‘Health Education in Schools’ and related subthemes.*

6.4.1 Marginalising Health Education

Curriculum crowding is a common feature within the secondary school environment [99]. School subjects compete for time and resource allocation from the often-constrained school timetable and operational grant [99]. In this study, the subject health education generally had a low priority in secondary schools. Across schools, there was wide variability in the face-to-face time allocated to health education and this time was often limited compared with other school subjects. In junior school, health education was allocated anywhere between ten to forty hours within the school-wide curriculum each year. In senior school, health education received a “*spare slot, not even a slot, if there is one extra period a week then a class might rotate through that*” (T7). One school did not timetable health education into the school curriculum; instead in junior school “*we take kids out of core subjects to receive some Health every year*” (T5).

Only one school offered health education as a subject option in NCEA. This occurred through the historical process of one teacher transforming social education into health education during the national curriculum changes during the 1990s and early 2000s. This teacher reflected that many schools had dropped the subject health education during the transition of health education to an NCEA subject in 2002. The complex and theoretical nature of the content had made this subject inaccessible to both teachers and students.
With achievements standards coming in a lot of schools dropped Health; it was just put in the too hard basket. (T8)

It became a very rigorous quite academic subject at senior level, which is a shift that a lot of the old guard didn’t really agree with because it meant that it became less accessible to kids who would struggle academically. (T8)

Even if teachers were determined to establish health education as an NCEA subject, school management ultimately made this decision. School management decisions related to subject prioritisation, timetables, student numbers, and staffing ratios.

We didn’t have the numbers and the people that organise the timetable just wouldn’t let it happen because it would mean it would drop numbers from other courses. (T4)

I think if we were trying to introduce it now [Health at an NCEA level], you have got your staffing mixes and you’ve got your timetable; that is where most schools are hamstrung. (T8)

Teachers were also aware of the crowded curriculum, which is a result of the pressure placed on schools to offer a broad school curriculum without the time to manage this effectively [200]. They reflected that the “timetable is so, so pressured” (T6). Teachers who were the Head of the Health and Physical Education (HPE) department advocated for adequate resources from school management staff. This included time and financial and material resources.

My head of department is very passionate about Health, and he is very vocal and supportive. (T8)

I guess the leadership is pulled in so many different directions, so it is just about managing that and we will
always keep asking and pushing and nagging for more. I guess that is all we can do. (T3)

Some teachers reflected that resources were often inequitably shared amongst different subjects, across the wider school. One teacher stated the Head teacher of their HPE department “speaks very strongly to try and promote that equity across the subjects, because we are still working towards it” (T8). This inequity partly stems from the prioritisation of subjects, which are traditionally viewed as academic subjects, or subjects that are offered in NCEA.

We still have a very heavy traditional hierarchy based around science, maths, and English; they are still the status subjects. physical education and Health: we do feel like the poor cousins. (T8)

Schools are compared on NCEA, so as soon as that happens, we have got boys in this town that are compared on the percentages of the results. If we are not seen to be delivering you would lose numbers, which means jobs. You need to be seen to be offering academic subjects. (T2)

Subject inequity also occurred in some schools through the constant removal of students from health education classes so they could attend other activities. A few teachers also expressed concern that sometimes any teacher took health education to fill up the school timetable.

One of the frustrations that I have is if students are pulled out of classes for, maybe extra literacy or numeracy support or they choose to do speech or something like that, then that sometimes comes out of the Health classes. Probably as a school it’s not necessarily seen as an academic subject, so kids get pulled out. (T1)
Most health education teachers at high decile schools felt they were provided with enough resources by senior management to teach health education, given the constraints of the school budget and timetable.

*The amount of time we have got; it fits our programme. If we were to ask for more time, to do more Health, we would have to present a fairly strong argument as to why that would be needed as there are lots of subjects all vying for student time. It is a pretty good Health; sadly, there is stuff that I think could be extended a bit more.* (T7)

Most health education teachers who taught at mid decile schools reflected on their struggle to implement an effective programme for health education. They reported a lack of resourcing. This led to the use of outdated or free resources.

*I think all the videos need to be updated, and at a level that meets kid’s needs... There must have been lots of money around in the 90s to produce all this stuff because that is when most of them were made. But it is expensive purchasing things like that to... so we pretty much make do with what we have got.* (T4)

Despite the marginalised position of health education, teachers perceived school personnel did “*value the Health curriculum*” (T3), and were “*fully supportive*” (T3) of a subject that enabled students “*to be looking after themselves, and setting them up for being successful; not only in school, but outside of school*” (T2).

Health education teachers viewed the subject health education as “*an umbrella subject*” (T4), “*it’s one of the subjects I think permeates every other subject*” (T5), and is “underpinning everything that we do” (T4) in schools. The underlying values of health education “*transcend the classroom really, and are applicable to everyday life*” (T1) where students are “*looking at how they can be healthy throughout their lives; applying it now, but also as they move forward in various stages*” (T1).
Some teachers were passionate about making health education a separate subject, which was compulsory across every year level in secondary school.

I would really like it to be a separate subject, so we could do more, more Health, but I still like it being alongside PhysEd... But I do think there should be some compulsory stuff in there for seniors as well. (T4)

6.4.2 Integrating Health Education

The 2007 New Zealand Curriculum (NZC) [4] advocates for a “broad education that makes links within and across learning areas” (p. 9). Most health education teachers recognised the value of integrating aspects of health education into school-wide practices. This would work towards ensuring that students’ health education remained on everyone’s agenda.

Sometimes the school books say health promotion is just looked after in Health classes. Where, I think sometimes that needs to be a much wider aspect of what’s happening in the school, and bigger groups of students and staff need to be involved in that. (T1)

I think that’s why a lot of these initiatives are trying to be school wide through their regular classes, such as the mindfulness programme or these clubs, just so these underlying values are always present. (T3)

Integrating health education might also assist schools to challenge some of the dominant public pedagogy health messages such as ‘healthism’ that students’ assimilate outside school. Some teachers recognised their capacity to challenge these messages was limited by the time students spent in health education classes and the role the school took in promoting student health.

It is that message once a week, and I guess there is only so much you can do. It’s how they use skills, and whether they
hear the message from inside the school more than they hear those messages from outside school, which obviously, we can’t really manage. (T3)

At some schools, particularly girls only, a school-wide systems approach that supported student health was utilised. Aspects of health education were integrated into pastoral support systems, and used as a foundation for creating an inclusive school culture.

The environment, it is a culture that has been established, it is really supportive, it’s a really family oriented atmosphere, and most of the relationships are really good… So the staff are very engaged; it is an advantage of being a small school, I think. (T3)

Most health education teachers reported that schools integrated aspects of health education into a variety of school subjects, although, this occurred to varying extents.

Schools with a special character often integrated aspects of spirituality into religious education. One school with a special character also integrated several key areas of learning outlined by the NZC into religious education. These were sexuality education and grief, loss and dying. Health education teachers in these schools often viewed health education and religious education as two distinct, but supportive, subjects. Communication between teachers from these two subjects was minimal.

There is a real cross over in a school like School X, that is as special character school. We do R.E [Religious Education] courses right the way through, so there are components of the health curriculum within that as well. So all of the sexuality for example is done through R.E, and there is a lot of cross over that I would guess in other schools would be Health topics. (T1)

Other school subjects that integrated aspects of health education included computer science, science, and physical education. This integration generally occurred at the topic
level, such as a speech topic, rather than a deep immersion with health education content or teaching practices, such as taking health promotion action.

*Nutrition we cross over a bit with science classes. I know some of the Science classes will look at healthy eating, and I think the Year 7–8 also use it as a topic for a speech they give, so there is some support there.* (T7)

One state-integrated girls only school had established a school-wide mindfulness programme which was integrated into all school subjects. The counsellor supported teachers to integrate this into their classroom practices.

*The mindfulness programme, and that is one that we use in class, so they will go to maths and they may do some mindfulness.* (T3)

Some health education teachers reported that integration was challenging, due to a lack of collegial communication and non-health teachers’ lack of confidence with unfamiliar health education content and practices.

*We try and do inter-curriculum integrated approaches, but I don’t think we do it as well as we used to do it... I think kids tend to see the subjects as separate entities, and they always have crossovers, and I don’t think we always push that either, and that perhaps is something that we need to look at, and are looking at.* (T4)

All schools integrated aspects of health education into a variety of extra-curricular approaches. Some schools focused on ensuring canteens were providing nutritious food and some met the healthy heart award. One teacher was concerned that the health education department was not seen as the food police. Other approaches involved newsletters, investing in school values, religious services, and student led activities.
Schools can get a healthy heart award; you have to pass five out of eight criteria to get the health tick, but one of those five has to be something related to the canteen. (T5)

We didn’t want to be caught in the position of being the food police, the Health department. But we certainly brought to attention fundraising things around chocolate. (T6)

Most of my Health class are trained mediators, so we have a peer mediation group that we train every year. Most of the kids that applied have come through Health, because they see the benefits of supporting others. (T8)

All schools, except one, according to the Public Health South Health Promoting Schools (HPS) team (personal communication [201]), engaged at some level with a HPS settings approach. Only one health education teacher in this study mentioned they were directly involved, and only one other health education teacher expressed insight into how HPS operated in their school. These two teachers reflected that HPS involved groups of students implementing health initiatives at the school level. HPS teams had little involvement in influencing school policy or community relations. A principal teacher and the local district health board supported students to implement health initiatives, and build relationships with HPS teams from other schools.

They are kids, any kid who wants to come, can come to a health committee. We meet fortnightly and we discuss what we are going to next. One idea we had was a healthy cooking competition, and that will promote hopefully healthy eating and stuff. We’ve got a smoke free logo on our school newsletter. We want to do a weekly health quiz in our daily newsletter... They just have ideas and we try to pull off as many as we can. (T5)

Most health education teachers recognised the value of HPS. Workload issues prevented some health education teachers from engaging in the programme within their school.
In the last couple of years, we had some senior health people that did that (talking about HPS), and I think that is partially my fault, it is something I always try to do. I guess just with all my roles in the school, it is really hard to; it should be one of the things you make time for. (T3)

6.4.3 Summary

The subject health education is generally marginalised within the school environment, despite teachers perceiving that school personnel value this subject. Advocacy work by HPE departments ensures health education has enough resources, but this is often inequitable compared to other school subjects. Some schools are establishing the voice of health education outside the classroom. This occurs through integrating content and practices taught in health education into systems level approaches, other school subjects, student-led activities or HPS. Integration is often constrained by time, limited resources, or relations between subject teachers.

6.5 Wider School Community Relationships

School environments and students’ health are intricately linked to the communities of people who are located within the geographical boundary of the school. External agencies and families are involved in supporting students’ health, both within and outside the school environment. Health education teachers foster community relationships to interlink health education with the wider school community. The theme ‘Wider School Community Relationships’ outlines health education teachers’ relationships with ‘Parents and Caregivers’, and ‘External Agencies’ as shown in Figure 6.5.1.

6.5.1 Parents and Caregivers

Health education teachers foster relationships with parents and caregivers to support students’ health learning needs. The 2007 New Zealand Curriculum (NZC) and the Education Standards Act 2001 [25] outline the legal requirement for schools to consult with the community every two years about the delivery of health education, which includes health content and teaching practices.
All schools in this study engaged in the consultation process every two years and some schools specifically consulted on sexuality education every year. The consultation process occurred through two main strategies: community meetings and online or paper surveys.

Health education teachers reported that parents and caregivers generally did not attend consultation meetings. Those who did attend often had an agenda that focused on a particular family health priority. Most teachers reflected that the views expressed at these meetings did not generally represent the views of the wider school community.

We invite people into a parents’ night and they can talk with us any time. Realistically, we don’t get much of a response from parents, but I guess we go through the motions of doing that. (T4)

Often a lot of them would have some focus, especially in a special character school, there would be a focus around sexuality education. They would often be extreme one way or another. We changed it because we thought we were not getting a very representative group of parents. (T1)

Most teachers were using surveys to obtain a more representative perspective of parents’ and caregivers’ views about school health education. Surveys were used as a

Figure 6.5.1 Map of the theme ‘Wider School Community Relationships’ and related subthemes.
stand-alone form of consultation or in conjunction with meetings. Some teachers reflected that it was difficult to speak with parents about survey results, so meetings provided this opportunity.

*We do a health survey. We had 120 families respond, so we are getting a much wider representation of what the school community is and we are getting a lot more positive feedback and ideas about adding to the programme or taking things out. (T1)*

Some teachers reported that most parents were happy with school health education, as long as it was developmentally appropriate.

*I think a lot of parents come from where their own students are, which is fair enough. We will get parents responding from year seven; we don’t necessarily want our students learning about this or that, because it is not age appropriate. Whereas later on down the track perhaps it is more important. (T1)*

Most concerns from parents and caregivers were related to sexuality education, such as puberty or sexual relationships. Legislation supports parents’ rights to exclude students from this form of tuition [25]. Some teachers also chose to inform parents or caregivers about sexuality education through newsletters. Student inclusion consent was often obtained even though it is not a legal requirement.

*I guess our default is that students opt into Health. We don’t necessarily give them the option to pull out, except in the sexuality programme. There is a letter that goes home saying that this is going to be happening in the class, these are the things that are being talked about. Students can opt out of it, but it doesn’t happen very often. There is the occasional parent that sort of said, we want to cover that at home. But*
the school’s positions is, here is what we are doing, it is
giving you an opportunity to talk about it at home. (T1)

Some schools ran parent or caregiver seminars and interviews, particularly girls only schools and schools with a special character, to provide an opportunity for teachers to discuss students’ learning priorities with parents and caregivers.

We try and encourage the kids to go home and talk to their parents. We try and open up avenues of communication, and when we have parents’ interviews we always warn parents about what we are going to be talking about, this is what is coming up, and we always send a letter home telling them what we are doing in each unit. (T4)

6.5.2 External Agencies

The term ‘external agencies’ refers to the private and public agencies that are involved in producing and marketing educational literature and programmes, that can be utilised in schools [155, 156]. This theme emerged through health education teachers’ reflection on the various relationships they have with health and educational agencies such as Police Educators, Rape Crisis, Family Planning, Accident Compensation Corporation, and Attitude. These agencies generally provided health related programmes that focused on sexuality, relationships, and cyber safety. Some agencies also provided professional development which some teachers had attended.

A few teachers felt that they were often inundated with numerous agencies wanting to provide programmes in the school. One teacher reflected there were now a lot of programmes that focused on the health priorities of minority groups, such as queer students.

One thing, a lot of health seems to be driven by minorities...the whole rainbow youth gender led GLBT stuff. (T5)
Most teachers used external agency programmes to support health education, and not as a substitute.

Generally, it is best if the teacher, the Health or class teacher, is delivering these kinds of messages. I know that there are schools who invite people in, and they are it, that’s the extent of their health education. It’s just not effective. (T8)

I do think it is good for the girls to meet and hear other people talking about their experiences, and what their agencies offer and that sort of thing, but it doesn’t substitute for knowing your kids and doing your own programme. (T4)

However, one male teacher who taught at a boys only school was open about using external agencies for sexuality education. This teacher did not feel confident in teaching about this topic.

We have an outside provider Agency A, which covers the, I suppose, sexuality education, which has now gone in a new direction where they are more looking at, I suppose with technology once again, they are looking at being appropriate with girls and so forth. We have an outside provider that does that… so it is very much driven by the agencies. I just don’t feel comfortable taking part in sexuality based stuff with the boys. (T2)

External agency programmes were used more in senior school health education. They offered one off programmes that could fit around the school timetable.

And Year 11, we follow the same modular system, and we get a lot of expert speakers in. (T3)

R: So senior Health is very much the external agencies.
T4: At this point yep, which is a bit of a shame. (T4)
Most health education teachers expressed concern that external agencies did not always provide appropriate health messages to students and often lacked pedagogical expertise. This contributed to most Health and Physical Education (HPE) departments reflectively determining which external agency programmes were allowed to be presented within the school.

*The problem with Agency B is that they come from a little bit of a Christian bias. I have to be very careful. We are a secular school. The messages they do deliver have to be consistent with our health education messages.* (T8)

*There are some that come into the school and not saying they are not effective, but I don’t want to seem arrogant here, but sometimes they are not educators, they are experts in their field, but their ability to communicate to students can often hinder the message that needs to be given.* (T3)

Some teachers spoke with external agencies about what should be included in their programmes. Agencies seemed amenable to adjusting their programmes to fit with teachers’ expectations.

*Tomorrow we have Agency C coming in... And I have talked to them about what we want to do with cyber safety, and the best way to present and supply that, and generally they are pretty open to that, which is good.* (T7)

External agencies sometimes provided free programmes to schools whereas others came at a financial cost. Two teachers from mid decile schools reported engaging mainly with external agency programmes that provided free or marginal cost programmes.

*Agency D has offered to come in and do 5 hours for free, for all our classes over two years, and I hope by the third year I will be able to do it, which from my perspective would be great. It gives a professional who is really up to date, but*
what values are they bringing that perhaps don’t match with mine is an issue, but because it is free it is a big, big carrot.

(T5)

6.5.3 Summary

Health education teachers generally reported parents’ and caregivers’ lack of engagement in health education consultation meetings. Surveys tended to provide a more representative view of parents’ and caregivers’ wish for a developmentally appropriate programme, particularly for sexuality education. Girls only schools offered more opportunity to have face-to-face communication with parents and caregivers, and tended to communicate broader student health priorities. Teachers generally selected external agency programmes that were pedagogically appropriate and supported school health messages. Most teachers reflected that external agency programmes should supplement, not substitute, school health education. However, timetable restrictions in senior school meant external agencies often delivered one off programmes. This ensured students were receiving at least some health messages.

6.6 Becoming a Teacher of Health Education

This theme arose from teachers’ inquiry into how their professional experiences influenced their pathway into becoming a health education teacher. These understandings are captured in three subthemes, which are reported in Figure 6.6.1.

Figure 6.6.1 Map of the theme ‘Becoming a Teacher of Health Education’ and related subthemes.
6.6.1 Reflexive Inquiry

The 2007 NZC is explicit that health education teachers should engage with the teaching as inquiry cycle [4]. This is a reflexive cycle that supports teachers to make links between their teaching practices and students’ learning experiences (refer to Chapter 4.5.2). Part of this reflexive inquiry involves thinking about the purpose of health education. All teachers in this study were individually reflexive about the purpose of health education. Teachers reflected heath education improved students’ health and learning outcomes.

*Just trying to prepare them and give them skills, to actually at the end of the day, in a relationship, in a social situation, they are aware of what they want and they can be stubborn and actually say no, no I am not going to settle for less. I guess that is the ultimate goal. (T3)*

*For students to live a good life, to understand how crucial it is that all areas of their lives are looked after and catered for. Just to make good decisions; that is the crucial thing. (T2)*

Teachers’ subjective concerns about their personal capacity as a health education teacher, generally led them to be reflexive on both the strengths and weaknesses of their practice.

*I think I have my strengths and I guess it is what your focus is on. Through PE you kind of learn about the breadth of things, but then I went into sociology. I am comfortable in challenging media and exposing that side of things, but if I had done a degree in psychology, maybe in other areas, I would be better at this sort of stuff, making that next step. Yes, so I guess that it is just what that element within your degree was, or in your qualification was, that’s led you to this stage. (T3)*
Most teachers were adapting or sustaining their teaching practices based on their reflexive inquiry about how classroom activities were meeting the needs of their students.

A real strength is working in small groups in class, it is important. I think to, letting students work with who they want to work with. Probably one of the things that I was guilty of a lot when I first started was engineering the groups and mixing people up a lot, but I found that the information wasn’t as good. Some students were a bit guarded if they were talking with someone they didn’t feel comfortable with. It is understandable, it makes sense. (T1)

Collegial inquiry enables a deeper exploration of teaching experiences, through sharing different understandings. Health education teachers at most schools spoke of belonging to the HPE department where they were reflexive about their teaching practices. All teachers to some extent, but particularly the HODs, were engaging in collegial inquiry with wider school personnel. This included pastoral care staff, counsellors, a public health nurse, and HPE departments from other schools.

The PhysEd teachers who we have got here are engaged in our health program as well, and I know that at some schools that it is not necessarily the case. Where Health is almost an add on that people have to do. Whereas we have had some really good teachers. In terms of the group of us here, we have been here for a while, we have developed the programmes that we are working through. I think it is pretty strong. (T1)

6.6.2 Falling into Health Education

To become a health education teacher in NZ schools, it is generally expected that teachers have completed a professional teaching qualification. The professional backgrounds of teachers in this study consisted of either a Physical Education Degree with a Graduate Diploma in Teaching or a general Bachelor of Education Degree.
Health education teachers in this study generally fell into teaching the subject health education by default. As both health education and physical education come under the learning area of HPE, there was generally an expectation from school management that teachers taught both subjects.

*I think I fell into it more than anything. I was teaching PhysEd and often they go hand in hand, or you get tagged in. Then I took up a new position and that was where the gap was in Health, so sort of by default really. (T6)*

*And then the school here, the PhysEd teachers they take Health, so there are no separate Health teachers. (T1)*

In NZ, teachers with a Bachelor of Education generally begin their careers in primary or intermediate schools, and have general skills in all subject areas. Health education teachers who had a Bachelor of Education in this study had generally taught students at Year 7 and 8, and had moved into the secondary school setting as a professional advancement opportunity arose.

*I am primary trained, so I guess there are elements of Health that I was doing when I began teaching in Form One and Two classes, or Years 7–8 now. I fell into Health. The lady left who was the head of Health and someone suggested that I should put my name up for it. Because, I guess there was an opportunity, and I’d been teaching for a long time without having achieved anything beyond an experienced classroom teacher status. And it ties into PhysEd, but more good luck than good management, I think. (T5)*

### 6.6.3 Professional Development

Maintaining teacher competence is a continuing process of engaging in reflexive practice and professional development. This is valuable in extending teachers’ pedagogical and health knowledge. In this study, health education teachers engaged in various forms of professional development opportunities. These opportunities included
pre-packaged professional development programmes offered by external agencies, conferences, cluster schools, online educational resources, collegial reflective practice, and collegial observation.

Next year we are bringing in Year 7–8 cyber safety with Agency G based on keeping yourself safe. I haven’t had a close look at it yet, but the plan is to do that, because it is a well resourced packaged unit that you can give to teachers, I guess they can get stuck into. (T7)

A lot of my professional development now comes from talking to the guidance counsellor, talking to the people who are the expert groups that come in, and watching what they are trying to deliver, and I can see, I can take this and reinforce this and revisit that. (T3)

All teachers in this study had engaged in some form of professional development over their careers. Some teachers acknowledged the support it offered in the early stages of their professional journey.

Going to professional development opportunities was great, because that was where I got a lot more of an insight into Health, because I had not majored in Health during my undergrad degree. (T8)

Most teachers reflected that professional development programmes were not always supportive of school health education messages. They also focused on classroom content, rather than strategies to develop students’ skills.

Yeah the professional development thing is a tricky one, sometimes it is just not what you want really, or it is kind of on that minor level, and let’s look at facts and figures and nutrition, which is good but you can get it anywhere. It is about the values-based professional development, but it is
probably not as prevalent as the content-based professional development. (T3)

Some teachers reported there had been a decline in face-to-face professional development opportunities, alongside an overabundance of easily accessible online resources.

I did a lot of professional development throughout the years... There isn’t much Health professional development at the moment at all, but in the 90s and probably 2000s there was a lot of professional development, so I have done lots and lots of courses... There were lots of videos and resources that were produced as well, as well as in-service courses, whereas now, well I think there is very little. (T4)

There is quite a lot of finding resources online. One of the good things about Health, it is quite heavily resourced. If anything, it’s almost a challenge to work out what to put in and what to leave out. (T1)

Teachers generally reported they do not access professional development as much as they should despite their awareness of the supportive role it plays. Some teachers reported that time and financial constraints acted as barriers. Some HPE departments also prioritised physical education professional development over health education professional development.

There are still resources out there and a bit of professional development, and we probably don’t access it as well as we should perhaps. (T1)

I think to be able to provide some more training to Health teachers, and a lot of that is time. To be able to have teachers out of their classes, to learn some of the things that they need to be knowing, to be able to deliver our Health programme.
But there is a cost factor with that, which often schools don’t have the access to that, to be able to take 4–5 teachers out for a day and be able to work through developing a programme.

(T1)

6.6.4 Summary

Teachers’ professional pathways are variable, and there is often limited opportunity to engage in professional development. Most teachers are engaging in individual and collaborative reflexive inquiry. This enables them to improve their teaching practices, which supports students’ positive health education learning outcomes.

6.7 Student-Centred Health Education

The theme ‘Student-Centred Health Education’ embodies the approach health education teachers in this study are employing to deliver health education. Teachers also reflexively draw from school community perspectives to inform this health education approach.

![Figure 6.7.1: Map of the theme ‘Student-Centred Health Education’ and related subthemes.](image)

6.7.1 Student Health Priorities

In this study, all health education teachers were prioritising health issues relevant to students. Teachers reported several important student health priorities, which informed the direction of their health education programmes. Students’ health priorities varied according to the particular context of the wider school community. Most teachers
reported nutrition, exercise, social media use, sexuality and relationships, mental health, and substance misuse were student health priorities in their school.

Students’ use of social media was a perceived health priority for most of the teachers, particularly in relation to sexual relationships.

*We have got some really poor statistics in terms of our sexual health, and we are just doing positive sexuality with our level 1 students... But it’s about raising the profile that, yes STIs [sexually transmitted infections] are out there, and so making it relevant to our local kids. (T8)*

All teachers’ perceived that students’ mental health and the anxiety generated around exam performance were health priorities.

*We see mental health, a lot of anxiety, huge anxiety, depression, self-harm, that happens here; probably not as obvious as other places, but it does happen. (T3)*

Teachers at state boys only and state-integrated girls only schools were concerned about nutrition and exercise. These issues related to girls being undernourished and boys being sedentary.

*So that is probably not your traditional message, our message that we try to deliver to kids, because to be fair they don’t eat enough, probably the students at this school are an inaccurate cross section of society, you probably label, you could probably count the number of students who would fall into the overweight categories on one hand. I guess eating issues and nutrition is a big factor here. (T3)*

Teachers at state-integrated boys only and state girls only schools were concerned about peer pressure and bullying.
I think the cyber safety is huge, and there is a lot of bullying and information that is out there for kids to access easily. Gossip is terrible; I think that is one of the worst things for girls, they are really bad at spreading silly rumours about people. (T4)

All teachers provided space for students to share their health concerns and what they felt were important health priorities to consider in health education. Strategies such as classroom discussions, question box, or student surveys were employed to gain students’ perspectives.

I always ask them [students] what they want to know, what they want to find out, what are their questions, what they have done before, or what they would like to pick up on at the start; so the units, I gear it towards their needs. (T4)

The teacher who taught health education as a subject option at Level 3 of the National Certificate of Educational Achievement (NCEA) reported a focus on student health priorities was tempered by NCEA requirements. Learning about health focused on both international and national health priorities. The teacher tended to be more directive about the health priorities that were explored and these were not always directly relevant to the students’ health needs.

For my level 3 they have just studied a mental health condition... and they had to research a western science treatment option, a complimentary alternative medicine, or a traditional medicine, and compare the three through research, through valid research, and look at that and make a conclusion about which one they would recommend the most. (T8)

6.7.2 School Community Perspectives

Health education teachers in this study were aware of the various school community perspectives that related to the teaching of health education in schools. Teachers were
reflecting on these different perspectives and this informed the health education approach embraced by schools.

The teaching and learning perspectives outlined in the NZC [4] have a strong influence over school health education. Some teachers saw working with the national curriculum as an accountability expectation, which just needed to be managed. This perspective was apparent in the interviews through teachers’ lack of conversation when asked about the influence of national curriculum directives on their teaching practice.

*The new NZC… I think it is great, it allows flexibility and it allows you to do what you believe is fundamental for the students in your specific school, but you just have to justify it. There is a little bit more of a paper trail, this is how I will do things, just for that accountability, and they can see the process that you have done rather than just you do this because this is easy, or something like that.*  

(T2)

Within the 2007 NZC [4] various instructional perspectives are blended, such as constructivism and instrumentalism (refer to Chapter 4.4.1). These perspectives influenced how teachers planned health education.

All teachers within this study prioritised a constructivist approach focusing on students’ health and learning needs through “*putting that student at the centre*” (T3) and focusing on the context of students’ lives.

*But it’s just a matter of trying to do a lot of student centred learning activities, where I guess where the contexts they choose or discuss or they inquire about, are relevant to them.*  

(T3)

Health education also focused on students’ development of competencies. The NZC [4] outlines student competencies as ‘contributing and participating, managing self, thinking, and relating to others’ (p.12). These competencies are generic in nature, and oriented towards managing a variety of health and workplace contexts, which is a
feature of instrumentalism [58]. Mid-decile schools also tended to place a heavier emphasis on the competency “Using language, symbols, and texts” (p.12).

The content really is changing. I think a lot of health programmes formally were quite deficit model programmes… There is a big change, and it is a skills-based programme, and that is how it should be. It can be a lot more difficult to teach because it’s about discussions and reflection and challenging and expressing ideas and understanding different perspectives, rather than just let’s do some reading, writing, which is a really traditional style of lessons. (T3)

All health education teachers were drawing on the instructional perspective of traditionalism. Teachers were acting as an expert by providing some health information to students. This supported students’ application of generic competencies and skills in a given context.

And again we always give a little bit of information, because making informed decision is an important part of decision making, so we outline information, statistics, we bring in people to give information with them as well. (T3)

Schools that are founded upon a religious ideology often have a special character, which teachers are required to implement, alongside the NZC. One teacher expressed strong views about the relevance of the special character to health education.

We have a special character committee… so we have to deliver what the NZC states, but we also have to meet requirements for our special character committee and uphold the X faith within our school, so that is the tricky thing. I guess that is where I need to justify… I am not saying this is right, I am saying this is what the X special character would perceive as a sexual relationship and this is how, you know, someone at the other end of the spectrum would. We are
doing them an injustice by only covering the X faith, and that is how I see it. We are not saying you can’t believe that, but I am saying that not everyone in this classroom is going to listen if I only preach that sort of stuff, or only cover that area, I need to cover everything because that is who I am talking to. (T3)

All health education teachers, particularly Heads of Departments, communicated with other schools, parents, and wider school health personnel. This enabled them to obtain different perspectives about the contexts of students’ lives and their health needs. All teachers collaborated with school counsellors and parents or caregivers.

We work a lot with the counsellor at school... I think that the counsellor has got a good gauge of what is happening in the school, in terms of some of the issues the students are having, and even a wider perspective of what is happening in the community. They can liaise a lot with each other. (T1)

Planning health education was a collaborative and reflexive process. Health education teachers within the HPE department worked together, drawing on the different school community perspectives. Teachers generally remained in control of planning health education, prioritising students’ health education learning needs. Most health education teachers attempted to be responsive to students’ health and learning priorities.

We have to consult every two years with the community, as to what we are doing in regards to that whole programme. While we are picking it based on the needs of our students and what we are hearing from the counsellor, there is also input from the parents and wider community as well. (T1)

I think we are hopefully responsive rather than reactive. We don’t jump at something and it suddenly becomes an issue. It’s something that is discussed and we mould our programme around what is needed. (T1)
6.7.3 Summary

Health education teachers generally supported a responsive approach to health education. Health Education was student-centred; focusing on student health priorities, competency development and the contexts of students’ lives. Teachers drew on the national curriculum and wider school community health perspectives to inform health education. Providing space for students’ voices generally enabled first-hand knowledge of what students wanted to learn.

6.8 Teaching Practices

This theme reflects the teaching practices used within the health education classroom. Three subthemes, as shown in Figure 6.8.1, craft a deeper analysis of how teachers are sequencing and pacing classroom learning to meet the learning needs of diverse students.

![Map of the theme ‘Teaching Practices’ and related subthemes.](image)

6.8.1 Modular Health Education

Most schools in this study were using a modular approach to junior and senior health education. Learning was located to a particular health topic, for a set period of term time or throughout the year.

We only have health to Year 10. So we have a three segment module in Year 9, which is over one term, then a two segment module for Year 10 in one term. (T2)
A modular approach was generally utilised to fit health education within the school timetable.

We have tried different formulas to do this, such as a day of PhysEd and two days of Health. We found it doesn’t really work very well for continuity, so we tend to teach in blocks. It is not so good for PhysEd because they are not being active all the time, and not so good for Health either, but we have found that this is the way that works best for us, if we had four periods we would probably do it differently. (T4)

All schools, except one, had a designated health education classroom. When there was not a designated classroom, the health education teacher reported students struggled to identify the teacher or curriculum content. Students often located school subjects to a physical classroom space.

When I first taught it was like well what are you doing teaching Health you’re a PhysEd teacher... they think T5 is a PhysEd teacher, because whenever they see me it is in the gym. Whereas, if there is a Health room that every kid knew when they walked in they knew they were doing Health... Well it would be nice to have a health room. (T5)

All of the teachers recognised, and some felt frustrated by, the fact that the modular structure of health education created discontinuity in students’ engagement with health knowledge. This was amplified when students missed classes.

It (Health) only being once a week it can sometimes be quite challenging especially if you miss a class, because it’s like remember two weeks ago when we did this. If you miss one or two classes you find yourselves having to squeeze stuff in, getting students engagement back again can be quite challenging. (T1)
Across different year levels, some teachers revisited content that had been taught in previous years. The flexibility of the sequence of the achievement objectives outlined in the NZC [4] supported this, as students do not have to meet all of the objectives in any one year. This meant student were provided with the opportunity to consolidate knowledge.

*So that is why we keep scaffolding and coming back to things, so we pick up on what they did in intermediate and do that in Year 9, then pick up on that in Year 10, and try and touch base with as many seniors as we can, at Years 11,12,13.* (T4)

In NCEA, subject content is located to achievement standards at one of three levels [10]. Achievement standards are units of work that student receive credits for when completed, but completion does not have to occur in a specific sequential order [10]. At the school that offered health education as an NCEA subject, it was not a prerequisite to complete health education at NCEA level 1 or 2, prior to taking health education at NCEA level 3.

*At this school, students are given an adequate preparation to move into level one NCEA. Having said that, I have got kids that are doing level 3, that have not done level one or two, but they had sufficient grounding at junior level to be okay, to pick up these concepts and then to get their heads around them. Our junior programme is okay.* (T8)

NCEA achievement standards can be offered as single units of work, rather than being offered as a full subject. Some schools had attempted to offer a single NCEA achievement standard in health education at junior or senior school. These teachers reported that content was often narrowed to meet the achievement standard requirements rather than the needs of the students. Subsequently they no longer offered these achievement standards.

*What we did do for a while, we have stopped doing it this year... we had an achievement standard 1.5 around the*
sexuality unit, so we did that at Year 10, but we found we were teaching to the assessment task and we really liked the unit that we had... and the content we tended to be working towards the assessment, rather than towards the needs of the kids, so we decided to cut that out. (T4)

6.8.2 Collaborative Learning

Student learning is facilitated through teachers’ understandings of the unique characteristics of each student, and the relationship dynamics within the class. One teacher reported that “the way it is delivered is probably more essential in Health, instead of what is delivered” (T3). This was an understanding of all the teachers interviewed.

All health education teachers believed that building relationships with students facilitated students’ engagement in classroom activities.

If the teacher in front of the class knows the class best, they can adjust programmes or ask different questions to different groups to try and get the best out of them. (T1)

So the whole relational aspect is all part of delivering Health, you can’t do it without being and getting alongside those kids individually. (T8)

Most teachers felt that students needed to take an active role in classroom activities. Learning was more than about acquiring knowledge; it was about applying that knowledge as well. This knowledge was often applied to factitious health scenarios that were relevant to the context of students’ lives.

An ideal Health class is one where the students are engaging in and driving a lot of the stuff, because I think that to give lots of knowledge is good, but to have them apply it and think about and maybe analyse it or critique it is more valuable to
them. (T1)

So a typical Health lesson would be information giving, then discussion around it, tends to be a lot of scenarios, working through different ideas and ways to apply whatever it is that they are learning about. (T1)

Most schools in this study had a collaborative health education library from which teachers drew resources to facilitate classroom activities. Some schools had also developed a student health education book. All of the teachers identified that classroom teaching was not prescriptive; they adjusted resources and activities to meet the needs of the students in the classroom.

We’ve got a booklet that we have made up ourselves that is taking bits and pieces from various resources that we use. And it’s sort of like a live document, we take stuff out of it, we put things into it. Based on what’s been working well, and as part of our department cycle meeting we talk about the things that are going well in class and not so well. Things change. (T1)

We have got units that are written that you can pick up and use and teach it however you like yourselves, it is not here is your prescribed unit, teach it on this day and in this order, it is just there as a beginning. (T4)

Collaborative group work was the dominant strategy used by all the teachers in this study.

A real strength is working in small groups in class, it is important, and I think to letting students working with who they want to work with. (T1)

The teacher, who taught health education as an NCEA subject, took a more directive and expert approach to organising classroom activities and discussions. This ensured
that students had learnt enough knowledge and skills to complete NCEA achievement standards in health education.

I am sitting there and I am reading about the ethics principles and the normative approaches... and my voice is droning on and on and on and the students looked bored... you know it's not an ideal way of teaching... so today we looked at examples to make sense of those totally irrelevant words on a page. (T8)

Some teachers drew on the expertise of other health professionals to support the facilitation of classroom learning. Most teachers used the guidance counsellor to facilitate some classroom lessons.

We actually have a school counsellor and she does an introduction to a topic with Year 9. (T7)

6.8.3 Inclusive Learning

Students come from diverse backgrounds and have diverse learning needs. All health education teachers recognised this, and utilised strategies to ensure health education was inclusive of all students learning needs.

Scaffolding was the dominant strategy used to ensure learning was inclusive of diverse students’ needs. Classroom activities were arranged so there were various levels of learning challenge. Scaffolding took place both within the activities, but also through teachers working one on one with students to support their individual needs.

A number of boys who have are on the dyslexic continuum in particular, so some classes have 3–4 boys that fit into that camp, so therefore it is finding something for the whole class, while they are just as included and learn just as much rather than having a story to read through and answer questions about it, that is not going to be good for them, so looking at discussion or scenarios, scenarios work really well, but once
again it has to be the right scenario, you put them in groups,
and you have one person who is the recorder, and one person
feeds back, that stuff can be engaged, and some really good
discussion comes from that, and the last period, end of the
day.  (T7)

The teacher who taught health education in NCEA level 3 also scaffolded learning
activities to meet the needs of both academic students and those that had not done health
education at NCEA level 1 or 2. This teacher reduced the number of achievement
standards offered to enable more time to cover the learning requirements in-depth, and
to make learning fun.

I make sure for those students [who missed level 1/2] that it is
scaffolded as well, so that I don’t assume that they have had
that learning at level one and two. I mean it may not be as
thorough, but it is adequate.  (T8)

I think that we have got to be looking at what the assessment
requires, so that we are teaching effectively enough for the
kids to be able to be successful, right. The problem with that
is that it “sucks all the fun out” of teaching. That’s one of the
reasons why I made the decision to go from 24 to 19 credits.
Because we’ve got time, we now have time to go over wider
issues around that topic and inject some fun into it.  (T8)

At some schools, students were streamed into health education classes according to their
learning competence. One teacher reported that students who needed more learning
support flourished when explicit and clear guidelines were provided.

Clear guidelines are pretty important... We have streaming
here at Year 10 level. The top stream class are fantastic to
work with in the health setting and a higher order of
learning... whereas we look at other classes that are either
lower down or middle stream. Unless you have got set
guidelines and expected outcomes and how that is going to be delivered then boys can get distracted pretty easily so I think that the boundaries have got to be set, but then also I think the discussion's important, it is good for the boys to have that freedom to open up and discuss some of those topics. (T7)

Most teachers were attuned to students’ developmental diversity. Tension was sometimes experienced when teachers had to balance the knowledge and learning needs of individuals against the needs of the whole class. Most teachers were particularly aware of this issue when covering the learning area of sexuality education.

In all honesty, even within a class, there is a big difference between the majority of some students. I think of my Year 10 class, there are a couple of boys who are emotionally very, very young... we have had somebody from Agency G come in and talk about relationships, consent and those sort of things. And for these two boys in particular it is so far from their realm of understanding that you know potentially there is not even any point in them being in the classes, and it makes them quite uncomfortable. But for a lot of the others kids in the class, it is something that is really relevant, and I think that becomes a challenge. (T1)

Students with physical disabilities raised unique challenges to inclusive learning. One teacher reflected that you had to think creatively. The learning support offered to these students, such as teacher aides, also influenced how students were included within the classroom. One teacher reported teacher aide support was minimal.

We had a kid in a wheelchair ten years ago... We tried to incorporate him in PhysEd and we were doing hurdling at the time. How do you do hurdling with a kid in a wheelchair? So we didn’t incorporate that necessarily. However, we would play island tag, he would be in his wheelchair, and he would
be king of his island... So where possible he would join in.  
Think creatively.  (T5)

There is a teacher aide and stuff... It is hard to get. You have twenty-six hours and they might only attract ten hours of funding, and you have got them for twenty-six hours... You have to split and spread it out, English, maths, science.  (T5)

Most teachers reflected that the diverse sex characteristics of students influenced how they facilitated activities. Some teachers perceived there was a sex difference in how students engaged in health education classes. They perceived females were more likely to engage in learning than males.

I have taught at co-ed schools, and female students are, you know, they are quite happy in that environment, and it can be a little more board based in how you teach it.  (T7)

It’s quite feminised [Health at NCEA level 3] which isn’t a bad thing. We do have a mix, but for example in my level 3 Health class I have got 25 students and one male... So we have the kids that are drawn to Health. They are the slightly academic girls, that aren’t really interested in PhysEd.  
[laughter]. Because originally the option was PhysEd or Health or a combination of both. So the ones that take Health, purely, are those that are not really interested in doing PhysEd, if they think it [PhysEd]is a very physical subject.  (T8)

This perceived sex bias influenced how some teachers facilitated their classroom activities. At one co-educational school, female and male students were separated into different classes for some of the health education topics.

What I have tried the last two years. The guidance counsellor is very health focused and so we would always try and
arrange at least two of the five hours with her, so we can split the guys and girls. The boys tended to dominate the class sessions. If she was available for at least a couple of those five hours. The girls then got more out of that, than if they were with the boys. And she has worked in whole the variety of health areas, and so I think the girls really appreciated that too. (T5)

Two teachers who taught at boys only schools reported that they used particular strategies when teaching boys.

One teacher reported collaborative group work did not work well at the end of the day.

One thing would be when the lesson is at the end of the day, the last period or second last period, my experience is group work doesn’t really work as effectively then. (T7)

The other teacher reported boys worked best if the group work occurred in a competitive learning environment.

They like to be doing things, to see it in a competitive environment, so if there is a task, maybe there is a reward for the group that finishes first, I think their competitive edge is important, they like to be compared and be seen to be better. (T2)

6.8.4 Summary

Schools generally took a modular approach to health education, where learning was located either to a health topic or to achievement standards. Most teachers placed an emphasis on building relationships with students, which facilitated group work. Health education teachers were generally responsive to the diverse characteristics and learning needs of students, scaffolding classroom activities to support different learning needs. The teacher teaching at NCEA level 3 balanced the expert transmission of content with the facilitation of students’ active learning.
6.9 Health Education Content

This theme outlines the ‘Health Education Topics’, ‘Models of Health’ and ‘Inclusive Content’ taught in the health education classroom, as shown in Figure 6.9.1.

![Figure 6.9.1 Map of the theme 'Health Education Content' and related subthemes.](image)

6.9.1 Health Education Topics

The classroom content covered in health education was generally located to a particular health education topic, such as sexuality. These topics were generally identified through teachers’ inquiry about students’ health and learning priorities.

The health topics covered varied across schools and at each Year level. The most common topics were mental health, alcohol and other drugs, interpersonal relationships, personal safety, body care, cyber safety, nutrition, and sexuality.

All schools covered sexuality, drugs and alcohol, and cyber safety. Most schools took a ‘healthy choices’ approach.

*Year 9 will do peer pressure, bullying, focus more on cyber bullying, cyber safety, sexuality is the main topic we focus on, nutrition is another one, um those are the main ones, Year 10: we follow sexuality programme, sort of pushes on from the Year 9 level, looking at healthy choices, contraception is involved in that as well, and it’s a main focus for that programme, nutrition is involved.* (T7)
Interpersonal relationships were included in girls only schools and state-integrated schools, which had boarding hostels connected to them. This topic was often covered in the first few health education classes to establish a supportive classroom culture.

In an interpersonal sense, the relationships, the dynamics between them and the new students, whether they are living at the boarding hostel, how they relate to the different teaching styles they will be exposed to, we look at relationships in various forms, and that is skills like negotiating, decision-making, communication that is going to help them build relationships and maintain them. (T3)

Cyber safety tended to be a major focus at all schools. Content focused on using technology safely, and managing its intrusiveness into students’ lives.

With the advent of so much technology in the boys’ lives... they get lost in a cyber being of who they are and the real one is a bit different; we look at a lot of that. It is easy to be a keyboard warrior who can put out comments and things and hurt people through being behind a screen, that is probably the biggest thing I have noticed, we just try and empower them to make sure they are not a slave to the technology that they have, whether it is Facebook or their phones. (T2)

Sexuality education was a major focus at all schools. It was taught within health education, except at one school where it was included in religious education. The topics that were often covered related to sexual relationships, contraception, and physiological aspects. External agencies generally played a large role in providing sexuality education in schools.

Then we progress into sex and sexuality, and that is a broad topic, and that may be more of a content driven one as well, but still a lot of discussion about the choices that people make, looking at self-esteem, pressures that exist, messages
they get from society and learning to interpret those, and make decision based on what they see. (T3)

Most schools included a nutrition topic; however, each school took a different approach depending on the needs of the students. The teacher at the state-integrated girls only school was concerned with students’ low nutritional intake and took a sports nutrition approach.

I guess eating issues and nutrition is a big factor here. So we try and cover it through the angle of meeting your requirements, and the girls are very active. So a lot of sports nutrition; making sure they are getting balanced diets. (T3)

At schools where the occasional health education class was offered in senior school (outside of NCEA), the content of these classes had very little structure. The time available tended to be sporadic and the content was limited.

Year 11, 12, 13 is, we don’t have any set curriculum, Health curriculum, but we do have sort of little blocks that we do… so the seniors, their programme is very piecemeal I think and it’s not, it is not based around an assessed course. (T4)

One state-integrated girls only school offered a more formal approach to the subject health education in Years 11 and 12. Although health education was not taught as a NCEA subject option, the teacher covered content that was partially informed by the health education achievement standards.

R: Do you do any assessment in senior school?
T3: Because it is modular (Health) we don’t. We used to do an achievement standard, but through time constraints, we cut it off for that, but we still cover the content and that is still fine. We don’t want people just to engage in Health, just for credits, and we want people to engage in Health for actually getting some life skills. (T3)
The teacher who taught health education at NCEA level 3 used the NCEA achievement standards as a framework for the selection of content taught in the health education class. These achievement standards influenced the teacher to cover complex international and local health issues.

*I'm a little bit spontaneous, because sometimes things come up that are really current and they are in the news and it is right there. I bring that straight in. We have just started with preimplantation genetic diagnosis.* (T8)

### 6.9.2 Models of Health

The NZC outlines four key underlying conceptual models that underpin the learning area of HPE, which are hauora, socio-ecological model, attitudes and values, and health promotion[4]. Teachers were extrinsically and intrinsically teaching these models within the health education classroom. Some teachers also drew on models of health from the discipline of health promotion.

Hauora, a Māori model of health (refer to Chapter 4.3.1), was the main health model taught in all forms of health education at all of the schools in this study. One teacher reported this model was taught to students because it was an effective model for looking at health, not because it was outlined in the NZC.

*R: Do you find that, it sounds like you focus a lot around the idea of hauora.*

*T3: Yeah – that is a concept through the NZ curriculum, which, we don’t use it because the curriculum says so, we use it because I think we buy into it fully, and the students do too.* (T3)

Hauora was generally the first model of health to be introduced in health education, at junior school. Most teachers used this model to provide students with a holistic framework for understanding health. It also provided a model that students could use when exploring different health contexts.
The first thing I always cover off is hauora, and we talk about what the healthy person looks like, and they always assume who looks fit and strong, and then I will see, we look at the different components, they may have the physical appearance but then their spiritual and emotional, their social wellbeing may not be very flash. (T2)

Hauora, wellbeing that is just key, they learn wellbeing equals four and that just keys them into describing and explaining more about each of those dimensions of hauora. So that gets drummed in (laughter) right from the start and of course they have got to know it. (T8)

One dimension of hauroa is spirituality. A few teachers lacked the awareness of how to include content that enabled students to explore this dimension.

There is still spiritual mentioned, which is really hard, PhysEd and Health got split into mental, emotional, social, family and spiritual, and even when I go hear experts talk about the spiritual thing, it is really fudged over, because they actually feel, when I say they, I haven’t yet met someone who can really explain that in a coherent workable concept. (T5)

Most health education teachers taught students health skills which they could apply in their everyday lives. Some teachers taught critical thinking and reflection skills. These skills were sometimes intrinsically linked to the socio-ecological model, where students were critical thinking about the role different factors in society had on their health.

I think the big one for me is critical thinking. Any chance you have to examine what you see in front of you, and try and look for the assumptions and hidden messages, who is benefiting out of this, who is marginalised... because I think it is so transferable into all situations and particularly in health. (T6)
I referred to the news bulletin about the Albanian woman who had a down syndrome baby, and we talked about how cultural determinants had such a huge pressure on this poor woman and her view of her baby. That was a really awesome way... to reinforce the determinants of health. (T8)

Most teachers focused on ethical decision making, which is intrinsically linked to students developing healthy attitudes and values.

We are trying to get them to make the decisions, make them buy in to what’s right and wrong for them. Considering their specific upbringing, their culture, their environment, and how that has led to who they are, and I guess what the issues will be if they try and conform to these norms that they get. (T3)

Most teachers also included content that focused on generic models of decision making or problem solving. These skills were often linked to the concept of health promotion. Students were beginning to learn about making decisions or managing how they would take action for their own and others’ health within society. In health education in junior and senior school, most teachers provided factitious health scenarios to which students could apply these skills, rather than applying them at an experiential level in a real world context.

The focus of the group activities is the theoretical application of health and decision-making models to different health contexts students may find themselves in. (T7)

Health promotion action was more evident in health education within the NCEA framework. One teacher reported that students, who take the subject health education at NCEA level 2, were involved in taking health promotion action within the wider school environment. Health promotion models were also explicitly taught in health education in NCEA level 3.
R: How do you weave the health promotion, taking action aspect into your programme?

T: So that comes in at level 2, and the kids have to do an achievement standard worth 5 credits, on taking action within the community or within the school, to enhance the wellbeing of a particular group of people. (T8)

We do health promotion at level 3 as well, so they look at different health promotion models and we look at how that fits. (T8)

A few teachers reflected that health promotion action was generally not taught effectively in the junior school.

We are not really doing health promotion as well as we could do, and we don’t really do it at junior school directly, it is more indirectly, so we are not looking at any particular issues that we are focusing on that we are working towards change, making a change in behaviour, or a change, yeah anything like that. (T4)

6.9.3 Inclusive Content

The NZC outlines that learning should be inclusive of the diverse cultural, gender, and ethnic experiences of students in the classroom [4]. Teachers used various strategies to ensure that the content raised through group discussions was inclusive. This also supported students to learn about healthy attitudes and values.

All teachers took a broad approach to inclusion, where health education content naturally emerged as students shared their diverse health experiences during classroom activities.

R: How do you manage that diversity you have spoken of in the class?
Several teachers established classroom ground rules that guided how students shared and listened to the diverse experiences of students in the class.

You have to set up the atmosphere, I always start with setting up ground rules... like we talk about setting up an emotionally safe learning environment, and then they have got to talk about how that would look, feel and sound and what you would see happening and then you would try and really reinforce that when you are teaching it... so I think that is really, really important to make it successful. (T4)

One teacher used a teaching framework that enabled students to develop their own personal definition of health.

Again just getting that student buy in. You don’t want to preach to the kids, and again saying if you do this, this is what is going to happen, what is your definition of health, what is your decision going to be, how are your decisions going to impact on your definition, so it is just about them. (T3)

Most teachers shared their own personal stories, role modelling how to share personal health information within the classroom. Some teachers expressed care needed to be taken, so their personal values were not forced onto students.

It is very important if we are asking students to share, I share myself. I give my perspectives, and it’s not what I am trying to impose on them, but this is how I feel and what has led to my
choices and, I guess, just the confidence and the satisfaction
in following your own decisions. (T3)

You do have to really not bring your own baggage or your
own stuff and everyone has their own cultural capital that you
do bring to your teaching; but you have to remember that
there are so many different values in your class and that you
can’t really push your own point of view; but I guess we all
do indirectly. (T4)

6.9.4 Summary
Health education teachers were selecting content and activities that focused on students’
health priorities. Key topics generally related to drugs, alcohol, sexuality, and cyber
safety. Teachers extrinsically and intrinsically taught models of health, such as hauora,
the socio-ecological model, and ethics. Content that related to health promotion was
more likely to be taught at an NCEA level. Most teachers embraced an inclusive attitude
towards students’ experiences; however, it was less clear how teachers explicitly
explored inclusive content in health education.

6.10 Student Assessment
The theme ‘Student Assessment’ has no subthemes (see Figure 6.10.1). This theme
reports on how teachers are assessing students’ health knowledge and engagement in
class.

Figure 6.10.1 Map of the theme ‘Student Assessment’

The subject health education is compulsory until Year 10. The compulsory status means
students are generally required to participate in health education classes. Teachers
perceived that some students engaged well with activities and other students were less interested. One teacher noted that students often preferred physical education to health education.

But there is a mix, like there is a mix, I am not going to say all kids all 100% are engaged, because they are not, some of them may sit there and think this doesn’t apply to me, I know everything already, which is quite concerning, some of the students will be like not that engaged because it is probably so far in the future, but we generally get a good mix. (T3)

In terms of where it sits, sometimes the students we get feedback from our students’ surveys that they probably prefer to be in practical PhysEd. A lot of them would rather do that than sit in the Health class, but in saying that too, the engagement within the Health classes are quite strong. (T1)

Most teachers did not place a great emphasis on assessment in junior or senior health education. Some teachers used assessments to meet school performance requirements, for both the student and teacher. Other teachers were just concerned that students were learning about health and applying their knowledge in class.

Not a whole lot of assessment... We over the course of the year, we have two assessments in Health, at each of the year levels. They are often small project base things. (T1)

I give them a pre-test and then a post-test on it, same test, just to see what knowledge they have gained... you know, it is good to report back and say, well, that class had a good understanding and then it reinforces that the way you taught it is perhaps effective for those individuals, that would be more the purpose. (T7)
Most teachers generally informed parents of how students were engaging in health education. This occurred via student reports and in parent interviews. Teachers shared general comments about students’ competency development.

_There are the parent teacher nights, we send reports home twice a year, every three weeks there is a sign posting report sent home, that basically talks about kids’ engagement in classes, that kids are either doing well in class or they are not engaging, their work breaks, their attitudes, behaviour._ (T1)

All teachers were aware that it was difficult to measure how effective health education was in supporting students to engage in health behaviours. One teacher reflected that these health outcomes often occur later in life.

_In all fairness the only proof of being successful in Health, is when they are in the actual environment ten years from now, they will have the actual confidence to choose what they want to._ (T3)

_It is how I see Health, sometimes it is directly relevant to them at that moment, but at other times it may be years down the track when they think, Oh, yeah I remember doing that in Year 10. It is quite tricky when they are not at that readiness level… like anything, if you don’t identity with it, until you identify with it, do I need it?_ (T4)

Most teachers were concerned that students often faced many challenges when applying their health learning outside the school. This sometimes led to teachers’ frustration that students learning about health did not necessarily translate into immediate changes in their health behaviours.

_I think one of the things that has stuck with me about Health, is the students that we have, they do generally engage in the topics really well. One of the frustrations is, they do seem to_
know a lot of the stuff that we are going over, and they come up with great ideas and concepts when they do models and scenarios, but then the frustration... and seeing what some of the kids are up to, it’s probably no different from when I was a kid. But they do things that are against perhaps what we have looked at in Health. (T1)

In senior school, student learning is focused around the attainment of credits associated with NCEA achievement standards. Teachers perceived that students struggled to value learning unless it was associated with earning credits. At one boys only school, the teacher reported some students did not complete the NCEA external assessment for health education. The students had already attained enough credits, and they prioritised the credits in more traditional subjects.

*In terms of a lot of the assessment stuff in senior subjects right across the board, it becomes quite narrow, so the students are also quite driven by assessment. You will be doing something in class, and they will be like, you know, is this assessed, is this for an assessment, is it worth credits, and perhaps if it is not worth credits, some students struggle to see the value in it.* (T1)

Students’ performance in health education at level 3 in NCEA was measured through both internal and external assessment procedures. Internal assessment throughout the year enabled students to explore health issues more in-depth. External assessments generally occurred at the end of the year.

*With internal assessment it’s a little bit easier with your internal achievements standards because you can chew the fat, you can go off on a tangent and look at things that are really interesting and then bring it back to the theory. (T8)*

*Now you have a mix of internal and external assessments, so you try and do as much work internally over maybe a two to
four week period, where the standards are only worth 2–3 credits, and really focus on that. But you try and sit tests when the kids are ready rather than just blindly following a programme. (T5)

The teacher who was teaching health education at level 3 within the NCEA framework reflected that assessment requirements associated with NCEA had increased her teaching workload. This increase was associated with moderation and assessment requirements, leading to frustration and reduced planning time.

So my experience being a Health teacher with this whole policy stuff, it is the bureaucracy of the job, it is really one of the main challenges of the Health teacher, or about being any teacher. You just have to take a whole lot of work home and get it done... It is at times, really is just excessive... It reduces my time to do some really awesome preparation... What I would really love would be to have time to make lessons really come to life. That would be a far more effective way of me spending my time. (T8)

6.10.1 Summary

Health education teachers reflected that students have variable levels of health knowledge in secondary school. Teachers generally placed minimal emphasis on assessment procedures in junior or senior health education; they were more concerned with students’ competency development. Teachers generally perceived, and sometimes felt frustrated, that students took time to translate their health knowledge into healthy outcomes. In NCEA, both teachers and students prioritised assessment procedures. Teachers often perceived students were only concerned with attaining credits. One NCEA teacher who taught health education at level 3 was concerned with the increase in workload associated with assessment requirements.
Chapter 7 Discussion

7.1 Introduction

This chapter seeks to address the aim and objectivise of this thesis; the aim is to provide an analysis of the underlying processes involved in the teaching of health education. The objectives (refer to Chapter 2) relate to: understanding the knowledge processes underpinning health education, the role of the health education teacher, and the social relations between health education teachers, students, and the wider school community members. The themes generated and discussed in the previous chapter provide the first step in analysing the underlying processes. Literature and theory will be drawn on throughout this chapter to deepen this analysis.

This chapter is organised into five sections. The first three sections discuss the themes located to each level of the thematic map: Wider School Community Relations, Teaching as Inquiry, and Classroom Delivery (see Figure 6.3.1). The last section discusses insights from Health Promoting Schools, which can further support health education in schools.

This section will impress on the reader several key understandings. The first relates to teachers’ reflexive inquiry, which is a powerful resource for managing a complex teaching environment and ensuring learning is relevant and meaningful for students. The second understanding relates to classroom health education content, which is generally oriented to the everyday health context of students’ lives. The last understanding recognises the expertise of the health education teacher in facilitating and building, to varying extents, relationships with wider school community members. These relationships ultimately work towards enabling students’ inclusive participation in health education.

The next section explores some of these relationships, particularly those with other school subjects, parents and caregivers, and external agencies, alongside the position of health education in schools.
7.2 Health Education and the Wider School Community

The following section discusses the underlying processes that govern the relationships between health education and the wider school community. These processes underpin the themes ‘Health Education in Schools’ and ‘Wider School Community Relationships’.

Many schools in NZ have a pressured school timetable and limited operational budget; this means subjects compete for time and resources [99]. Health education, in this study, generally held a marginalised position within the school environment, compared to other school subjects. This was despite teachers’ perceptions that school personnel generally valued health education “It has always been a subject that is considered important” (T4). This marginalisation was evident through the wide variability and sometimes very limited (ten to forty hours) allocation of time students would be spending in health education classes each year, in junior school.

In this study, teachers perceived that schools and parents prioritised subjects such as English, mathematics, and science. These subjects, historically, are viewed as requiring greater academic prowess and therefore often receive greater resource allocation [99, 202]. Most schools in this study were influenced by national education priorities related to improving students’ numeracy and literacy skills [16]. The undervaluing of health education may also have been influencing students’ views of health education. One teacher in this study perceived that students often preferred physical education to health education. The NZ National Monitoring Study of Student Achievement (NMSSA) [38] also reported students’ positive attitudes towards health education declined with increases in age.

School personnel in the school community also contributed to the marginalisation of health education in schools. Teachers, in this study, perceived that school management members, such as Boards of Trustees, school principals and timetable administrators, maintained overarching control over the time and material resources allocated to health education. One teacher reflected that sometimes

the attitude of your leader, or principal would be one of the top tiers that really influences the tone of Health in the
school. If they are supportive and have got your back, things will happen. But if they are a bit dismissive, then that will be your lot (T6).

The underlying privileging of academic subjects by school management often left health education, in this study, in the position of the “poor cousin” (T8), receiving an inequitable distribution of time, funding, material resources, space, and professional development. To marginalise health education to the status of an “extra, and a bonus” (T6) is to devalue the foundational role that health education plays in students’ lives [203]. This perspective of health education as an ‘extra’ was evident in senior schools in this study. Students’ access to health education in senior school was generally limited “to any spare slot” (T6) in schools where health education at an NCEA level was not offered. Only one school in this study offered health education at an NCEA level and senior students not taking this subject option received no health education.

Health education needs to continue working towards becoming a specialist subject. Introducing health education as a National Certificate of Educational Achievement (NCEA) subject option in 2002 appears to have done little to improve health education’s academic standing. Most schools were influenced by the governments investment in numeracy and literacy; outlining an investment towards being “an academic school, first and foremost” (T2).

According to Bernstein, historically privileged disciplines such as English and mathematics, have a singular body of theoretical knowledge and specific rules of communication [51]. The boundaries around these subjects are tightly controlled by a specialist teacher and with a coherent induction process for students [51]. Health education is different, as it draws on several fields of knowledge, such as sociology, psychology, health promotion, education, and local culture. This enables a variety of expert, school and community members to communicate about aspects of this subject. This approach weakens the boundaries around health education allowing greater diversity in who can speak about this subject and what health messages are communicated [50]. In opening up space for diverse people to engage in conversations related to health education, “the gap between common practice and ‘what ought to be’ is greater for HE (health education) than for most other areas in the schools’ curriculum” (Seffrin, 1992 as cited in [99], p.563) [26]. The weak boundaries around health
education also open this subject up to a variety of public pedagogies, such as healthism [204]. This view positions the individual as responsible for their health and engagement in health practices [204]. Fitzpatrick [204] stated, “the visibility of such health discourses is a form of public pedagogy (Rich and Evans, 2012), fanned by a moral panic by which everyone learns to self-monitor, regulate and medicate their bodies in the name of health” (p.134). The proliferation of varying health views and health practices in the social media, media and public domains [204] can contribute to the uncertainty around the pedagogical approaches and health content delivered in health education. Teachers and students, through their use of social media, become both consumers and producers of health knowledge and the power of who speaks with an expert health voice can become blurred [205].

To build on the voice of ‘health education’ within schools, it needs to become “a much wider aspect of what’s happening in the school” (T1). Subject integration outside of the health education classroom may offer a way to find more space for health education. Lynott [206] suggested,

> at a time when accountability for both students and teachers is high and minutes in the school day are limited, interdisciplinary lesson planning has the potential to provide many benefits in terms of creating strong learning connections. (p.18)

Schools in this study were attempting to integrate health education content and practices into other school subjects, and school initiatives such as pastoral systems, Health Promoting Schools (HPS) and student-led activities. Teachers in this study did highlight the challenges of subject-integration, particularly teachers’ lack of confidence and time to collaborate across different subjects.

Brough [138] suggested that schools find subject integration challenging as “separate subject thinking is deeply entrenched in school systems, so much so that Beane (1991) (as cited in [144]) suggested it has ‘… virtually paralyzed our capacity to imagine something different ’” (p.20). For integration to be successful it requires a concern with both the content and context of subject matter, which supports learning to be meaningful [207]. Professional development opportunities for all teachers related to health
education and subject integration, might ensure that the same school-wide health imperative is supported. Lynott [206] acknowledged that integration can be challenging. He suggested that schools do not have to make sweeping changes; instead expertise can be developed through a commitment to setting small goals such as “to develop one authentic interdisciplinary lesson per semester” (p.18).

Involving the wider community in thinking about how health education occurs in schools may also prove useful but challenging. Hopkins [208] stated that “a school curriculum needed to reflect and build upon the wider interpretation of knowledge and understanding held by citizens in society at large” (p. 418). This process involves engaging with stakeholders and the community to ensure different perspectives are explored [208].

Community consultation was a dominant feature of this study. Despite most teachers’ efforts to involve parents in curriculum decision-making processes, teachers generally felt many parents and caregivers did not actively engage. Where parents did engage, teachers often perceived that some parents had an agenda; they “have got a really strong point to make about something, or a particular issue about Health” (T6), which was often related to sexuality education. NZ research also highlights the lack of community engagement in planning and implementing different aspects of the school-wide curriculum [8, 147-149] (refer to Chapter 4.4.4).

Building relationships with parents and caregivers is essential for increasing the “home-school alignment”, which involves “building relationships between teachers and families; encouraging families to include ‘school’ type activities into their homes” ([149], p.3). This home-school alignment should be reflected in health education, where local family health perspectives and expert health perspectives are blended within the programme. Schools in this study were attempting to build this alignment, as seen through one teachers’ experience where “a new resource at junior level... ‘Sexuality Road’ was introduced and there were aspects of the Year 8 programme that parents were very uncomfortable with” (T8), and the school said “we will take that out: that’s community consultation in action” (T8). Teachers in this study generally reported that alignment of programme content ensured that some parents and caregivers concerns “that their children... were not ready to hear certain things” (T8) was less likely to eventuate.
Family engagement offers a way to support students’ access to health education, both within the school and home. Brough [138] stated that “learning is strengthened when teachers connect new learning with students’ prior experiences as well as home and community practices” (p.18). Parents’ awareness of school health education perspectives enables them to engage in conversations about health education with students within the home environment, which for Bernstein is the second site of knowledge acquisition [50, 51]. It also enables teachers to provide curriculum content that focuses on everyday health contexts, making learning relevant and meaningful [50, 51].

Community engagement also involves forming relationships with external agencies who have an investment in education or health. These agencies are external to the school, such as health or social service agencies and universities [51, 209], and provide theory and programmes to support school health education [51, 209]. Health education teachers in this study were engaging with external agencies and sometimes reported the “sheer volume of people who want to come and talk” (T5) to their students. Some of these external agencies were Family Planning, Police, and Rape Crisis.

Health education teachers in this study often expressed concern that some external agency programmes did not provide relevant or developmentally appropriate content, or content aligned with best-practice pedagogic approaches. External agents are specialists in their particular health field, and may not have the pedagogical expertise required to communicate effectively within school health education [155, 156]. Penney [156] suggested poor programme evaluation by external agencies makes it difficult for teachers to determine programme effectiveness (refer to Chapter 4.4.5). Health education teachers in this study generally did not talk about external agency programme evaluation. Evaluation should be an essential part of any health education programme to ensure quality and equity of programme outcomes [47]. Teachers in this study were often in the unenviable position of deciding if using an unevaluated health education programme was better than none, particularly in senior school where health education was allocated any ‘spare slot’ (T7).

Enabling external agencies’ access to health education widens the boundaries around what constitutes an appropriate health message. Having clear policy guidelines for evaluating and interacting with external agencies might support teachers to have more
control over ‘who’ is speaking about health within the school environment. Many NZ schools often lack external agency policy guidelines [155]. Richards [155] stated strong policy guidelines entitle schools “to carefully evaluate the health impact of any outside partnership” and “this places some responsibility on health organisations to have available evidence of the effectiveness of their own programs” (p.334).

Drawing on the wider school community may further strengthen health education’s position within schools and provide much needed resources and support. Teachers’ reflexive inquiry can influence how teachers use different school community perspectives to inform their health education programmes. The following section will discuss the reflexive role of the health education teacher in guiding how health education is taught in secondary school.

7.3 The Heart of Health Education

This section discusses how health education teachers are engaging in the process of reflexive inquiry, both personally and professionally, as a way to create a health education programme that focuses on the needs of the students. The discussion in this section focuses on the themes ‘Becoming a Teacher of Health Education’ and ‘Student-Centred Health Education’.

The New Zealand Curriculum (NZC) encourages teachers to engage in reflexive inquiry, both individually and collegially, to ensure teaching practices support positive student outcomes [4] (refer to Chapter 4.5.2). The teaching as inquiry cycle is a “constructive process in which their [teachers] continuous deep thinking about students’ learning, and their responsive actions, pave the way for all students to succeed” ([108], p. 2). Archer ‘s notion of reflective agency is very similar to aspects of the teaching as inquiry. Both refer to the teachers’ capacity to engage in self-talk and reflexively think or inquire about the teaching and learning conditions within the school environment [48, 66].

Archer identified four forms of reflexive agency: meta-reflexives, autonomous reflexives, communicative reflexives, and fractured reflexives [49, 66] (refer to Chapter 3.4). Health education teachers in this study engaged in the three most advanced forms of reflexivity: autonomous, communicative, and meta-reflexive. Teachers’ reflexivity
guides how they fulfil their social roles and the positions they hold within the wider school community [48, 49]. Health education teachers in this study generally belonged to the HPE department. Collegial support enabled teachers to have a shared purpose and approach to health education.

Reflexive agency underpins why health education teachers perform their roles in different ways. Health education teachers in this study generally engaged in autonomous reflexivity. This involved being reflexive about their personal, economic, and school positioning, which contributed to them falling into health education. If teachers came from a professional background of a Physical Education Degree (PE) and a Graduate Diploma in Education they were often advised to take health education papers during their preservice teacher training. This enhanced employment prospects as schools tended to expect that HPE teachers taught both physical education and health education. Health education teachers with a Bachelor of Education Degree who had previously taught at an Intermediate school level often fell into secondary school health education as an employment opportunity arose for promotion within the school.

All health education teachers in this study engaged in meta-reflexivity. Meta-reflexivity enables teachers to be “critically reflective about themselves and about society” developing “transcendental concerns” ([68], p.478). Teachers’ concerns in this study often related to supporting students’ learning outcomes. Teachers were inquiring about “What is important (and therefore worth spending time on), given where my students are at?” ([4], p.35). For one teacher, students’ learning needs related to “knowing how to look after yourself, knowing how to treat others as well, and knowing where to get help if you are stuck” (T5). Reflective inquiry did not occur in isolation. Teachers often engaged in communicative meta-reflexivity, which involved engaging in collaborative health education conversations with other professionals, both within and outside the school. Drawing on different expertise supported teachers to draw on a wider theoretical base for deciding “What strategies (evidence-based) are most likely to help my students learn this?” ([108], p.7) [4].

Health education teachers in this study were not always able to deliver health education that aligned with what they perceived an effective programme should entail. Teachers sometimes had to creatively negotiate the constraints placed on health education due to its marginalised position. Teachers sometimes felt disillusioned that “sadly there is stuff
that I think could be extended a bit more” (T7) because of limited time and resources. Teachers were also inquiring into their personal strengths and weaknesses and how this influenced how they delivered health education. They recognised the role of their own subjectivity, reflecting that sometimes it indirectly influenced how they taught: “You have to remember there are so many different values in your class, and that you can’t really push your own point of view, but I guess we all do indirectly” (T4). Despite these reflexive issues, teachers generally attempted to be responsive to students’ health education learning needs.

Professional development is a resource that supports teachers’ reflexive inquiry and practice. It is through professional development that “teachers’ understandings and awareness of their own practice can be considered a fundamental resource in the definition of educational problems” ([64], p.347). External agencies often provided the majority of face-to-face, pre-packaged, and online professional development resources for health education teachers in this study. The wide variety of professional development organisations who offer programmes for teachers can weaken the boundaries around what an effective professional development opportunity entails [210]. This may have led to some teachers’ perceptions, in this study, that external agencies lacked pedagogical expertise and awareness of school health education approaches. One teacher stated, “I haven’t seen anything that I would like to go to that is Health related” (T2). Given how relevant professional development is to teachers’ personal and professional development, it was pertinent that teachers in this study often recognised that “we probably need to upskill ourselves more” (T4).

Teachers in this study generally valued the capacity to network with other health education teachers and health organisations, locally and nationally. The Ministry of Education is currently piloting a professional learning and development (PLD) programme for teachers which draws on the concept of networking [169] (refer to Chapter 4.5.2). Organisations such as the New Zealand Health Education Association focus on networking and sharing best evidence teaching approaches which further strengthen the specialisation of health education in schools [211]. Their mission statement focuses on “a community of professionals that operates with excellence, connectedness, and leadership to support Health Education” [211]. Robertson [26] states that
without access to a substantial and detailed body of locally
relevant health education-specific research evidence, it
becomes a challenge to sustain an argument seeking to make
a clear case for (or against) the maturity of health education in
NZC. (p 91)

Networking and research by professional bodies, health education teachers, and
researchers is essential if health education is to become more influential in schools,
challenging its current marginalised position.

The theme ‘Student-Centred Health Education’ embodied the overarching approach
generally used to teach health education in secondary schools. Underpinning this
approach was Bernstein’s principle of re-contextualisation [50]. Health education
teachers in this study were de-locating concepts from different knowledge sources and
school community perspectives and relocating them for a specific purpose; delivering a
student-centred health education programme [50, 51].

In this study, an instrumentalist instructional approach combined with a traditionalist
instructional approach in health education (refer to Chapter 4.4.1). An instrumentalist
approach blends a student-centred curriculum with students application of generic skills
[55]. A traditionalist approach privileges the voice of the expert teacher [51]. When
these two approaches combined the contradictions between concepts, constrained how
they interacted with each other [48].

In junior or senior health education, contradicting health concepts were blended and the
new blended knowledge form influenced teachers’ knowledge practices. Health
education teachers tended to privilege the instrumentalist approach and believed that
health education should focus on “student centred learning activities, where I guess
where the contexts they choose or discuss or they inquire about, are relevant to them.”
(T3). Teachers’ generally believed the traditionalist instructional approach should be
limited to the teacher’s role of providing relevant health education content to enable
students to make informed decisions.

In this study, only one teacher took NCEA health education. NCEA health education
also blended an instrumentalist and traditionalist approach. These blended instructional
discourses conditioned the NCEA teacher to privilege the instrumentalist approach. The teacher generally believed that student learning should focus on the development of local skills. The traditionalist approach had a greater influence on this teacher’s practices, compared to teachers in junior or senior health education. Given that NCEA health education has a greater theoretical orientation, this teacher believed she was obligated to provide students with enough theoretical knowledge to perform in NCEA assessments. To maintain an overarching local context and competencies focus, the teacher often manipulated the NCEA assessment requirements. The teacher believed that by reducing the number of NCEA achievement standards offered, and the associated assessments, students would have more time to apply health skills to local or international health issues.

The instructional direction of health education was also influenced by the views of school agents, such as parents and students. These health views were externally related to health education. Health education teachers generally aligned themselves with the instructional approach discussed in the above paragraph; but they often explored what these external agent views could offer. Teachers largely drew from what counsellors and students were saying, which enhanced the relevance of learning for students. Teachers were often selective in how they relocated concepts from parents and the school’s special character; choosing knowledge that was supportive of a student-centred health education. Teachers’ knowledge practices tended to lead to the emergence of a health education curriculum that prioritised a student needs competency approach.

In this study, all the different forms of health education, blended the contradictory regulative discourses of the neoliberal self-responsible individual (refer to Chapter 1.3) and a student-centred ideology (refer to Chapter 4.4.2). The neoliberal ideology locates the responsibility of relationships within the classroom to the capacity of the students and teacher to perform their designated roles [50, 51]. In junior and senior health education, teachers generally privileged the neoliberal ideology. Professional accountability requirements and student assessment monitoring systems often positioned teachers to maintain an expert position to ensure they were meeting expected teacher and student outcomes. However, teachers often held the firm belief that students should be actively engaged and at the centre of the learning process. Teachers generally manipulated the student centred ideology so students took an active role in classroom activities and discussions; but the teacher maintained overarching control of managing
classroom relationships. In NCEA health education, nationally prescribed learning requirements meant the teacher generally aligned to a professional responsibility of supporting students to attain this knowledge so they could perform in assessments. The participant who taught NCEA took a more expert and directive approach to classroom relationships.

Drawing on students’ and the wider school community’s perspectives infers a degree of democracy is necessary when planning health education [8, 147-149, 212] (refer to Chapters 4.4.2). According to Hopkins [208] democratic curriculum planning involves “ongoing discussion with stakeholders in the community to ensure points-of-view are raised and listened to from different perspectives” (p.421). If we consider Hopkins’ [208] view that the key to democratic curriculum planning is negotiation, then teachers in this study were attempting to build a programme where no single agent “owns the curriculum to the extent of determining aims and objectives without the agreement of other stakeholders” (p.426). Fully engaging the community in curriculum design was challenging for schools in this study, given teachers’ reports that parents and caregivers did not invest in current curriculum consultation processes and external agencies did not always align with best-practice pedagogy.

The overall instructional approach used in the delivery of health education in this study was a student-centred pedagogy. Different school community perspectives were blended, guiding teachers’ prioritisation of ideas that were relevant in supporting the needs of the students. Brough succinctly [138] summarises Dewey’s (1916, 1936, 1938) approach to a student-centred pedagogy which is centred “on the student and the community in which they lived… and where young people were actively engaged in subject matter through experiences” (p. 6). For most teachers, this meant health education focused on students’ skill development. This approach is similar to Boyd and Hipkins’ [145] student-inquiry approach which is “a teacher-supported process that provides a structure for students to learn through the process of inquiring into questions they develop themselves about a topic or concept” (p.13). This inquiry process requires teachers “to redefine power relationships in order to offer a more inclusive form of curriculum delivery” ([138], p.17). Bolstad suggested the student-teacher relationship should “draw on the strengths and knowledge of each in order to best support learning” ([102], p.89). Teachers in this study generally believed that students should be “engaging in and driving a lot of the stuff” (T1).
7.4 Teaching Health Education: A Student-Centred Approach

This section explores the delivery of health education within the classroom context. The themes ‘Teaching Practices’, ‘Health Education Content’, and ‘Student Assessment’ (see Figure 6.3.1.) will be discussed in turn; theory and literature will be drawn on to inform this discussion.

7.4.1 Teaching Practices

Health education in this study took a modular approach. The sequence of learning in junior or senior health education was oriented towards a specific health topic, and in health education at an NCEA level specific achievement standards [62]. This approach to learning focuses on the use of knowledge as it becomes relevant to the topic or achievement standard, rather than learning a clearly defined conceptual sequence of knowledge [50, 51].

Group work was the most common classroom strategy used by junior or senior health education teachers in this study. Activities often had various sections and levels of difficulty to meet the learning needs of different students. Teachers generally enabled students to determine the extent to which they would engage in each level of activity. During group activities teachers facilitated students’ application of knowledge, which generally enabled the completion of activities. This flexibility enabled students to have some control over the sequence of learning, as knowledge was drawn on when it became relevant to the activity and not on its conceptual sequence.

In NCEA health education in this study a modular approach was implemented. Learning was generally located to a specific achievement standard. The teacher’s privileging voice, in this study, determined which standards were taught and in which order in each year level. The teacher’s expertise was relied on to ensure students had learnt the required conceptual knowledge to complete each achievement standard. The teacher supported students to progress to higher levels of achievement, even if they had not necessarily completed earlier levels.

The teaching strategies used by health education teachers, in this study, closely resemble a form of generic student inquiry [145]. Boyd and Hipkins [145] indicated the essence of this approach is that “students are supported to develop skills in seeking,
critically reviewing and reporting on information by working through a predetermined process [the steps of a generic inquiry model] to help them to inquire into their own questions” (p.20). In this study, student-inquiry was a group process facilitated by the teacher, where groups of students discussed and worked together as they applied knowledge to factitious health scenarios. For Dewey (1950, as cited in [208]) facilitation of active learning creates the “conditions that are conducive to community activity” (p. 420). To further support ‘community activity’, teachers in this study scaffolded activities, offering varying degrees of learning challenge, to ensure learning was inclusive. Brough states that “teacher scaffolding takes place throughout the entire learning process through the use of exemplars, modelling, and explicit teaching” (p.18).

7.4.2 Health Education Content

The NZC outlines curriculum content in terms of achievement objectives: skills students should be able to apply to different contexts [4]. Teachers are required to translate these competency-based objectives into content and learning outcomes [15, 21, 24]. This flexible approach to curriculum content enables teachers to select health education content that is relevant to the needs of the students they are teaching [4, 16].

In this study, teachers’ reflexive agency mediated how the shared power relation over content selection occurred. Generic strategies were often used; it was it was less clear how teachers were planning to include explicit curriculum content related to, culture, gendered or disability. The NZC suggests this is an important component of school curriculum. Schools in this study generally had small proportions of Māori, Pasifika and Asian students, which may account for why teachers took a generic approach to diversity. Health education activities naturally opened up the opportunity for diversity to be explored. Students involvement in curriculum design remained narrowed to classroom content selection. Student-centred learning implies that students are involved more broadly in curriculum design and implementation [138, 212]. The limited time-frame and marginalisation of health education may have contributed to this lack of investment.

In NCEA health education in this study, social relationships within the classroom tended to privileged the expert health teacher’s voice. The teacher often selected theoretical health content that students passively learnt. This ensured that students had
enough knowledge to meet achievement standard requirements. The teacher recognised this form of learning was not effective and had reduced the number of achievement standards selected. This allowed more time and space for students to engage in active learning.

Health education content in this study generally combined the mutually supportive knowledge forms of constructivism, inclusivity and local health issues (refer to Chapter 4.4.1) [51]. These contexts focused on the local lives of students, which includes embracing the diversity of these different experiences [8, 9, 137]. Health promotion knowledge was also combined which supports the approaches discussed above; alongside providing theoretical models for understanding health issues and developing health skills [47]. Out of these mutually supportive knowledge forms developed a systematised student-centred curriculum emerged. This conditioned how teachers formed the knowledge components of health education.

In this study classroom activities and health education content generally included learning skills such as critical thinking and problem solving, which supported students to inquire into factitious health scenarios that reflected the everyday health contexts of their lives. Brough quoted Beane (1997, as cited in [138]) as stating that “critical inquiry into real issues helps young people develop an understanding of themselves and their world and, where appropriate, allow opportunity for social action” (p.16). Given that the selection of content in this study reflects both expert health information and students’ personal and shared health experiences, it seems logical that taking a critical inquiry approach to health education might support students to understand the value-laden nature of health experiences [213].

Teachers were utilising various strategies in this study to facilitate learning that was inclusive of students’ diverse health experiences. Brough [138] stated that effective pedagogical practice “involves establishing caring, equitable environments where learning takes place beside and with students” (p.19). Teachers often reflected that supportive relationship with students and getting “to know your students” (T4) was essential in ensuring students felt included within the classroom. It was less clear, in this study, how teachers were explicitly including health content that related to culture, gender or disability. By not making explicit different understandings of health, the silencing of minority voices in school health education may be perpetuated. Florian and
Linklater (2010, as cited in [214]) suggested that an inclusive approach to learning ensures “that learners with diverse needs and preferences (such as learners with disabilities) can have equal opportunities in accessing learning resources, services and experiences in general” (p.17). Waitoller [215] advocates for a classroom strategy that is founded upon social justice and takes an intersectional approach to inclusion, acknowledging “the complex and interacting forms of exclusion experienced by students” (p.339). The 2007 NZC clearly outlines an inclusive approach to school education through the principles of the Treaty of Waitangi, cultural diversity and inclusion [4].

In recognition of the bicultural relations in NZ, the 2007 NZC outlines health in terms of ‘hauora’ a Māori model of wellbeing, which is one of the underlying concepts in the learning area of HPE [4, 29]. Teachers in this study viewed this model as foundational in health education and it was extrinsically taught at all Year levels in health education. This model depicts health as having four interrelated aspects: physical, mental, social/family, and spiritual (refer to Chapter 4.3.1). For some Māori families and advocates this simplistic definition of hauora is “subjugating in the sense that alternative forms of Māori knowledge are buried under official or dominant discourses about the Whare tapa wha” ([29], p.109) and Māori health understandings of health “exist beyond the conceptual framework of curriculum” ([87], p. 6) [29]. For Māori

Health embodies a holistic philosophy that encompasses spiritual, mental, family and physical dimensions, along with connectedness with the land and rootedness with one’s tribal area. These dimensions cannot be regarded separately but are inter-related to form a whole on which good health depends. ([87], p.14)

For Māori, the “spiritual dimension is considered an inextricable aspect of identity and culture… To ignore the spiritual is to expect Māori to divide and fragment their lives and their values” ([216], p.93). Teachers in this study sometimes lacked an awareness of the spiritual aspects of health or relied on this aspect to be taught in religious education. This may have partially contributed to the latest NZ National Education Monitoring Project [38] (refer to Chapter 1.5) reporting Year 4 and 8 students struggled to articulate
the spiritual aspects of health. Teaching students about spirituality can be challenging and professional development opportunities may not be providing teachers with learning support. This was alluded to by one health education teacher in this study who reflected: “I am still waiting for someone to do that [teaching spirituality] well, and I can see that in action” (T5).

According to Fraser [216], “spirituality is considered to be a natural part of what it means to be human and this spirituality can be expressed in both religious and culturally specific ways” (p.93). This is the approach taken by the 2007 NZC [216]. An article by Briggs [217] reported ways to promote spirituality in secondary schools. Some of these strategies related to: students’ sharing and exploration of meaningful stories, where they learned about their personal inner strengths and resilience; mindfulness and students’ character profiles, which developed students’ inner awareness; and working in groups or supporting different social initiatives, which supported students’ interconnectedness and awareness of others. These strategies closely align with the idea of spirituality as the process of moral development and feeling connected [216, 218] which are components of ‘Attitudes and Values’, one of the underlying concepts in the learning area of HPE. In this study, some of the teachers were using strategies outlined by Briggs without possibly recognising their relationship to spirituality. In some schools, a curriculum that focuses on spirituality may not be viable, but a spiritual environment can be supported [219]. Health education teachers and schools need to create an inclusive environment where there is “a natural acceptance of spirituality” where “people’s values and beliefs can co-exist without excuse or apology” ([216], p.94). Research exploring students’ and health education teachers’ understandings of spirituality may enable clarity about how spirituality can be more effectively and explicitly taught within health education [87, 217, 219].

The NZC outlines curriculum content in terms of skills, which enables teachers the flexibility to select classroom health education content that is relevant to the contexts of students’ lives [4]. This means “HPE in the NZC is open to interpretation” ([26], p. 91) [50, 56, 62] and Robertson suggests “at times this interpretation is at odds with the intent of the curriculum” ([26], p. 91). Watanabe’s [181] comparative study of primary school health education in Japan and NZ reported benefits associated with both compulsory and student-centred curriculum content (refer to Chapter 4.6.2 ). Explicit health education content can potentially minimise health learning disparities across
schools and everyday health education content can ensure learning is relevant and meaningful to students [181]. Clearer content guidelines for health education may provide the needed support, particularly for new teachers, to align health education with the national curriculum [56, 57, 62]. This may also support health education to have a stronger theoretical base and academic positioning within the school environment [26].

The social realist believes that there are two main knowledge forms [56]. Specialised knowledge, such as health promotion models, is perceived as being more powerful than everyday knowledge, such as students’ health experiences [56]. Specialised or theoretical knowledge is composed of coherently sequenced abstract concepts; everyday knowledge is located to the everyday contexts and conversations of people’s lives [51]. A common trend over the last twenty years has been the diversification of knowledge [56]. Knowledge is drawn from different theoretical and everyday fields as it becomes important to understanding a particular concern [56, 60]. This means that the boundaries around each form of knowledge have become weakened. Knowledge no longer fits into a singular or pure form [55, 56, 62]. In schools, health education knowledge becomes diversified as it is integrated within different subjects or school initiatives. This suggests that curriculum debates that centre purely on the form of the curriculum taught in schools may need to shift to reflect the current curriculum environment.

Archer’s notion of reflectivity may provide another avenue to understand the power that knowledge holds. Reflexivity enables people to ascribe meaning to their cultural and social experiences, which in turn influences their interactions within society [48, 49] (refer to Chapter 3.4). In this sense, knowledge holds power both in form and meaning. It may be time to shift away from a focus on powerful forms of knowledge to a focus on the meaning of knowledge. Both every day and theoretical knowledge can be powerful if it supports students’ access to different conversations in society that are meaningful to them. Teaching as inquiry forms the foundation for discovering what knowledge is relevant and meaningful for students. One student may want the canteen to have healthy food. Specialised health promotion knowledge can enable this student to understand how to advocate for a canteen policy change. Another student may want to approach a local Māori community to be part of the local Kapa Haka group. Having an understanding of local Māori customs may support this relationship. Health education needs to provide students with relevant and meaningful health content and skills. If
knowledge is to be useful [70] then it needs to focus on supporting the health learning and wellbeing of students in their everyday lives.

7.4.3 Student Assessment

In this study, summative assessment in junior and senior health education was generally not a priority for teachers. Instead, health education teachers preferred to prioritise students’ engagement and application of skills in classroom activities. Health education in NCEA took a more formal approach to assessment, which is guided by the requirements of the National Certificate of Educational Achievement framework. Students were required to complete internal and external assessments throughout the year.

Teachers in this study often reflected on students’ application of health knowledge and skills outside of the health education classroom. Teachers were reflecting on both students’ health education learning and their health outcomes. Frustration sometimes arose around students’ inability to put into practice what they had learned. One teacher reflected ‘when it actually comes to putting that into practice [by the students], we have got a long way to go’ (T5). Tapps [220] argued that integrating some experiential learning into health education may provide an opportunity for students to practice applying health skills outside the school environment. Students at one school, who were taking health education at NCEA level 2, were involved in taking health promotion action within the wider school. Taking action outside the classroom can make learning meaningful; teaching students how to manage real world relationships, environments and processes [220]. However, as teachers in this study reflected, student’s behaviour change through knowledge learnt in school is a complex process and possibly only occurs at a point in time when that knowledge becomes meaningful in those students’ lives.

In this study, teachers were often using assessment procedures as a tool to reflect on their practices and students’ learning. This can be an aspect of ‘Learning Inquiry’ where teachers evaluate “what has happened as a result of teaching, and what are the implications for future teaching?” ([108], p.7). Several authors argue that by making evaluation criteria explicit, teachers and students become aware of what needs to be acquired and this can improve student performance [57, 60, 62]. However, explicit
evaluation criteria as outlined in NCEA achievement standards may lead to teachers narrowing curriculum content to each achievement standard, as shown in this study and literature [9, 26]. Research needs to be conducted to further understand how different evaluation formats in health education influence students’ acquisition of knowledge.

The next section discusses how HPS can offer a framework to further support health education in schools.

### 7.5 Insights from Health Promoting Schools

The thematic map (Figure 6.3.1) generated in this study highlighted three contextual levels in which teaching practices occurred: wider school community relations, teaching as inquiry, and classroom delivery. What the previous sections in this chapter highlight is a lack of connection between these three levels. This can be seen through: parents remaining largely uninvolved in health education; wider school health initiatives not being directly linked to health education, and vice versa; external agency programmes were not often oriented towards school health education pedagogy; and students’ health education learning largely remaining located to the classroom. This lack of cohesion between the different levels may be contributing to the marginalisation of health education, and students’ struggle to translate health learning into real life contexts.

These struggles suggest that health education

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still has some growing up to do. It will take some years to reach a level of maturity whereby health education can assert its independence, have its own unique identity, be autonomous of other subjects… make its own decisions, and sustain itself. ([26], p. 92)
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Given that the NZC supports a health promotion approach (refer to Chapter 4.3), understandings from this discipline may support health education to work towards maturity.

Health promotion supports a settings-based approach, which in schools is often termed Health Promoting Schools (HPS). This systematic approach ideally
brings together inter-related aspects of school and community organisation and acknowledges (among other things) that promoting health requires students to be engaged in health-related education which will involve them learning about and taking action in their wider school environment and working in partnership with their community. ([104], p.19)

Some schools in this study were already implementing HPS as an extracurricular activity students chose to join. This was generally organised by the Public Health Unit and a motivated teacher. Health promotion actions were often implemented as discrete components with little impact on school policy. Health education teachers in this study identified that academic privileging and limited resources sometimes constrained whether the true essence of HPS was embraced. Several authors also highlighted the lack of resource support by school management as a barrier to implementing HPS [127, 128, 133] (refer to Chapter 4.3.5).

HPS offers insights into how health education and health messages can find a voice within the school and community environment. At a classroom level, more health education learning could be experiential in nature. The critical action cycle offers an approach for students to address real world issues outside the classroom. This generally only happens in health education at an NCEA level in this study. Learning pathways should also support the diverse backgrounds of students [26].

HPS offers a framework that more explicitly fosters connections within the wider school community through collaboration with school management, subject teachers, counsellors, parents, and external agencies. School community members might begin to take a more active role in the construction and implementation of health education and school health initiatives. In this study, external agencies generally played some part in the implementation of health education whereas parental engagement was perceived as limited. While acknowledging the difficulties of involving parents in school life [152], several authors highlight that community engagement can be supported through creative, culturally aware and democratic processes [121, 133, 149, 212]. Community engagement is challenging and Langford and Bonell [221] reported that community engagement may not be effective in some schools. Instead, they suggest that focusing on school level approaches may be the best approach.
At the school ethos and environment level, the marginalised position of health education needs to be challenged. Senior management and school leadership could take greater ownership of actively supporting health education and aligning school policy with the health and wellbeing of students and teachers [86, 120, 122, 129-132, 222]. School health messages should attempt to be consistent with those included in school health education. Supporting the integration of health messages within other subjects and teaching practices would support this.

Health Education is an important subject in supporting students to learn about health. If the government and schools take this responsibility seriously they may need to provide stronger policy directives for health education in schools. Policy that legislates health education through to senior school and for a defined number of hours may support the subject health education to shift from its marginalised position. Some teachers in this study highlighted the need for this policy approach with one teacher stating, “I mean it should be a compulsory subject at every year level right through, for the same hours as English and maths and science” (T5). Better evaluation of school-wide health and health education initiatives in terms of educational outcomes [133] may also provide a starting point for supporting stronger health education policy. Rigorously establishing this link may form the platform for ensuring health education remains on everyone’s agenda.
Chapter 8 Conclusions

This thesis provides evidence of the social, knowledge and agential processes underpinning the subject health education in NZ secondary schools. Underpinning health education is an instructional direction that draws on three main discourses: student-centred learning, contextual learning, and competency development. This instructional direction and teachers’ reflexive inquiry generally guided how teachers delivered health education to students.

Classroom relationships were generally oriented towards a democratic approach; although the level of engagement in this approach varied across schools. Health education was delivered using a modular sequence and the pace was inclusive of students’ diverse learning needs. The selection of content was generally shared, to some extent, between teachers and students; teachers provided classroom activities and content and students shared their personal health experiences. National Certificate of Educational Achievement (NCEA) requirements meant teachers often maintained greater control over content selection. Underpinning classroom health education content were the mutually supportive discourses of health promotion models, health skills, and everyday contexts. This generally guided teachers’ emphasis on students’ informed application of health skills in a variety of everyday health contexts. Evaluation of students’ understandings of health education was generally driven by assessment procedures in NCEA, and in junior or senior school through observation of students’ participation and contribution in class.

Health Education was generally underpinned by an orientation towards the everyday health contexts of students’ lives. A focus on contextual learning ensured learning remained relevant and meaningful. An orientation to meaningfulness opens up dialogue about the diverse learning needs and health experiences of students and the relevance of the skills, concepts, and content included in health education.

This study affirmed that establishing the value and need for health education in secondary schools is essential. School and government policy directives need to work towards providing equitable time and resource allocation for health education, across all school Year levels. Establishing policy guidelines for external agency involvement in
school health education, which involves evidence of programme evaluation and effectiveness, may also further strengthen their relevance and alignment to the New Zealand Curriculum (NZC).

Building relationships with parents and caregivers can be challenging. Involving communities in co-curriculum creation, alongside the capacity to share opinions about health education, may create a greater sense of community ownership and investment in health education.

Professional development and pre-service teacher training opportunities that closely align with the socio-critical direction of health education, alongside alignment to the NZC, may ensure professional development remains meaningful for teachers. State provided advisors and national investment in oversight and evaluation of professional development programmes, may stimulate the growth of a learning environment that provides accessible and relevant learning experiences for teachers.

Further research exploring the role of culture, gender, assessment, and experiential learning in health education may provide further support for ensuring a relevant and meaningful health education experience for students.

As a subject, health education has increasingly found itself struggling for recognition in schools, particularly at a senior level. National and local investment is essential if health education is to reach a level of subject maturity and value within NZ secondary schools. It is important that students receive a quality teaching and learning experience in health education; teachers in this study were focused on this. Teachers valued the relevance and meaning this subject had for the students they taught; recognising in the future these skills may become useful in students’ lives.
References


164. Durling, N., L. Ng, and P. Bishop, The education of years 7 to 10 students: A focus on their teaching and learning needs. 2010, New Zealand Ministry of Education Wellington, New Zealand.


Appendix A: New Zealand Health Promotion Competencies Framework

Overarching New Zealand Health Promotion Competencies Framework, original [83], p.8-9.

The various shades of blue represent waiora: life-giving water and essence of spirit.

The pitau fronds symbolise the flow, direction and current taking us towards better professional practice, personal development and growth.

The fronds layer and blend, embodying the essential components of health promotion practice, the support of each other and the communities we work with.

**Explanation of the structure**

- The dark frond represents our commitment to Te Tiriti o Waitangi.
- The mid-blue frond at the back is the foundation of values and ethics.
- The turquoise frond represents the body of knowledge.

Ngā Kaiakatanga Hauora mō Aotearoa Health Promotion Competencies for Aotearoa New Zealand

- Nine small pitau depict the clusters of practice.
- The three wedges represent the toi huarewa, the appendages that Tāne and Tāwhaki used to ascend to the heavens to acquire knowledge.

All parts of the competencies are interdependent, interrelated and collectively complete the picture.
Ngā Kaupapa Whaihua – Health Promotion Values

The values that are central to health promotion practice in Aotearoa New Zealand are:

- **Te Tiriti o Waitangi** – Respect for, and commitment to, and protection of Te Tiriti o Waitangi, including the application of Te Tiriti o Waitangi to the actions and everyday practice of health promotion
- **human rights** – Respect for and commitment to hauora as everyone’s right based on the mana and dignity of people, communities and individuals; everyone being able to realise their human rights; and respect for and commitment to rangatiratanga, manaaki, tapu and noa
- **equity** – Commitment to improving health equity and the fair distribution of the determinants of health and wellbeing, taonga tuku iho, tinana, wairua, hinengaro and mana
- **determinants** – Commitment to improving the social and environmental determinants of health which include social justice, equity, participation – whakamana tāngata, whai oranga, whai wāhi, tia ao me nga mea katoa e whakapiki ake i te hauora
- **interdependence** – Recognition of the interdependence of individuals, families, communities and the broader environment. This includes recognition of te ao turoa, whakawhanaungatanga, whānau, whānau ora, kotahitanga and whatumanawa
- **aroha** – Respect for peoples’ rights to aroha, awhi and hauoratanga
- **integrity** – Commitment to acting honestly, ethically and with integrity – he mahinga i runga i te mahi tika me te mana tāngata me he ngakau tapatahi.
Appendix B: Archer’s Methodological Tools

The following table outlines Archer’s methodologic analysis of the knowledge relations and practices of teachers [48]. The internal relations between different discourses are shown in Column 1. From these relations a new knowledge property emerges (Column 2). This new property then conditions the knowledge practices of teachers (Column 3), from which a new knowledge property emerges (Column 4).

<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relations between different discourses</td>
<td>Emergent property</td>
<td>Teachers’ knowledge practices</td>
<td>Emergent property</td>
</tr>
<tr>
<td>Internal, concomitant complementary</td>
<td>Systemisation</td>
<td>Humans attempt to protect and deepen an ideology and diversity is ignored. Privilege is gained through problem-free advocacy</td>
<td>Reproduction</td>
</tr>
<tr>
<td>A invokes B, both mutually supportive</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal constraining contradictions</td>
<td>Syncretism blending of different thoughts</td>
<td>A person attempts to correct the relationship of A and B, by redefining both, so A remains correct. Maintains privilege and power</td>
<td>Unification</td>
</tr>
<tr>
<td>A invokes B, but B is in disagreement with A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>External and Contingent Complementary</td>
<td>Specialisation</td>
<td>People adhere to A but explore opportunities of B and take advantage of them</td>
<td>Sectionalism</td>
</tr>
<tr>
<td>Believe A, but there is freedom to explore B</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

153
<table>
<thead>
<tr>
<th>External and Contingent Incompatibilities</th>
<th>Pluralism</th>
<th>Choice</th>
</tr>
</thead>
<tbody>
<tr>
<td>A and B are incompatible. A does not invoke B, therefore people are needed to argue against B to initiate movement in knowledge</td>
<td>Groups argue against B to force ideational competition between interest groups, even though there is no direct ideational challenge. People choose sides</td>
<td></td>
</tr>
</tbody>
</table>
Appendix C: Category B Ethics Approval

Dr R Egan  
Department of Preventive and Social Medicine  
Dunedin School of Medicine  

19 May 2015  

Dear Dr Egan,  

I am writing to confirm for you the status of your proposal entitled “The purpose and practice of teaching health in New Zealand secondary schools: Exploring health teacher’s personal experiences”, which was originally received on May 5, 2015. The Human Ethics Committee’s reference number for this proposal is D15/145.  

The above application was Category B and had therefore been considered within the Department or School. The outcome was subsequently reviewed by the University of Otago Human Ethics Committee. The outcome of that consideration was that the proposal was approved.  

Approval is for up to three years from the date of HOD approval. If this project has not been completed within three years of this date, re-approval must be requested. If the nature, consent, location, procedures or personnel of your approved application change, please advise me in writing.  

Yours sincerely,  

[Signature]

Mr Gary Witte  
Manager, Academic Committees  
Tel: 470 0256  
Email: gary.witte@otago.ac.nz
Appendix D: Principals and Teachers Letter of Introduction to the Study

Principals’ email letter

Name

Cancer Society Social and Behavioural Research Unit

Department of Preventive and Social Medicine

University of Otago

04/05/2015

«AddressBlock»

«GreetingLine»

My name is X and I am a Masters of Public Health student at the University of Otago, conducting research exploring Otago secondary school Health teachers’ personal experiences of health education.

I am seeking participants who are interested in engaging in a 40-60 minute audiotaped interview exploring their personal learning and teaching experiences of health education. The information gathered will hopefully inform education stakeholders about how to further support teachers and students, to have positive and meaningful health education experiences.

I am writing to enquire if «School» would be interested in engaging in this research project. I have attached an information sheet outlining the aim of the research project and what teachers will be asked to do, if they choose to participate. The interview will occur in a location and time chosen by the teacher. If «School» is interested, would it be possible to provide me with the names of the Health teachers who may potentially be interested in participating.

If you have any questions after reading the project outline, please feel free to contact me at graan536@student.otago.ac.nz or Ph 0273057683.

I will follow up this letter with a phone call to see if «School» would like to participate.

Thank you for taking the time to consider being part of this research project.

Yours sincerely
Teachers’ email letter

Cancer Society Social and Behavioural Research Unit
Department of Preventive and Social Medicine
University of Otago
18/05/2015

Department of Health and Physical Education
X High School
-- Street
Dunedin 9013

To whom it may concern

My name is X and I am a Masters of Public Health student at the University of Otago, conducting research exploring Otago secondary school Health teachers’ personal experiences of health education.

I am seeking participants who are interested in engaging in a 40-60 minute audiotaped interview exploring their personal learning and teaching experiences of health education. The information gathered will hopefully inform education stakeholders about how to further support teachers and students, to have positive and meaningful health education experiences.

The principal of X High School where you currently work identified you as a Health teacher and a potential participant for this project. I have attached an information sheet outlining the aim of the research project and what you will be asked to do, if you choose to participate. We will do the interview in a location and time chosen by you.

If you have any questions after reading the project outline, please feel free to contact me at graan536@student.otago.ac.nz or Ph 0273057683.

I will follow up this letter with a phone call to see if you would like to participate.

Thank you for taking the time to consider being part of this research project.

Yours sincerely
Appendix E: Information Sheet for Participants

The purpose and practice of teaching health in
New Zealand secondary schools:
Exploring Health teachers’ personal experiences.
Information Sheet for Participants.

Thank you for showing an interest in this project. Please read this information sheet carefully before deciding whether or not to participate. If you decide to participate, we thank you. If you decide not to take part there will be no disadvantage to you and we thank you for considering our request.

What is the Aim of the Project?

This project seeks to explore Otago secondary school Health teachers’ personal experiences of health education. Three broad themes (personal, professional and policy) will guide the exploration. In-depth discussion will explore teachers’ personal experiences related to:

* The purpose and value of health education
* Health issues for students
* Health education models and concepts
* The planning and teaching of health curriculum
* School and community relationships
* Diversity, inclusion and gender issues
* School policy
* Classroom environment

Information gathered will build on current New Zealand evidence about health education in secondary schools and Health teacher’s experiences. This will hopefully inform education stakeholders about how to further support Health teachers and students to have positive and meaningful teaching and learning experiences.

This project is being undertaken as part of the requirement for Anita Grant’s Master of Public Health and being co-supervised by Dr Richard Egan (Department of Preventive and Social Medicine) and Catherine Morrison (Department of Education) from the University of Otago.

What Types of Participants are being sought?

Participants recruited for this study will be Otago secondary school Health teachers. Teachers will be sampled from schools selected by the researcher, based on school structure and social environment. School principals will be approached first to approve school and teacher participation.
What am I required to do if I participate?

You are invited to take part in a voluntary 40-60 minute interview with the researcher. The interview will occur in a location and time chosen by you.

This project involves an open-questioning technique. The general line of questioning includes; asking about your personal experiences of the purpose, theoretical foundation, planning and teaching of health education. Your experiences will be explored in relation to the classroom setting, the school community, and the political environment that you teach in. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops. Consequently, although the Department of Preventive and Social Medicine is aware of the general areas to be explored in the interview, the Ethics Committee has not been able to review the precise questions to be used. In the event that the line of questioning does develop in such a way that you feel hesitant or uncomfortable you are reminded of your right to decline to answer any particular question(s).

After the audiotaped interview is transcribed it will be emailed to you for verification of accuracy and meaning.

The risks for participating in this study are minimal. The interview will involve eliciting your emotions and experiences about your job. The only risk in this study is the possibility of experiencing some emotional distress from discussing aspects of your job. If you feel uncomfortable at any time, you may choose to skip the question and decide not to take part in the project without any disadvantage to yourself. If you need further support you can contact the Employee Assistance Programme (0800 327 669) or Lifeline 24/7 helpline (0800-543-354).

What information will be collected and what will happen to it?

Information that will be collected will include your demographic details, audiotaped and transcribed interview data and any documents provided by you. Interviews will be transcribed by a person who has signed a confidentiality agreement.

The data collected will be securely stored in such a way that only those mentioned below will be able to gain access to it. Data obtained as a result of the research will be retained for at least 10 years in secure storage. Any personal information held on the participants will be destroyed at the completion of the research even though the data derived from the research will, in most cases, be kept for much longer or possibly indefinitely.

The information will be analysed and reported in a way that makes every attempt to prevent identification of the participants or schools involved. Information may be published and will be available in the University of Otago Library (Dunedin, New Zealand)

What if Participants have any Questions?

If you have any questions about our project, either now or in the future, please feel free to contact either:-
<table>
<thead>
<tr>
<th>Student</th>
<th>Primary Supervisor</th>
<th>Co- Supervisor</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anita Grant</td>
<td>Dr Richard Egan</td>
<td>Catherine Morrison</td>
</tr>
<tr>
<td>Department of Preventive and Social Medicine</td>
<td>Department of Preventive and Social Medicine</td>
<td>College of Education</td>
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<tr>
<td>University of Otago</td>
<td>University of Otago</td>
<td>University of Otago</td>
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<tr>
<td>Ph- 03-4797209 / 0273057683</td>
<td>Ph- 03-4797206</td>
<td>Ph- 03-4794932</td>
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<tr>
<td><a href="mailto:graan536@student.otago.ac.nz">graan536@student.otago.ac.nz</a></td>
<td><a href="mailto:richard.egan@otago.ac.nz">richard.egan@otago.ac.nz</a></td>
<td><a href="mailto:catherine.morrison@otago.ac.nz">catherine.morrison@otago.ac.nz</a></td>
</tr>
</tbody>
</table>

This study has been approved by the Department stated above. However, if you have any concerns about the ethical conduct of the research you may contact the University of Otago Human Ethics Committee through the Human Ethics Committee Administrator (ph 03 479-8256). Any issues you raise will be treated in confidence and investigated and you will be informed of the outcome.
Appendix F: Participant Consent Form

The purpose and practice of teaching health in New Zealand secondary schools:
Exploring Health teachers’ experiences.

Consent form for participants.

I have read the Information Sheet concerning this project and understand what it is about. All my questions have been answered to my satisfaction. I understand that I am free to request further information at any stage.

1. I understand that my participation in the project is entirely voluntary.

2. I understand I am free to withdraw from the project at any time without any disadvantage.

3. I understand that personal identifying information from recorded demographic details, audio-taped and transcribed data or text documents, will be destroyed at the conclusion of the project, but any raw data on which the results of the project depend will be retained in secure storage for at least ten years.

4. I understand this project involves an open-questioning technique. The general line of questioning includes; asking about my personal and professional experiences of the purpose, theoretical foundation, planning and teaching of health education. My experiences will be explored in relation to the classroom setting, the school community and the political environment that I teach in. The precise nature of the questions which will be asked have not been determined in advance, but will depend on the way in which the interview develops and that in the event that the line of questioning develops in such a way that I feel hesitant or uncomfortable I may decline to answer any particular question(s) and/or may withdraw from the project without any disadvantage of any kind.

5. I understand that information about the project may be published and will be available in the University of Otago Library (Dunedin, New Zealand), but every attempt will be made to preserve both school and personal anonymity.

I agree to take part in this project.

......................................................................................  ........................................

(Signature of participant)   (Date)

......................................................................................

(Printed Name)
Appendix G: Hierarchical Code Book

Code Book.

School wide approaches
Health Promoting Schools
School ethos
School wide approaches for health
Support systems for managing students’ wellbeing

Teacher reflection
Personal reflection on identity values, purpose of teaching Health
Personal reflection on their social role as a teacher
Teachers collaboratively reflecting
Teachers reflecting on their position in school

External Agencies
What external agencies do teachers engage with? (What do they offer, what topics do they cover, how available are they, burden of agencies and resources, focus on minority issues)
Appropriateness of external agency programme content
External agencies as a support, not substitute
Greater use in senior school
Teachers are able to communicate what they want external agencies to provide

Assessment
Purpose of assessment
Senior and junior health is not assessed
Reporting assessment to parents
Assessment procedures
NCEA assessment

Structure of Health in school
Health and PE share overall time allocation given to HPE
School structure for Years 9–10
School structure for senior Years 11–13
School structure for year 7–8
Structure- throughout the year vs block courses
Structure of NCEA

Classroom transmission
Cultural diversity in the classroom
Gender differences
Collaborative group work and discussion (interactive, sharing, students’ health literacy enables group work)
Teacher directed transmission of information
Teacher facilitates classroom dynamics
Teachers create their own student relevant health resources to use in class
Use of school-wide personnel to teach in class
Teachers focus on enabling students to apply their knowledge to everyday contexts
Activities teachers are using in classrooms
Incorporating NCEA in junior health

**Learning levels**

School streaming
Teachers scaffold learning activities to ensure diverse learning needs are met
Teachers are aware of the different developmental, emotional levels of students
Sequencing learning
Students are able to choose to engage (opt in opt out)
Teachers are asking students what their health needs are

**Consultation**

Consultation attracts little parental engagement
Parents’ concerns driven around sexuality education
Parents’ views are often indicative of where students’ developmental health knowledge is at.
Teachers are aware of policy requirements for consultation every 2 years
Teachers are informing parents of students’ health issues
Teachers using surveys to obtain greater representative responses

**Health in the school**

Crowded curriculum (timetables)
Health competes against other academic subjects.
Health is valued for its foundational importance for student learning
Health requires a strong expert to advocate
NCEA health struggles for position
Senior management determine the structure of Health
Students are removed from health, as it is not seen as an academic subject

**Curriculum content**

Competency development (Managing themselves, literacy skills, self-confidence, relational skills, applying knowledge, healthy choices, thinking)
Curriculum topics
Theoretical models of learning (Hauora, decision making, critical thinking, critical action)

**Professional Development**

Benefits of professional development
Negative issues with professional development (Schools lack time and finances to attend, often narrow focus, burden of resources, lacks a focus on ethics and values, limited focuses on changing topic areas
Teachers take health by default
Teachers aware that they do not access professional development

**Planning curriculum**

Policy influences (NZC, special character)
Balancing different school community perspectives
Prioritising students’ needs and health issues
Collaborative planning

**Student Engagement**
Teachers are concerned that students are not hearing enough of the right messages
Students value health learning
Students do not put into practice what they learn outside of the classroom

<table>
<thead>
<tr>
<th>Teacher Attributes</th>
<th>Attribute Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
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<td>35-39</td>
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<td></td>
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<td></td>
<td>45-49</td>
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<td></td>
<td>NZ Māori</td>
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<tr>
<td></td>
<td>NZ Tongan</td>
</tr>
<tr>
<td></td>
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<td>Sex Teacher</td>
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<td></td>
<td>Male</td>
</tr>
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<td></td>
<td>Other</td>
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<tr>
<td>Bachelor Degree</td>
<td>Physical Education Degree</td>
</tr>
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<td></td>
<td>Bachelor of Education</td>
</tr>
<tr>
<td>Years of teaching Health at secondary school</td>
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<tr>
<td>School Attributes</td>
<td>Attribute Value</td>
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<td>---------------------------</td>
<td>--------------------------</td>
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<tr>
<td>Geographic Region</td>
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<tr>
<td>Special Character</td>
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<tr>
<td></td>
<td>Yes</td>
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<tr>
<td>School Type</td>
<td>State</td>
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<td>State integrated</td>
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<td>Student Membership</td>
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<tr>
<td></td>
<td>Single sex boys only</td>
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<td>Single sex girls only</td>
</tr>
<tr>
<td>School Year</td>
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<tr>
<td></td>
<td>9-13</td>
</tr>
<tr>
<td>Type of Curriculum Offered</td>
<td>Junior</td>
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<td></td>
<td>NCEA</td>
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<tr>
<td>School Decile</td>
<td>5-6</td>
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<tr>
<td>--------------</td>
<td>------</td>
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<tr>
<td></td>
<td>7-8</td>
</tr>
<tr>
<td></td>
<td>9-10</td>
</tr>
</tbody>
</table>
Appendix H: Thematic Mapping

I.1- Draft Thematic Map – Produced at the level of the codes on October 8th 2015
I.2 - Draft Thematic Map – Produced on December 2nd 2015
## Appendix I: Table of School and Teacher Characteristics

<table>
<thead>
<tr>
<th>Schools characteristics</th>
<th>School Attributes</th>
<th>Number of schools</th>
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<tr>
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<td>(sample size 8)</td>
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<tr>
<td>Geographic region</td>
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<tr>
<td>School type</td>
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<td>School Year</td>
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<td></td>
<td>Co-educational</td>
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<td>School Decile</td>
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<tr>
<td></td>
<td>7-8</td>
<td>2</td>
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<td></td>
<td>9-10</td>
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<tr>
<td>Special Character</td>
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<tr>
<td>Teacher characteristics</td>
<td>Teacher Attributes</td>
<td>Number of teachers (sample size 8)</td>
</tr>
<tr>
<td>-------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------------------------</td>
</tr>
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<tr>
<td></td>
<td>Female</td>
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<td>Ethnicity</td>
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<td></td>
<td>NZ Tongan</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>NZ Māori</td>
<td>1</td>
</tr>
<tr>
<td>Professional qualifications</td>
<td>Physical Education and Diploma for Graduates in Education</td>
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<tr>
<td></td>
<td>Bachelor of Education Degree</td>
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</tr>
<tr>
<td>Other schools roles</td>
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<td>Pastoral Staff</td>
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<td>Junior School</td>
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<tr>
<td></td>
<td>Senior School</td>
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<tr>
<td>Years teaching Health</td>
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</tr>
<tr>
<td>-----------------------</td>
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<td>5</td>
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<tr>
<td>Years of being HOD of HPE</td>
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</tr>
<tr>
<td></td>
<td>≤5</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>≥6</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendix J: Thematic Framework Construction

This framework reports on the construction of the final thematic map. Each column describes the themes and subthemes, with further exemplifying quotes developed from iterative coding of the transcribed interviews.

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Education in Schools</td>
<td>Marginalising Health Education</td>
<td>It has always been a subject that is considered important; unfortunately, obviously not important enough to have in senior school, but still considered really important. It is supported by senior staff, counsellors, PhysEd staff, and other people. Yeah it is just an integral part to our school ethos. (T4)</td>
</tr>
<tr>
<td>What status and position does health education have within the school environment</td>
<td>The value of health education within a crowded school curriculum</td>
<td>Year 11–13, we don’t have any set Health curriculum, but we do have sort of little blocks that we do… so we have kind of grabbed it from wherever we can now. (T4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The class was originally thirty-seven and I was told that I would only be able to have two NCEA classes so I had to pick and choose students, so I got it down to twenty-eight. (T8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>In terms of funding we do get a healthy budget for resourcing, they are very good at making sure what we get what we would like to have to teach to, within the restraints of what they can. (T8)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The amount of time we have got, it fits our</td>
</tr>
</tbody>
</table>
programme if we were to ask for more time, to do more Health, we would have to present a fairly strong argument as to why that would be needed, as there are lots of subjects all vying for student time. It is a pretty good Health, sadly there is stuff that I think could be extended a bit more. (T7)

Schools are under a bit more pressure now, especially at senior level to run courses that have NCEA credits. Just to run courses that don’t have them is not a done thing now. I think you have to justify having the standards, just to justify the paper. (T5)

<table>
<thead>
<tr>
<th>Integrating Health Education</th>
</tr>
</thead>
<tbody>
<tr>
<td>What subjects or school initiatives is health education integrated into within the wider school environment?</td>
</tr>
</tbody>
</table>

The messages that you are giving in Health should be reflected across the school in all areas. (T6)

And you don’t always know that the messages you are promoting are the same as what are coming from home. (T6)

It’s tough, you don’t know, you just hope that there is enough messages getting through. (T5)

We look at managing and planning meals, to meet the needs… It is really hard to change that mindset, it is a constant battle. And that is through the media and through their own school community, the parent input, there is a lot of parent pressure sometimes as well. (T3)
We have a really good guidance counsellor; our pastoral care is really good… There are lots of communications systems in place, and it’s easy for kids to either self-refer or we refer them to the counsellor. (T4)

Our Chaplin runs the RE courses and I guess she has her schemes of work which look at history and understanding religion for what it is, but elements of spirituality within that… the girls have a quite good understanding of spiritual wellbeing and morals and values and identity. (T3)

The level 2 PhysEd programme and level 3… I don’t teach that, but that’s all around health promotion and the action learning competency cycle. (T4)

I think the only issues are through the school-wide health initiatives. People are maybe a little bit apprehensive, and not because they don’t believe in it, just because maybe their self-confidence, you know, are they capable of running a mindfulness session or something like that. (T3)

But we have a lot of student driven clubs, wellbeing clubs, peer supports. (T3)

Although there is the health promoting schools group… so they will have meetings through the year with students from different schools and talking about programmes set up in various schools. (T1)
I wasn’t part of the health promoting school when I was there, but I think I should have been, but it was one step too far to think about… That certainly raises your profile. (T6)

<table>
<thead>
<tr>
<th>Wider School Community Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health education teachers’ relationships with people or agencies within the wider school community</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Parents and Caregivers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relations between parents/caregivers and health education teachers</td>
</tr>
<tr>
<td>Community consultation processes for health education planning</td>
</tr>
</tbody>
</table>

I think you have to have a strong hope that families are supporting what is going on in school. There has got to be a bit of a relationship there, I think, a bit of collaboration, ideally. (T6)

I have found that while people say they are going to come (to the consultation) and be part of that, they tend to forget and not turn up. (T6)

We send out surveys to the student body to all the parents, so what would they like to see, and then they can actually reflect and evaluate what goes on and that is an opportunity as well, we have a community seminar and they can come and contribute and that just informs the process as well. (T1)

We haven’t had any, like I haven’t had any parent, maybe one parent, over the last seven years who has said they are not sure if my son should be in that class, otherwise I haven’t heard from any parents at all. (T7)

We always warn the parents that we are going to be talking about, this is what is coming up, and we always send a letter home telling them
what we are doing in that unit. (T4)

When we have Mates and Dates, we have an evening so the parents can come in and look through the programme, and obviously there are consent forms and so forth attached with that. (T2)

We also try to hold a lot of parent seminars, saying this is what the issues are, this is what we are trying to do, and we require your support. (T3)

<table>
<thead>
<tr>
<th>External Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External Agency involvement in providing health education in schools, and their relationships with health education teachers</strong></td>
</tr>
</tbody>
</table>

As the head of department I get a lot of mail from various organisations that want to come in and present stuff or provide resources. (T1)

We get people from family planning and Agency X and G and other organisations come in and run things, we are perfectly capable of doing it ourselves but sometimes it is quite good to get other people as well. (T4)

It is always interesting with outside providers because they don’t have a teaching background, they seem to struggle because they are coming in cold. It takes, the boys see it more as a novelty, they obviously use it to ask silly questions and things. (T2)

People may come in, there was some people last year, and they were good, and the messages were fantastic, but it just was not
| **Becoming a Teacher of Health Education** | **Reflexive Inquiry** |
| Teacher’s personal and professional journeys into becoming a health education teacher | How teachers’ reflexive inquiry influences their teaching practices, and perception of the purpose of health education |
| | I think that Health is a really cool subject to teach and most of the time the kids enjoy it… because they are talking about themselves, so they can readily identify with some of the issues, and they get to ask those questions they might not be able to ask at home, and get, you know, clear information. (T4) |
| | We are trying to build within the students resiliency, decision-making skills, confidence, and awareness and those sorts of things… trying to get them to identify their responsibilities and expectations and encouraging them rather than kind of fall into line. (T3) |
| | We monitor the kids closely, and the guidance counsellor, and the head of our pastoral team are involved… they will be, this is a really common theme for the last few weeks, we need to kind of watch the students in this form, how can we support them, what are we doing, reflecting on ourselves and what is happening in our programmes. (T3) |
| | We are both Christians, and I guess that drives a lot of our values and stuff, in terms of the spiritual thing that perhaps other people don’t feel… I don’t teach that particular component very well either. (T5) |

that engaging for the students… the ones who we find really effective have a good balance of engaging the students, they are great. (T3)
You do have to be careful not to share too many intimate things about your own life. We have all learnt from sharing different things and later it has sort of turned on you, but you do have to really not bring your own baggage or your own stuff. (T4)

We have a questions box. And I have learnt some scary stuff doing that… The first year I had a philosophy, I will answer everything; the second year I decided not to address stuff that was clearly designed to make probably me feel embarrassed. (T5)

Our PhysEd department is really strong and every single one of us are confident teaching health, and have good knowledge and you know we don’t have any problems with any of the units that we teach, and we have all been teaching it for a long time, and feel we have the tools there to do that. (T4)

I guess every PE teacher is going to be teaching Health. (T3)

I went to university planning on becoming a PE and Health teacher, and along the way I got side tracked and ventured into sociology, and looked at the role of the media and those sorts of things… Then went back to do a Graduate Diploma at the former Teachers’ College… and by rights you need to do PE, Health, and another subject. But Health is really interesting, and they have a really good
| Professional Development Teachers’ experiences of engaging with different professional development opportunities | R: Could you share a bit more about the cluster meetings that you might have been involved in?

T3: It is usually driven by the Teachers’ College; they will have someone from a specific area, from the mental health organisation, and you will just go and listen to what they do, and strategies that they think are working well… I guess a lot of them are focused around probably the physical education side, but it is just the Health teachers who go. (T3)

On the TKI website there are quite a lot of resources in terms of some of that senior stuff which I look at, because I think that often your junior programme feeds into that. So looking at what is expected at higher up can give us some ideas about what may be useful. (T1)

I have got two teachers who are doing professional development through family... |
planning on puberty… they call it, Road Map… that is a separate resource that is relatively current, that is good for Year 8 puberty, sexuality. (T7)

R: Did you do professional development?

T6: Yeah I went to every course I could get my hands on, but that kind of petered out I suppose over the years. I just got too busy to go. (T6)

I go back and talk to the people at Teachers’ College about the strategies they use to develop that. (T3)

The funding I suspect has dropped off for delivering health education professional development… I don’t see so much of that offered… And I guess it totally would be a resourcing thing, and they would think ‘oh well those teachers would have got all of that professional development in the past’, but many of those teachers may not be teaching any more. So the new wave of people coming through miss out. (T8)

Often it is sort of individual organisations will run programmes and if we have the money in our budget to go to them, we will send people to them. (T1)

Because teachers are always wanting resources, and they are wanting, okay how can I get a cool fun activity for my kids to do in my lesson… this one (health education
curriculum) is a little bit more flexible, little bit more airy, discuss, reflect, feelings and emotions and these sorts of things, and it can be different, so there is a bit of professional development about that, maybe it’s dropped off because lazy people like me haven’t made that step to pursue more, and so therefore people aren’t getting the feedback, or the interest, umm. (T3)

<table>
<thead>
<tr>
<th>Student-Centred Health Education</th>
<th>Students’ Health Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>The school perspectives health education teachers are inquiring into when planning health education</td>
<td>Teachers’ perceptions of students’ health priorities and health concerns.</td>
</tr>
</tbody>
</table>

Just I suppose recognising that there’s a clear relationship between Health and PE, and the two work together, to stop this obesity epidemic that is currently happening in NZ. (T2)

I guess there are all of those issues around pregnancy and girls being taken advantage of, I think they find it really hard to be assertive and to state their needs and wants and not to be manipulate. (T4)

Instagram, and all those things when people send photos of themselves, and talk about what they are going to do and all those sort of things. (T4)

We don’t have a lot of bullying, it is fairly open, boys are generally pretty respectful, but that is still something that needs to be reinforced. At senior level I think perhaps being independent, independent thinkers would be one, and having the self-esteem and confidence to be that, so therefore looking at
peer pressure and relationships and how boys can think on their own rather than going along with the crowd. (T7)

We actually have a school counsellor… and I know through talking to him, he does deal with a number of boys stressed out with exam pressure, and dealing with mental issues in terms of coping mechanisms, depression and anything else. (T7)

There is very high expectations in our students… they are quite competitive, so there is huge anxiety and a lot of burnout. (T3)

It is students’ needs and the health consultation with the community informs that as well. (T3)

I don’t know if it’s particularly in a girls’ school, but healthy eating, exercise and nutrition comes out quite strongly as well. Often at the start of a unit I would say what do you think we should be covering here? We just do a big brainstorm on the board, I keep a list of that and at the end we go back over it with them, we talked about this and this, so they can see that they have fed into it. You can tailor what you were planning to do, make sure you cover the things that they thought were important. But they don’t deviate very much. (T6)

If I look at the juniors we do a feedback survey at the end of each year, and the Year
9–10 are always asking for can we learn more sexuality, that is a really common thing for boys, and done in the right way is very empowering and it is good knowledge for them, so they are very open to it.  (T2)

---

**School Community Perspectives**

How teachers are drawing on different local and school community perspectives when planning health education

(Referring to the NZC) It is a juggle – but a lot of it is around just around organisation really. The thing is to, it becomes almost like a bit of a cycle, you know when things are due. For example, when we are setting up a program we look at the curriculum and what’s covered. (T1)

And it is a skills-based programme, and that is how it should be, it can be a lot more difficult to teach because it’s about discussions and reflection and challenging and expressing ideas and understanding different perspectives. (T3)

I also try and get them to do some writing too, so because we are trying to increase kids’ literacy skills. (T4)

I have a lot to do with the Head of Health and PhysEd at X school, and a few of the other schools around. There is a group of us that often meet to discuss what is happening in our programmes. (T1)

It would be collaborative with your guidance counsellor and your Chaplin if you are in that kind of school, and if you’ve got a health
nurse they would all be part of the team. (T6)

So we look from what has come back from the parent consultation and talking with the students or talking with the counsellor, and determining what are the key things for our school and our students. (T1)

We try and pick up on trends in different years, it’s about having a response I suppose, digital awareness and various other risks like that, we would have a response to things, according to what is happening. (T4)

<table>
<thead>
<tr>
<th>Health Education Content</th>
<th>Health Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>What health topics, content, and skills are included in the classroom health education curriculum?</td>
<td>Dealing with sexual relationships, dealing with mental health, dealing with cyber safety, keeping themselves safe, so I guess that is the focus, I imagine most schools will kind of try and promote that thing as well. (T3)</td>
</tr>
<tr>
<td>Then Year 10 we have a drug and alcohol unit, mainly alcohol and drug, oh Year 9 we also do tobacco education, Year 10 we have drugs and alcohol, sexuality, and that’s pretty much all we do at Year 10. (T4)</td>
<td>Mental health I think would be another popular area, Like in terms of the top three drugs, alcohol, and sex. Mental health, is gaining credibility I think, within health education, and I think that is helped by the curriculum acknowledging health is more than just the physical and that it is social, mental, and spiritual emotional aspects are</td>
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</table>
| Models of Health | We look at relationships in various forms, and that is skills like negotiating, decision making, communication that is going to help them build relationships and maintain them. (T3) 

If we can give skills, and they can see decision making is the most important thing in dealing with drugs and alcohol. (T3) 

It gives young people a view of the wider aspects that influence them, and it encourages them to critically analyse how this influences them positively or negatively. (T8) 

We assess in our junior school their ability to reflect and explain and identify how situations probably lead to impacts on their own different areas of hauora. (T3) 

I think it is really getting students to reflect a little bit on their own personal health, looking at models of health, things that are influencing their health, and reflecting on that. (T1) 

The first thing I always cover off is hauora, |
and we talk about what the healthy person looks like. (T2)

<table>
<thead>
<tr>
<th>Inclusive Content</th>
<th>What practices are teachers using to enable students to share their diverse experiences?</th>
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<td></td>
<td>So there needs to be input from the students, so it is just about establishing a culture where the students are comfortable in doing that. (T3)</td>
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<td></td>
<td>I think it has got to be taught by the right people… and if the wrong information is taught in a way that is not accepting of diversity or accepting of difference and that safety nets are not in place, I think that is really important. (T4)</td>
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<td>One of the things with Health classes is a lot of the comfort level is built from the start of the year. We spend a lot of time working on the ground rules for a class. I guess in terms of just respect within the class... If the people are feeling more comfortable within the class they are much more likely to share. (T1)</td>
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<td>I love cultures and languages, so for me embracing cultures is really easy, I know some teachers struggle with it… it’s really just teaching the rest of the class inclusion as well, so it’s about learning some aspects of their culture and language, and starting conversations like that, so encouraging the rest of the class to be actively involved in that inclusion process. (T8)</td>
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<td>That’s why that personal definition (of health) is good so again we just deliver a spectrum</td>
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and when we discuss what decisions you are going to make, we go right from A to Z, and saying well this is how these people from this culture may see it and this is how this culture may see it, and this culture, so you need to choose what is right is for you and your morals and values. (T3)

I think that because of the nature of the age of the boys they are all learning… they are all going through different things so they are aware of that and no one is made to feel uncomfortable if they are different… That is the good thing about our school… once you come through the gate you are just an X Boy and there are no real labels or anything. (T2)

I just said I will be as honest with you as I can… but obviously not share intimate details, but coming from my experiences and knowledge. (T5)

I definitely have found that stories and sharing stories is what they can engage with, and that’s someone in a video sharing a story… and the kids just hang on that, they want to hear real life stories. I find them the most powerful. Some kind of distance, it doesn’t relate to me. (T6)

<table>
<thead>
<tr>
<th>Teaching Practices</th>
<th>Modular Health Education</th>
<th>The PE component we believe is more important in terms of the kinaesthetic nature of it… so we are trying to make sure we have the split; that they have time outside the</th>
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<tbody>
<tr>
<td>students with diverse learning needs</td>
<td>knowledge students learn in health education?</td>
<td>classroom… that’s why we’ve done it based on our clientele, which is energetic boys. Then we try and link PE and Health together so it is mutual courses.  (T4)</td>
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<tr>
<td><strong>Inclusive Learning</strong></td>
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<td>The idea now is you don’t have to cover every bullet point in the curriculum at any given year level.  (T1)</td>
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<tr>
<td>Teachers employ diverse classroom</td>
<td></td>
<td>You know cyber safety which is covered at junior level, we kind of revisit that at least every two years we touch on things again. (T3)</td>
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<td>strategies to meet different students’ learning needs</td>
<td></td>
<td>That’s right, but they do need to know these kinds of concepts, so you have just got to keep coming back to that and making that platform, and if they have got that then come the exam things should fall into place.  (T8)</td>
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<td>We do have those theoretical concepts as well… But if we can break those down and unpack them and we can scaffold them to their (student) experience… so looking at discussion or scenarios, scenarios work really well, but once again it has to be the right scenario.  (T7)</td>
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<td>I guess what I shy away from when planning, is making it too dry and too based on literacy skills. I think that even though we have got some boys that perform highly, other boys have got learning support issues. Well health learning shouldn’t really be affected because of your literacy skills, so it is finding ways</td>
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around that, it is not to say that it happens all the time, but it is definitely one of the things I plan for.  (T7)

If the teacher in front of the class knows the class best, they can adjust programmes or ask different questions to different groups to try and get the best out of them.  (T1)

So some kids, you just know that they just want to know everything, but they are not really into anything, and other kids need to know everything, because they’re into lots, and it just depends on the class I think, so I think it is really important to know your students.  (T4)

You have got to do it according to the clientele and who your class is. If you have a bottom set class who is struggling with hygiene, you cover off some of that, where you may not need to cover that off with the high set class.  (T2)

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<tr>
<th>Collaborative Learning</th>
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<tr>
<td>Teacher as the facilitator of classroom group work</td>
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</table>

I think it is really important to know your students.  (T4)

But generally it is best if the teacher, the health or class teacher, is delivering these kinds of messages.  (T6)

It really comes down to the teacher, it absolutely comes down to the teachers… We have topics that perhaps where we are better at than other topics, and also a lot of it comes
down to the classes in front of you, and how much they give back.  (T1)

One of the focuses that we have talked a lot about in Health that we want them to be active in terms of discussing and engaging with other people in the class. (T1)

So we use those books, I use a whole bunch of my resources that I have developed as well, and they change every year, as I try to keep things current.  (T8)

The Year 10 are similar, they have a Health book that we work through that, sometimes it is writing down, activities, guest speakers, but we have this book that we refer to and can come back to.  (T7)

We just have like a big kete of resources that have been made over the last fifteen years and then we just access any kits that come out.  (T2)

We do a lot of scenario-based work with the students, and a lot of it we work quite closely with the counsellor at school to give real life models of things.

Working a lot in small groups, a lot of discussion, a lot of learning to listen and respond appropriately to different perspectives and always try and make links back to their own individual.  (T3)

The focus of the group activities is the
theoretical application of health and decision-making models to different health contexts students may find themselves in. (T7)

We try and make it as, a lot of group work, and a lot of interaction and a lot of talking and I do also get them to do writing and reflection. (T4)

We have our guidance counsellor comes as the link in keeping ourselves safe unit, talking to the kids. (T4)

| Student Assessment | I think that is helped by the curriculum acknowledging health is more than just the physical and that it is social, mental and spiritual, emotional aspects are important as well. I think kids coming through now have got a good grasp of that and that makes the teaching of Health easier. (T6) But there is a mix, I am not going to say all kids all 100% are engaged, because they are not, some of them may sit there and think this doesn’t apply to me I know everything already, which is quite concerning, some of the students will be like not that engaged because it is probably so far in the future, but we generally get a good mix, it is just about how we engage them, and to some level they are sharing, whether it is to themselves, or to their closest friend, or the class. (T3) It’s what I like about health education, children love learning about themselves |

| Teachers’ perceptions of students’ engagement in health education Assessment Strategies | |
(laughter) and then like T5 said, if you have a
great unit on alcohol, applying it to real life
situations outside of school, and that’s when
you know you have achieved something, but
you don’t often know that.  (T6)

I just know that the knowledge that is given to
them is always well received, as long as it is
topical, topical and current and relevant to
them, which is how we have really tried to
structure it, then they see the value in it.  (T5)

You can do a great unit on alcohol and the
kids can all write the correct answers, but you
only have got to watch the news and read the
papers to suggest that when it actually comes
to putting that into practice, we have got a
long way to go.  (T5)

I think of my Year 10s, we have just finished
a unit looking at around cyber safety, which is
something that is quite intrusive... They have
great knowledge and they know about
keeping themselves safe, keeping themselves
healthy, but they don’t necessarily put that
into practice. They can have all of the ideas
but they are still likely to send something silly
on Facebook, or respond to something they
shouldn’t. So I guess as well as making
students become more aware of these issues,
to actually try to put it into their everyday
lives as well.  (T1)

Where they can reflect on and talk about it
when it is maybe not necessarily happening to
them, they are looking at it from a third person type thing. But if it does come up for them in the future hopefully that little light flicks on. They say I remember doing this in Health. There is some relevance to it. (T1)

We report on it to parents, we just put it down as a report comment about their contribution in class their general understanding. (T7)

We have had in the past Year 11 – in the PhysEd course, we have used drugs and choices, decision making with drugs, which is an achievement standard there, and we probably used that for 3–4 years. That one we found because it was, it sounds bad, was the very last timetabled NCEA exam of the whole schedule. It was the boys’ very last exam, by that stage they had counted up how many credits they needed and half of them didn’t turn up for the exam… They prioritise what they need at that stage, in Term 4, learning about drugs and choices, well they have Maths, Science, English, which they perceive as being more valuable to them. (T7)