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**Teaching Health Education
in New Zealand secondary schools:
Policy into practice**

**A thesis presented in partial fulfilment of the requirements for the degree
of Doctor of Philosophy in Education at Massey University, New Zealand**

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ABSTRACT

Teaching Health Education in New Zealand secondary schools: Policy into practice.

Health education has a long informal history in New Zealand schools. This study attempted to illuminate and explain the effects on a small sample of secondary school health teachers of official policy changes in curriculum and assessment for Health Education in the period 1999 – 2004.

These teachers were deeply concerned about the health issues that they perceived their students were facing, and saw Health Education as a means of helping students address these. The publication of *Health and Physical Education in the New Zealand curriculum* (Ministry of Education, 1999) legitimated their teaching in a general way through the inclusion of issues they were concerned with (such as mental health and sexuality).

Teachers positioned themselves idiosyncratically in relation to a variety of personal discourses. Different subject positions were possible at school level because of the weak classification (Bernstein, 1971; 1996) of the 1999 curriculum. This was less likely to occur in senior health which was assessed at system level through the National Certificate of Educational Achievement (the NCEA). Health Education's inclusion in the NCEA resulted in pedagogical change for teachers in the study due to greater prescription of content and assessment requirements.

This study also illustrated the pedagogical and relational tensions that were created when Health and Physical Education were placed within the same official curriculum. Internal subject politics were intensified as teachers competed for resources within the one learning area.

Sexuality, gender and emotionality were three further layered discourses of teaching secondary Health Education illuminated by this study. Teachers generally positioned themselves in relation to a reproductive health discourse and several positioned themselves within an essentialist gender discourse. Emotionality was shown to have both personal and institutional dimensions.

Implications based on the findings were considered for teachers, policy makers, teacher educators and researchers.

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Chapter One

Introduction to the study

In this chapter the study is introduced; the research origins and focus are described; the relationship between the researcher and research is explained; and an overview of the thesis is provided.

1.1 Introduction

This thesis concerns the policy and practice of Health Education¹ teaching in New Zealand secondary schools. Policy and practice are examined discursively, that is in terms of their language, behaviour and relations over time. In the study, the dominant policy discourses are those of curriculum and assessment, and these in relation to broader political, economic and social discourses. Interwoven with these policy discourses² are three other significant discourses of teaching practice: sexuality, gender and the emotional dimensions of teaching. Underlying contemporary teaching discourses is the discursive inheritance of previous eras in New Zealand's Health Education history. Accordingly, contemporary policy and practice are examined in their historical context.

¹ In this thesis upper case is used to identify Health Education as part of the New Zealand curriculum. Since 1993, Health Education has been part of the Health and Physical Education Key Area of Learning, first in *The New Zealand Curriculum Framework* (Ministry of Education, 1993) and more recently in *The New Zealand Curriculum* (Ministry of Education, 2007). For other references lower case is used to identify the field of health education in its more general and historical sense. The teachers in the study referred to Health Education in abbreviated form (health) and this is also used in the thesis.

² 'Discourse' refers to knowledge shaped by words and actions and, always, power. A substantive discussion of discourse is located in Chapter Two.

The study began as an attempt to understand the impact of a rapidly changing policy environment on New Zealand secondary school teachers who teach Health Education. The analysis is based on interviews with twelve teachers from six schools during 2003 and 2004. The study's focus broadened in response to what was talked about during these interviews. Unsurprisingly, given the current policy emphasis on curriculum and assessment, the teachers talked extensively about these topics. They also talked about other topics and alluded to the emotional impact of teaching Health Education, indicated that Health Education was favoured by females, and shared insights about their experiences of teaching sexuality education. The study's parameters were therefore extended to accommodate other discourses, specifically sexuality, gender and the emotional dimensions of teaching.

1.2 Origins of the study

I first became interested in Health Education as a classroom teacher in a primary school during the early 1990s. The two aspects of Health Education which engaged me during this early period were sexuality education (then a controversial topic) and the potential for Health Education to influence school culture. As a primary school teacher, I was an enthusiastic supporter of Health Education – it fitted easily with my beliefs about the purposes of education, particularly the relational foundations of learning.

In 1996 I began a career as a Health Education teacher educator, working with early childhood, primary and secondary pre-service students. It was as a teacher educator that I realised I knew very little about the evolution or theoretical basis of Health Education. I also became aware that the meanings and importance I attached to Health Education were not always shared by other tertiary curriculum specialists, including those who taught Health Education. It became apparent that different experiences, knowledge and values affected meanings about Health Education and that it was a marginalised and low status

subject, particularly in secondary schools. In hindsight, this was the beginning of my realisation that for a teacher educator, it is not sufficient to be an enthusiastic and experienced teacher of Health Education; a more critical orientation is required.

After a few years, my lack of scholarly knowledge and understanding of Health Education became more significant as my craft knowledge (developed over some twenty years in the primary class room) became less immediately relevant. While I was comfortable with the applied nature of Health Education (my education students were generally enthusiastic about Health Education's relational pedagogy and opportunities for personal development), I was increasingly interested in gaining a clearer sense of purpose and direction. Discussions with colleagues and reading did little to move me closer to a deeper understanding. I therefore decided to take a more structured and academic approach and looked for university papers which would advance my understanding.

I was unable to find a paper which addressed the development of Health Education in New Zealand or one which shed light on my own experiences of teaching Health Education. Motivated by these absences, my master's thesis (Weir, 2000) investigated the evolution of Health Education in New Zealand from its early beginnings and with an emphasis on the period from 1970 to 1985. In the course of carrying out the research, I discovered that there was no other comprehensive coverage of the development of Health Education in New Zealand so my thesis, based largely on archival research, was a unique contribution to education scholarship. A central argument of the thesis was that the publication of *Health Education in Primary and Secondary Schools* (Department of Education, 1985) was the culmination of numerous attempts to make values education and the associated topic of sexuality education explicit in the New Zealand curriculum.

With the successful completion of my thesis in 2000, I became increasingly interested in what was happening to Health Education and those who taught Health Education in the contemporary policy context. My questioning fell into

three broad but related categories: (i) Health Education's development and place in New Zealand's curriculum in the early years of the twenty first century; (ii) the relationship between this development and the broad policy shifts in educational administration and curriculum which had taken place in New Zealand since the mid 1980s; and (iii) the effects of these recent changes on those who taught Health Education in secondary schools.

1.3 The research focus

This study therefore arose from questions about educational policy change and how those who taught Health Education in secondary schools might be affected by these changes. My personal experiences of teaching Health Education in the tertiary sector during a period of policy changes (from 1996 onwards) had alerted me to the possibility of contested meanings and divergent practices. As a consequence of these experiences, I sought to address the reasons why and how different meanings and practices about Health Education had developed and were sustained in the secondary sector. Thus it was the personal effects of educational policy change on individuals (and in particular, individuals who taught Health Education) which interested me. It was apparent from the beginning of the study that I needed teachers to tell me about their experiences.

It was clear from my own experiences of teaching Health Education and interaction with Health Education colleagues that there were conflicting responses to policy developments. The expansion of opportunities for the formal assessment³ of Health Education in secondary schools, for example, was met with a mixed response.

³ In 2002, Health Education was included in a new assessment and qualification system for New Zealand secondary schools, the National Certificate of Educational Achievement (NCEA).

My early motivation for the study is perhaps best summed up by an observation by Whitty, Furlong, Barton, Miles and Whiting (2000) with reference to their research on the effects of the 'eforms' on initial teacher education:

One of the problems of much of the writing about the New Right ideology is that it tends to be based purely on reading the discourse rather than studying the effects and resistances that constitute the 'ideology-in-practice' (p. 17).

The questions for this study were developed in 2002 with the above observation in mind, and had a secondary school focus. The questions were not informed by a systematic literature review; rather they arose from my own teaching experiences (primary and tertiary), my understanding of Health Education's history in New Zealand, conversations with teachers, and exposure to the views of a number of New Zealand education academics⁴. I selected secondary teachers of Health Education rather than primary teachers because I knew I would find out more of interest in secondary schools. This is because, unlike the primary sector, teacher identity is strongly associated with curriculum affiliation and because of the effects of formal assessment systems. Thus these tensions in teachers' work were going to be more obvious in the secondary sector.

The questions which follow remained a focus for the study but the ways I sought to answer them changed over time. In the early stages of the study, my own experiences (both craft and scholarly) were dominant. Personal views based on these experiences were extended with ideas gleaned from education and Health Education literature and empirical studies, historical studies (including my own), interview data, and discussions with colleagues. It was by no means a neat and tidy process. The circuitous nature of the research process is described in Chapter Two.

⁴ In particular: Ivan Snook and the late John Codd.

The main question for the study was: How is the current policy environment affecting the practice of Health Education and the well-being of Health Education teachers? In slightly expanded form, the questions were:

- How do secondary teachers make meanings about Health Education in the current policy⁵ environment?
- How do secondary teachers practise Health Education in the current policy environment?
- How does the current policy environment affect the personal well-being of the Health Education teachers in secondary schools?

1.4 My relationship to the research

I consciously did not position myself in the research as a Health Education expert. To do so would have invoked explicit power relations between me and the participants and would most likely have had an inhibiting effect upon what the teachers told me. In reality, even had I wished to, I could not have projected the expert image with any confidence. This is because I was all too aware of tensions in my own practice of Health Education and therefore did not believe myself to be an expert. These tensions were mainly concerned with what constituted Health Education – what was a valid realisation of its content and teaching methods and what were its boundaries with other curricula?

I came to the research as both an insider and an outsider. I had taught Health Education for many years, but my professional background was in primary and tertiary education, not secondary education. In addition to my lack of secondary school experience, I did not have the Physical Education qualifications and experience of many of those who teach Health Education in secondary

⁵ The use of the terms policy, well-being and practise in the research questions is clarified in Chapter Two.

schools.⁶ Another factor which contributed to my position as an outsider was that I had experienced the radical policy changes which had taken place in New Zealand education mainly in the tertiary sector (I had left primary teaching in 1996).

1.5 Thesis overview

The first two chapters of the thesis introduce the study and explain the logic of decisions made during the course of the research. In this introductory chapter (Chapter One) I have described the origins and focus of the research. I have also explained my relationship to the research. This relationship is further explored in Chapter Two, the methodology⁷ chapter.

Chapter Two is the first substantive chapter of the thesis. It discusses and theorises the research. The chapter's rather unconventional placement (before the contextual and theoretical chapters) is because of the significance of the theorising which took place. It was a very personal experience which represented my personal and professional growth as a tertiary health educator. Chapter Two records the development of my research orientation, theorises the study's purposes and methods, and documents the methods used to gather, analyse and present knowledge. The metaphor of a 'toolbox' (Ball, 2005) is introduced as the rationale for using a combination of methodologies, methods and theories used to address the research questions. Chapter Two also serves to highlight a number of methodological issues.

⁶ The teachers I interviewed were all aware that I taught Health Education but I did not tell them about how I came into the field unless they asked for this information – none of them did but assumptions were made in at least one case, for I was later told that one of the teachers believed I had a background in Physical Education.

⁷ The aim of methodology in its broad sense is to provide understanding of the research process (Cohen & Manion, 1994). Methodology should make the overall logic and orientation of the research clear and explain the reasons why the researcher has gone about the study in certain ways.

Chapters Three and Four provide the context for the study of contemporary teachers and their work. These chapters contextualise the present study by examining the *macro* historical and socio-political discourses (Chapter Three) and the *mezzo* discourses evident as educational policy was put into practice (Chapter Four).

These two chapters highlight some enduring discourses for Health Education such as the links between social concerns and schooling and the contested nature of sexuality education. These discourses have their origin in the broader political, economic and social policy discourses which influence and interact with education policy. The chapters highlight the continuity of historical and contemporary discourses and are important because of the links with the empirical study of contemporary policy and teaching practice.

Chapter Five introduces the discourses of power and knowledge, sexuality, gender, and emotion to the study. These discourses were introduced because they illuminate the *micro* worlds of the teachers in this study. The work of Basil Bernstein (1971, 1996) dominates Chapter Five. Bernstein offered vital tools with which to explore power and knowledge in contemporary discourses of Health Education pedagogy. These tools are described and their relevance to this thesis is proposed. Sexuality, gender and recent work on the emotions and teaching are also examined.

The study situates theoretically informed insights or ‘rich description’ (Bogdan and Biklen, 1992) about the micro worlds of twelve Health Education teachers in relation to macro (socio-political and historical) and mezzo (educational policy into practice) discourses. Thus Chapters Three to Five work together to set up the study – to foreshadow the tensions, problems and questions. The data presented in Chapters Six to Nine record what was found about the issues raised in Chapters Three to Five.

The theoretical basis for Chapters Six and Seven is largely derived from aspects of the work of Bernstein, particularly the way power operates to define what is valued as knowledge in schools. Bernstein’s (1971) concepts of

classification (the degree of insulation between areas of knowledge) and framing (the way power operates within a subject classification) were particularly useful.

Chapter Six illustrates the effects of Health Education's weak classification and framing. Chapter Seven is concerned with the effects of a change in classification and framing strength on Health Education through a new discourse evident in this study, the national secondary qualification of the National Certificate of Educational Achievement (NCEA). Chapter Eight addresses two further pedagogical discourses in this study, those of gender and the emotionality of teaching.

The final data presentation chapter (Chapter Nine) shows how individual teachers' pedagogies negotiated curriculum, assessment, gender, sexuality and the emotionality of teaching Health Education. In this chapter, data were presented as composite biographical⁸ (Connell, 1985) vignettes. Data were presented in this way for the following reasons: i) the careers and life histories of the teachers provided valuable knowledge about the pedagogical choices they made; ii) the vignettes illustrated a typology of teachers who teach Health Education; and iii) the use of composite biographies protected participant confidentiality.

Chapter Ten provides a synthesis and analysis of the findings about teaching Health Education discussed in Chapters Six to Nine. The findings are analysed with regard to the methodology, literature and theory discussed in Chapters Two to Five.

Chapter Eleven concludes the thesis. The chapter consists of a reprise of the purpose, approach, theory and main findings of the study. The chapter also discusses the study's strengths and limitations, its contribution to knowledge, suggestions for further research, and implications for policy and practice.

⁸ Composite biographies are explained in Chapter Two.

Chapter Two

Methodology: The research journey

This chapter explains and justifies the research methodology and methods which drive this study of the policy and practice of Health Education teaching in New Zealand secondary schools. The chapter is organised into five sections comprising: **2.1 Introduction and research questions** – the purpose of the chapter and explanation of the research questions; **2.2 Research methodology** – explanation and justification of the approaches used in the study; **2.3 Research methods** – explanation and justification of the empirical part of the study and data presentation; **2.4 Methodological issues** – the criteria for evaluating the ‘truthfulness’ of this study and reflection on two aspects of the methodology (the interviews and ethical considerations); and **2.5 Chapter summary**.

2.1 Introduction and research questions

In Chapter One I explained the origins of the study, the research focus and my relationship to the research. Chapter Two builds on each of these explanations with the purpose of constructing a methodology chapter which illuminates the research ‘journey’. I have used journey rather than ‘process’ as journey better represents the iterative nature of my experience – following Lather and Smithies (1997, p. 200), —I have learned to lose my way in this journey”.

I wrote this chapter conscious of contrasting ways of documenting the research experience. One possible approach was to emphasise the highs and lows of

working through methodological issues; the second approach was to present a cleaned up version of this process. The sanitised approach to writing about methodology ignores or glosses over the challenges which are an inevitable part of qualitative research. This approach is situated in a positivist methodological tradition⁹, which while still powerful in education, is less pervasive than in the past (Lincoln & Guba, 1985).

Problems inherent in positivist conventions of research methodology have been addressed by Opie (1994) in her analysis of her experiences of doctoral study. Opie argued that ideas of how research should be undertaken and presented (a smoothly executed and unproblematic progression of research activity), did not adequately account for her experiences of qualitative research. She noted that some researchers had challenged this paradigm and drew attention to “~~the~~ complex, unordered, recursive, contradictory and suppressive processes” (p. 60) which are characteristic of qualitative research. I have been influenced by Opie’s analysis and have written a reflexive account¹⁰, one which represents the complexity of the research journey.

The chapter draws on the literature which informed my approach and also uses notes written during supervision and study group meetings beginning in 2002, when this study commenced. I have used these personal notes because they illustrate my thinking at critical stages of the research.

Research questions

The research was guided by questions developed early in the study, after I had decided that my research would focus on teachers’ perspectives of teaching Health Education.

⁹ Positivism in general terms privileges a natural sciences conceptual framework for investigations of social phenomena. In this tradition it is claimed that knowledge can be value-free and gained through sensory experiences, particularly observation. Positivist methodology implies expectations of set procedures, control, detachment and smooth progress in the research process. Studies of the complex social worlds inhabited by teachers are unlikely to proceed in such measured and controlled way.

¹⁰ By a reflexive account, I mean that I have made public my reflections on methodological issues such as my changing perspectives on the research and my relationship with the research. The concept of reflexivity is further developed in 2.2 of this chapter.

The overarching question for the study was:

How is the current policy environment affecting the practice of Health Education and the well-being of Health Education teachers in New Zealand secondary schools?

The research was guided by three questions:

- How do teachers make meanings about Health Education in the current policy environment?
- How do teachers practise Health Education in the current policy environment?
- How is the current policy environment affecting the personal well-being of Health Education teachers?

An explanation of some of the key words in these questions follows. I used 'make meanings' (Ball, 2005) with the intention of finding out how the teachers in this study developed their ideas about Health Education. Was it, for example, from their tertiary studies and teacher education courses or from personal experience or professional development? By 'practise' I meant what constituted the day to day social interactions of teaching – what did the teachers report about what they said and did in their day to day interactions with students and staff?

'Policy environment' referred primarily to curriculum and assessment policy discourses. I was particularly interested in how teachers made sense of, and implemented, the curriculum policy statement, *Health and Physical Education in the New Zealand Curriculum*¹¹ (Ministry of Education, 1999). I was also interested in the effects of the qualifications system introduced into New Zealand secondary schools in 2002, the National Certificate of Educational Achievement (NCEA). Taken together, these two policy initiatives created a new policy environment for secondary school Health Education and seemed likely to affect teacher workload and wider issues of teacher well-being.

¹¹ Henceforth referred to as the 1999 curriculum.

‘Policy environment’ also included the broader historical, political, economic and social policy discourses which influence and interact with education policy. These broader policy discourses, which affect all curricula, are particularly significant for Health Education. This is because the purposes of Health Education were developed as responses to perceptions about what is ‘healthy’ for individuals and for the nation. Sexuality education is the most palpable example of this. In this study, the interrelationship of broad policy discourses and Health Education is examined in Chapters Three and Four.

The term ‘well-being’ was used in a more conscious way than ‘policy environment’ as it was linked in my mind with the holistic dimensions of the 1999 curriculum. In this document, ‘well-being’ is defined as —“the physical, mental and emotional, social and spiritual dimensions of health” (Ministry of Education, 1999, p. 31).

The questions developed for this research were only partially informed by research literature. This was because, while I found much of interest in the literature at this early stage of the study, there was very little that told me about the responses of New Zealand secondary Health Education teachers to current curriculum and assessment issues¹². The questions for this study were therefore largely developed on the basis of my knowledge of Health Education history in New Zealand and my experiences of teaching Health Education in the primary and tertiary sectors. My experiences of teaching Health Education led me to believe that while policy certainly affected teaching practice, other factors such as personal disposition and school culture were also influential. Question development was also influenced by conversations with teachers who taught Health Education in secondary schools and the policy critiques of a number of education scholars¹³.

One aspect of my research journey is exemplified in relation to the research questions, and here I use the ‘well-being’ question as an illustration. The question was articulated on the basis of my Health Education knowledge and

¹² Literature on New Zealand Health Education (mainly in the form of theses and reports) is referred to in Chapters Three and Four.

¹³ The work of Codd and Smyth, for example, is referred to in Chapter Three.

experience as it was in 2002. At this time, I drew on an official curriculum discourse and expected to find some ‘answers’ about teachers’ well-being as it was defined in the 1999 curriculum. The ways I attempted to answer this question shifted from this curriculum discourse to discussing teacher well-being in terms of the emotional dimensions of teaching and teacher agency. Hence, although the question stayed the same, the ways I answered it have changed as I worked on the thesis.

In this introductory section I have explained why I have written a reflexive account, explained the origins of the research questions, and used one of them as an example of my development as a researcher. In the following section the methodological rationale which supported this study is explained and justified.

2.2 Research methodology

In this section of the chapter, methodology is justified in terms of the research questions and methodological terms are defined.

The research paradigm

This study is situated within a qualitative research paradigm¹⁴. Qualitative research is based on assumptions about what the world is like and how the world works (ontology). Theories about how this world can be known (epistemology) are developed from ontological assumptions.

Qualitative research is based on the premise that there is no one world out there to be discovered, rather that the world is experienced in different ways by different people. The aim of the qualitative researcher is therefore to understand the social reality for individuals as best she can. In other words, to identify what is going on for individuals in their social worlds and how individuals understand

¹⁴ By ‘paradigm’ I mean an overarching conceptual framework which gives direction to the study.

and shape their worlds. Axiology, or theories about what is valued by individuals (Clark, 1997), is also an area of enquiry for the qualitative researcher.

Qualitative research does not favour one methodology over another (Denzin & Lincoln, 2000) and instead offers a range of methodologies to guide the conduct of research. The questions which gave direction to this study (finding out about and communicating how secondary teachers of Health Education were affected by current policy) placed the study in a “hermeneutic/interpretive epistemology” (Usher, 1996a, p. 18). Hermeneutics, in simple terms, is concerned with interpreting data (in this case the interviews) in a manner that conveys understanding (Crotty, 1998; Kincheloe & McLaren, 2005).

A central assumption of hermeneutics relevant to this study is that analysis of policy texts¹⁵ and human actions (including the actions of the researcher) can never be pure and objective because of what each of the participants brings to the process. “*Hermeneutics* is an approach to the analysis of texts that stresses how prior understandings and prejudices shape the interpretive process” (Denzin & Lincoln, 2005, p. 27).

Hermeneutics and reflexivity belong together in the sense that my “reflexive hermeneutic stance” (Josselson, 1996, p. xii) can be traced back to the beginning of the research. I can, for example, detect my tentative understanding of the significance of the teachers’ backgrounds and experiences in the early stages of this study. My first report to my supervisors in 2002 noted the difficulties of determining what was meant by ‘Health Education’ because of the political, pedagogic and personal elements associated with the subject. I noted the personal variables of academic background, primary subject affiliation (particularly the impact of academic and professional background in Physical Education) and professional development on the implementation of the 1999 curriculum and the NCEA. I also noted: “Just what teachers think Health Education is about is very dependent on their history, experiences, culture and

¹⁵ Texts can be both written (e.g., curriculum and assessment documents) or oral (e.g., discussions about Health Education programmes and professional development).

values. Teachers' approaches to sexuality and mental Health Education are particularly likely to be affected by the personal" (Weir, 2002). I felt able to write this because this was my experience and was therefore going to be located explicitly in the study'.

The anticipated result of this study was my interpretation of the teachers' interpretations of their participation in social practices. Scott and Morrison (2005) describe this as —~~double~~ interpretation or double hermeneutic" (p. 124). Another way of putting this is taking heed that —~~the~~ specific characteristic of her point of view is to be a point of view on a point of view" (Bourdieu, 1996, p. 34). Interpretations do not stop with the research being published because readers will interpret the work in different ways.

There was an ending' of sorts when the understandings I settled on were recorded for this study, but the interpretations will go on as others read my work. My interpretations in this sense will be just as much data for others to interpret as the data produced by the teachers (Diaz, 2002). Opie (1994) talks about the difficulty of releasing work to other readers: —~~Once~~ done' there is no way you can control the interpretation. What seemed blatantly self-evident to you as writer can be overlooked or misinterpreted' (to your great chagrin) by someone else" (p. 91). I am, however, resolved, not to be overly protective of my interpretations; they will not be definitive, just the best explanations¹⁶ I am able to offer, based on the evidence that was gathered for the study.

A 'toolbox' approach

The metaphor of a toolbox' (Ball, 2005) provided a rationale for using a combination of methodologies and theories¹⁷ to address the research questions.

¹⁶ Criteria for assessing the truthfulness of qualitative research are discussed in 2.4 Methodological Issues.

¹⁷ I draw a distinction between methodology and theories here. Methodology is the reasoning behind the research – why the research was carried out one way and not another. It involves underpinning' theories, eg theories about perceptions of the world. In this chapter, and particularly Chapter Five, I also talk about theories in a more specific way eg theories about educational policy, pedagogy and gender. (These theories are themselves underpinned by ontological and epistemic theories.) In combination, methodology, theories and questions form a conceptual framework (Burgess, Sieminski, & Arthur, 2006).

Ball used the toolbox metaphor to advocate for policy research which used a combination of theories:

...the *complexity* of and *scope* of policy analysis – from an interest in the workings of the state to a concern with contexts of practice and the distributional outcomes of policy – precludes the possibility of successful single theory explanations. What we need in policy analysis is a toolbox of diverse concepts and theories – an applied sociology rather than a pure one (2005, p. 43).

Methodological and theoretical directions were determined by the broad question: —~~h~~ow is the current policy environment affecting the practice of Health Education and the well-being of Health Education teachers in New Zealand secondary schools?”

The macro (education policy) and micro (what teachers reported they did and how they negotiated practice) dimensions of the study necessitated a multi-faceted approach, one that addressed and connected both parts of the main research question. Questions about individual practice set the study within an interpretive/hermeneutic framework and validated the choice of face-to-face interviews as a research method. A defining characteristic of qualitative research is the idea that data generated by research (in this instance, interviews) can only be fully understood if it is analysed with reference to the whole – its social and political contexts (Goodson, 2003; Morrison, 2002). As Goodson stated: —~~S~~tries and narratives are not an unquestioned good: it all depends. And above all, it depends on how they relate to history and to social context” (2003, p. 26).

The methodological and theoretical concepts which make up the toolbox are indicated and their location in the study’s chapters is outlined below:

- In this chapter, Chapter Two, methodology and methods are explained and justified;

- Chapter Three provides the *macro* socio-political and historical background (the discursive inheritance of previous eras in New Zealand's Health Education history);
- Chapter Four functions as a *mezzo* commentary and examines educational policy as it was put into practice across the education system (the dominant policy discourses here are those of curriculum and assessment); and
- Chapter Five focuses on pedagogy and an explanation of what goes on in the *micro* worlds of teachers.

Thus the purpose of the historical, socio-political discourses (Chapter Three) was to provide the background for examining the relationship between contemporary health education practice and the past (Louden, 1991; Fraenkel & Wallen, 2003). Chapter Four contributes to the thesis by examining the discourses evident as educational policy was put into practice in New Zealand from the early twentieth century until the early twenty first century when the empirical part of this study was carried out.

Chapter Five completes the methodological and theoretical framework by illuminating the micro worlds of teachers through a discursive examination of power and knowledge, power and sexuality, gender, and the emotionality of teaching. Discourse, as it is used in this study, is explained below.

The substantive part of this section has located the study within a qualitative research paradigm (interpretive/hermeneutic) and made the case for interviews as a means of generating data. The study's conceptual framework (based on the toolbox rationale) and chapter structure have also been outlined. In the final part of this section, the significance of 'discourse' and 'reflexivity' are explained and their use defined.

Discourse

This part of the section on research methodology explains how discourse theory supports the broad methodological and theoretical aims of the study. Theories

about subjectivity, agency and teaching discourses are also explained in relation to this study.

The discursive framework for this study was developed within a Foucauldian tradition. Olssen (1999), one of a number of social researchers who uses Foucault's ideas, observed that Foucault's attraction to social researchers was that —he problematised the meta-narratives of the Enlightenment and advocated the possibility of treating all knowledge as *contingent, specific, local and historical*" (p. 160). I understand this to mean that there is justification for concentrating on localised and particular examples of meaning making by the teachers in this study and that these examples should be analysed discursively, that is in terms of their language, behaviour and relations over time.

Foucault (1972) argued that discourses are —practices that systematically form the objects of which they speak" (p. 49) and not —mere intersection of things and words" (p. 48). In other words, discourses are not something out there but circulate through everyday activities and social interactions. The location of discourses in daily life was emphasised by Codd (1994, p. 43): —*Discourse* refers not only to the meaning of language, but also to the effects of language-use, to the materiality of language. A discourse is a domain of language-use and therefore a domain of social practice" (p. 43).

Texts (both oral and written) cannot be reduced to one discourse; rather they are —*multidiscursive*" (Luke, 1995). By this, he means that texts —draw from a range of discourses, fields of knowledge, and voices. In this way, discourses are dynamic and cross fertilizing, continually relocated and regenerated in everyday texts" (p. 15). For example, different discourses, both competing and complementary, are present in the language, behaviour and relations apparent in professional development and assessment texts. The mix of discourses represented in these texts is interpreted differently by teachers and then made real in their everyday actions — their discursive practices.

Teachers made meanings about Health Education through drawing on overlapping and sometimes competing discourses and these were then enacted

in their discursive practices. These overlapping, sometimes competing discourses offered the teachers “a range of modes of subjectivity” (Weedon, 1987, p. 35). Discourses both ‘positioned’ teachers but also provided opportunities for teachers to ‘position’ themselves. In other words, teacher ‘subjectivities’ were constructed. In feminist theory, subjectivity is concerned with “who we are and how we understand ourselves, consciously and unconsciously. These understandings are formed as we participate in, articulate and circulate discourse” (MacNaughton, 1998, p. 161).

Positioning then refers to the way people locate themselves either consciously or unconsciously in relation to different discourses. Moore (2004) made the point that positioning is an inevitable and dynamic process:

...teachers are continually involved in adopting professional ‘positionings’ in which personal values must negotiate accommodations with the sometimes contradictory purposes promoted by the wider practical and ideological-political contexts of their working lives (p. 123).

This creative process of ‘positioning’ was described by Youdell (2005) as a “discursive constitution” (p. 249) of subjectivities where the subject is said “to be perpetually but provisionally constituted through discourse” (p. 254). Discursive practices, the everyday actions of teachers, take on a life of their own and are themselves productive. Moore (2004, p. 30), reminded us that for Foucault discourses were not entities “waiting to be discovered” and argued that “discursive practices are themselves ‘producers’, actually *creating* ‘common sense’, ‘reality’, ‘truth’”.

The subjectivities which come about through positioning are not fixed: “Social subjectivities, furthermore, are not unitary or singular. In negotiating everyday life, we tend to assume various positions in discourse” (Luke, 1995, p. 14). This study therefore acknowledges the principle of ‘agency’, both individual and collective. Agency is the capacity people have to control their lives (Connell, 1985; Weiler, 1988; Middleton, 1998; Acker, 1999).

The capacity to exercise agency is, however, related to the discursive resources available to individuals and is likely to be restricted by the discourses: “We may only be able to conceive of the possibilities of response in and through the language, concepts and vocabulary which the discourse makes available to us” (Ball, 2005, p. 49). Our agency is therefore shaped by and shapes the discursive resources, or social capital (Bourdieu, 1986), we are able to access.

The teachers in this study were both positioned by discourses (such as curriculum), but equally, they were agents of their own positioning. Teacher agency, however, occurred in relation to the constraints of the current ‘regimes of truth’ (Foucault, 1980), such as teacher accountability. A discursive approach then argues that knowledge is socially produced and that it always includes power relations. In Butler’s words, “What, given the contemporary order of being, can I be?” (2004, p. 192).

Teaching discourses drawn from the typology of teaching constructed by Bernstein (1996) were relevant to this study and helped explain discursive practices. Bernstein examined the traditions which shape “pedagogic identities”, that is the way schools and teachers “perceive and present themselves and their professional practice” (Moore, 2001, p. 42). Bernstein (1996) differentiated between three types of pedagogic identity – the decentred, retrospective, and prospective identities. Of these, the decentred identity proved to be the most relevant to this study.

The decentred identity is developed at a local level and has two categories – ‘instrumental’, which is associated with the ‘market’, and ‘therapeutic’, which is opposed to market driven instrumental identity. At a school level, Moore (2001) applies these two categories as:

...the packaging and selling of the school *by the school* as a product in the local marketplace and in contrast to this instrumental construction, the therapeutic identity is divorced from the market with decisions about education being made on the basis of values and beliefs, that is what is

best for students, *regardless of the impact of such views and practices on student recruitment* (p. 43).

In this study a number of teachers stressed that student well-being was more important than the school's image and they were prepared to advocate for students, even if this resulted in hostility from senior staff. For one teacher in particular, pursuing what she perceived to be in the best interests of her students brought her into conflict with senior staff members who were concerned about the school's reputation.

In this subsection, the reasons for using a discursive approach and the related theories of subjectivity and agency have been argued. In the following subsection, reflexivity is discussed.

Reflexivity

At an early stage in the study it became clear that my role as a Health Education teacher educator had to be taken into account because there was never going to be a clear boundary between my interests, values and frameworks and those of the participants (Scott & Morrison, 2005).

Following on from this belief is the importance of being aware of this on-going tension (without being paralysed by it). Scott and Morrison (2005) define reflexivity as —~~to~~ a process by which the researcher comes to understand how they are positioned in relation to the knowledge they are producing, and indeed, is an essential part of the knowledge-producing activity” (pp. 201-202). At the core of this process is critical self scrutiny’ (Usher, 1996b) that is, acknowledging that —~~a~~ each strategic decision of scholarship bears theoretical, ethical and political consequence” (Fine & Weis 1998, p. 273).

Early in my reading for this study (2003) and before I began interviewing, I came across Grace’s (1998) writing on reflexivity and found it helpful in clarifying my own reflexive disposition. Grace’s chapter is one of a set of —~~r~~eflexive narratives” which provide —~~a~~ richly diverse perspective on the

intersection of the methodological and the biographical” (Shacklock & Smyth, 1998, p. 8). Here Grace (1998) explains what being a reflexive researcher means to him:

For me reflexivity implies a making visible of the suppressed culture of research activity as opposed to the making visible of only its formal face. By ‘suppressed culture’ I mean the backstage reality of research life – the struggles over project selection and formulation, difficulties of access to the field, problems of methodology and analysis, change of direction, ethical dilemmas, constraints upon writing-up and publishing and, perhaps the most difficult of all, to be honest about, the ‘critical intent of the wider research project’ (p. 204).

Now, at this much later stage of the research process and this year (2009) having read Opie (1994), I can see how much I have been influenced by this position. I recognise now, for example, why it was invariably an enjoyable task to ‘wite up’ the notes taken at meetings with my supervisors. Let me emphasise that this was not a self indulgent activity but one which I believe has been of significant benefit to the research and my development as a researcher. As Etherington (2004, p. 31) observes, ‘including our selves in our work needs to be intentional, in terms of the research outcome: a means to an end and not an end in itself. It does not mean ‘anything personal goes’”.

Scott and Morrison (2005) draw on Usher’s work to suggest three types of reflexivity: ‘personal’, ‘disciplinary’ and ‘epistemic’ (Usher 1996b). This typology is useful for developing the idea of reflexivity beyond the life history and personal context of the researcher. Grace’s explanation of what it means for him to be a reflexive researcher is an example of disciplinary and epistemic reflexivity.

I see elements of all three in my beliefs and values about research. I believe that it would be dishonest not to make clear my career autobiography or try to ignore the connections between myself and the teachers in this study (all interested in Health Education and some of whom I had worked with in other

contexts). But there is more than this: —Disciplinary reflexivity comprises the belief that knowledge-making has political, social and cultural implications” (Scott and Morrison, 2005, p. 202). In this study I am presenting things in certain ways in the knowledge that my research will be judged by others, for it is —positioned within a community’s disciplinary matrix, which is a network of power relations that determines which types of research are acceptable and which are not” (Scott & Morrison, 2005, p. 202).

My epistemic reflexivity, that is, awareness of my beliefs about how the world is known, has influenced the —epistemological products” (Scott & Morrison, 2005, p. 202) of the research. An example of these —products’ is the use of teacher vignettes in Chapter Nine. The vignettes reflect my belief that valuable knowledge is embodied in the life and career stories of the teachers in this study. The responsibility which comes with epistemic reflexivity is that the researcher should try to, —as best as they can, understand the nature of their knowledge-producing activities and write them into their account” (Scott & Morrison, 2005, p. 203).

My understanding and use of discourse in this study is an example of the operation of reflexive responsibility. Using a Foucauldian lens, Kelly (1992, p. 26) argued that —biogs make sense of their behaviour and that of others through discourses: socially produced forms of knowledge which define and organise experience and which always embody power”. An ethical consideration for myself as a researcher who uses discourse as a means of making sense of the texts of others is the importance of being reflexive about —how and whom we construct and position in our own talk and writing” (Luke, 1995, p. 41).

This section of the chapter has set out and justified the methodological framework for this study. The broad intent of the research (finding out about Health Education teachers practice in the current policy environment) and my relationship to the research determined a hermeneutic/interpretive and reflexive approach. The data generation method selected for the study (interviewing), was justified within this approach and the —toolbox’ concept proposed as a

means of addressing the multi-faceted nature of this study. Finally, discourse and reflexivity were explained and their use defined.

2.3 Research methods

This section explains and justifies the empirical part of this study – the interviews and how the interview data were analysed and presented.

The interviews: 2003-2004

In this part of the section on research methods the reasons for the small sample of Health Education teachers are explained, the process of gaining access to teachers is described, and the form the interviews took is explained and justified. Reasons are also given for decisions to restrict the data analysis to the first round of interviews.

I set out to interview a small number of teachers for this study, no more than fifteen. I decided this number was sufficient because I expected the interviews to yield rich accounts of teaching practice. I also felt I would be able to maximise this data through a close and systematic analysis. (This process is described later in this section.)

Letters were sent to the principals of thirty schools in the local region requesting their permission to approach Health Education teachers in their schools. I was a little disappointed, but not surprised given the low status of Health Education, when only eight principals responded favourably to my request. In addition to these responses, two principals expressed support for the research but declined on the grounds of protecting their staff from additional workload. A number of the teachers in the schools I had official access to declined the invitation to be part of the project. In all, thirteen teachers agreed to be interviewed. A number of ethical dilemmas arose in the process of gaining access and these are discussed in the last section of this chapter.

I chose a form of unstructured interview because I did not want to impose a priori limitations on the teachers or the study. The design of the first interviews was therefore very open as I wanted the teachers to talk about what mattered to them. I was, however, conscious of a tension between an inductive and a deductive approach. Although I was not out to prove any of my hunches, I was nevertheless hoping that what they said would be relevant to the issues I had tentatively identified. These issues were based on my knowledge of Health Education, informal conversations with Health Education teachers and the reading I had reviewed and written about up to this point.

Prior to the interviews I had contacted the teachers to confirm details of the interviews and asked them to construct a timeline which showed significant events in their teaching careers. Ten out of the thirteen people interviewed did this and it proved useful as it served to document what they considered important in their careers. Some also included critical points in their lives which had affected their teaching, such as the birth of a child or illness. Before the interviews took place I sent them copies of the open-ended statements I wanted them to respond to in the interviews.

The statements were adapted from the “experience sampling method” developed by Cohen and Manion (1989, p. 247) and were prefaced by “Tell me about a time... ” (see Appendix B). In retrospect I am aware that there was an imbalance of negative over positive statements. There were too many statements such as “When there was a misunderstanding between you and someone else (or several others) about Health Education...” in comparison with statements such as “When you were talking to someone else about Health Education and you discovered you were both on the same wave length...”

This imbalance came about for the following reasons: it was an indication of my inexperience as a researcher (I recall the imbalance was pointed out to me at the time but I did not feel there was an issue), but more significantly, I can now see it as an example of the way “prior understandings and prejudices shape the interpretive process” (Denzin & Lincoln, 2005, p. 27). The beginning of the

research process was inevitably grounded in my own experiences and feelings about Health Education. At this time I was in the early phases of my career as a tertiary health educator and felt a sense of professional isolation. Another reason for not critiquing underlying assumptions about these teachers' experiences was that this first round of interviews was intended just as a starting point. I anticipated that subsequent interviews would be more structured and focus on issues which had been raised.

The first of the interviews (eight of the thirteen) took place in November and December of 2003. The timing of the interviews was the result of gaining ethics approval for the study and practical considerations: the academic year was winding down and it was also a time when teachers were likely to have more discretionary time as their senior classes would be on study leave. A further five interviews took place early in 2004, making a total of thirteen for what was intended to be the first round of data gathering.

Three of the original participants were interviewed on two occasions each year from 2004 through to the end of 2006. Data gathered from the second round of interviews was intended to add substance to the issues which had emerged from the first interviews. I questioned whether I would need the data from the second round of interviews as I engaged with the literature and began to analyse the transcripts from the first interview cycle. By the time I was half way through the second interview cycle, I decided that I would complete the cycle and have the interviews transcribed, but not use them.

The decision not to use material from the second cycle of interviews was because the first round of interviews had generated such rich data. The depth and complexity data of the first interviews was unanticipated. The impact of the data is evident in the following extract from notes written after I had completed the first round of interviews:

What started out as a study of the ways teachers are affected by policy change (the health curriculum), has folded in on itself during the first round of interviews when it seemed to me that the teachers were telling

me stories about their teaching lives, which contained common themes which had something to do with mediating policy and teaching Health Education, but more to do with themselves as teachers. So what seemed to be happening (more in some interviews than others) was a glimpse of the intensity and complexity of teaching through the medium of these teachers. It was a very moving experience which changed me as a researcher and where I thought the research was going. I had expected the interviews would confirm the preliminary reading I had done and they generally did give substance to the themes I had already identified. What I was not prepared for was to find such depth so early in the study (Weir, 2004).

This quotation is significant because it captures a moment in my research journey when the research changed as I realised that teachers' responses to policy change could only be understood in relation to other discourses. The quotation also illustrates the growth' in my understanding as I conducted the research.

This part of the section on research methods has focused on the interview process and discussed the interviews with regard to the small sample, access and interview type. In the last subsection of this chapter (2.4), I have written a reflexive account which critiques the familiarity' and neutrality' of the interview.

Data analysis

I began a close reading' of the data early in 2004 as the interviews were transcribed and while completing the fieldwork. The interviews were transcribed using an orthographic convention developed by Opie (1995, cited in Nash 1997). I was attracted to this because it seemed closer to speech and was therefore a more accurate representation of the interviews. According to the convention, no punctuation was used in the transcripts. Instead the symbol ʹ was used to represent a short pause and /' an extended pause. At this time (2004) I thought I would use the transcriptions in this form in the thesis. Subsequently (from 2007), I decided to use conventional orthography and also

edited the transcripts to remove the ‘ums’ and ‘ahs’ and repetitions. My decision to insert punctuation was in part because of my assumptions about what a formal piece of academic work should look like; more compelling reasons, however, were that I wanted the teachers’ words to ‘read well’ and reflect positively on them.

Once all the interviews had been transcribed and edited in response to changes requested by the teachers, I began a more formal process of analysis (Bogden & Bilken, 1982). I wanted to read the transcripts in a way that ‘let the interview breathe and speak for itself’ (Seidman, 2006, p. 117) but I also wanted to make sense of the data in terms of the research focus.

The ‘experience sampling method’ had resulted in exciting interviews but also a mass of unstructured data. The unstructured data was daunting, but with perseverance, I was confident I could follow the original questions and ‘map’ the teachers’ words on to them. I began coding each transcript under the headings of ‘making meaning’, ‘practice’ and ‘well-being’, using the qualitative data coding programme NVivo2. I felt a growing sense of discomfort with this process, however, as I felt I was getting further away from my actual experience of the interviews. I became aware that it was not just a technical problem of how best to manage the data; I felt I was losing the authenticity which I sensed during the interviews.

It was about this time that I was introduced to content analysis (Berelson, 1952) by a senior colleague who persuaded me that I would be able to identify the main themes of the study using this method of analysis. The process I used is detailed below.

The first stage of content analysis was to break up the transcripts into chunks of meaning. This was done by drawing a line around each unit of meaning on the transcripts. The units of meaning were then paraphrased (re-worded in summary form). I was anxious I would miss something and as way of overcoming this (and ensuring some consistency for the ‘first cut’ of data analysis) I asked a retired secondary school English teacher to mirror this

process. It was reassuring that there was a high degree of agreement in our delineation of content units and paraphrasing. I believe this consistency occurred because we are both to some extent insiders'; he as a secondary teacher of long standing, me because I was the interviewer and also because of my understanding of Health Education. When there was a discrepancy, I looked at each version and decided which paraphrase best described the content unit.

After each interview was paraphrased (and labelled with the teachers' pseudonym and the units of meaning numbered according to where they occurred in the transcript), I sorted them into the groups of units which seemed to go together. This was a time consuming and iterative process which involved checking the context of the unit (this sometimes meant listening to the tape) and in some cases reassigning units from early analysis into topics which emerged from interviews analysed at a later stage in the process¹⁸. Early on in the process (February 2006), I began to get a feeling for what the major themes of the study were. Field notes written in March 2006 document my growing confidence about naming what the teachers were saying:

The big categories so far are curriculum (their own constructed one) and assessment – whether it's a good idea or not and the impact of NCEA. The thing that strikes me at this point is how little is to do with the outside contexts, very insular, curriculum construction is very idiosyncratic (except I suspect when I get to Anna and Nicole who are big on senior health and then the curriculum is NCEA). Other preliminary findings are the positives and negatives of being a minor subject in a shared curriculum and the effects of credentialing – more strife e.g. Anna and Nicole trying to push through senior health courses (Weir, 2006a).

By the end of this sorting process, the largest number of units were concerned with (in descending order) curriculum', school relations', assessment', , community' and personal and career history'. It was at this stage I abandoned

¹⁸ The number of content units in each of the 12 transcripts ranged from 146 to 237.

content analysis as a method of data analysis. This was because I had achieved my data analysis goals of: i) carrying out a close and systematic interpretation of everything in the transcripts, and ii) developing a thematic framework based on this systematic evaluation.

Another factor which influenced my decision was my increased understanding of the methods origins and current use. Content analysis is a form of quantitative data analysis which originated in efforts of researchers to analyse the content of newspapers, and is “essentially a counting exercise” (Scott & Morrison, 2005, p. 37) as it “generally involves recording how often words or concepts are used” (Shuker, 2003, p. 347).

In its pure form, “descriptive categories are constructed which refer to properties of the text being examined, and the content analysis is designed to identify the number of times that property appears in the text” (Scott & Morrison, 2005, p. 37). My version of content analysis did not reach the counting stage; it finished at one of the first stages of the process – the development of ‘descriptive categories’. These categories, which I called themes, covered all the units of meaning from the interviews and indicated what most of the teachers’ talk was about. Knowing the relative weightings was useful but it was not a strong basis for shaping the data chapters. As Hayes (2000, p. 125) pointed out: “simply reducing everything to numbers can be misleading, in that how often something is mentioned does not automatically show how important the theme is”. The next stage of data analysis occurred as I wrote the data presentation chapters. This process is described below.

Data presentation

The data presentation chapters were written in two stages from 2006 to 2008. This first stage foregrounded the teachers’ accounts around the themes identified in the data analysis: ‘curriculum’, ‘school relations’, ‘assessment’, ‘community’ and ‘personal and career history’. When I reread these chapters certain additional themes stood out which I realised I had to incorporate in the data presentation. The three most striking were gender, the contrast between

the junior curriculum and the senior curriculum, and a sense of the emotional dimensions of teaching.

In 2008, when I began writing the second draft of the data presentation chapters, I incorporated the additional themes into a coherent integrating narrative with each substantive point being supported by the data. It was at this stage that I judged that there needed to be a more explicit and comprehensive theoretical framework, one which would enable me to “search for meaning, patterns, regularities and principles hidden within the rich uniqueness of these stories” (LeCompte, 1993, p. 24). The theoretical framework for the study which would facilitate a “theoretically informed grip” (Silverman, 2000, p. 47) on the interview data, is explained in Chapter Five.

The chapters written in 2008, though now informed by the theoretical framework, were like the earlier drafts, a synthesis of the data extracted (through content analysis) from the transcripts explained in Chapter Five. This process of data extraction was essentially a deconstruction procedure, and while it was a defensible way of gathering empirical data to ‘answer’ in a ‘partial’ (Gadamer, 1975) but finely grained manner the study’s main research question, there was also an absence.

I identified this absence as the inner worlds of ‘motivations and desires’ (Scott & Morrison, 2005) and concluded that I had lost these ‘inner worlds’ in the thematic process I had used to manage and report on the data. To address this issue I decided to use the idea of constructed biographies (Connell, 1985). Constructed biographies are a method of combining data from a number of interviews to become one person’s story. Connell justified use of constructed biographies on the grounds of confidentiality and “also for readers’ understanding of the social processes we were studying, to convey in the published report the *sense* of biography, the way things hang together and take shape (and sometimes fall out of shape) in teachers’ lives” (p. 3). I decided to use a form of constructed biographies to show how teacher agency operated across the data themes.

This decision also helped to resolve an ethical dilemma in my research. Confidentiality, particularly in a small subject community such as Health Education, must be strictly adhered to. Although I had to protect the confidentiality of the teachers in my study, I also wanted to document the richness and complexity of their practice. This desire would involve using personal interview material which had been approved for use by the teachers, but which I felt was sensitive. The use of composite material from several teachers resolved this dilemma. In a departure from Connell's work, I called my composite biographies 'vignettes' to indicate that their empirical base was less substantial than in his comprehensive study of 128 teachers.

Informed by the theoretical framework explained in Chapter Five, the revised content and structure of three of the four data presentation chapters was organised around curriculum, assessment, gender and emotionality. The vignettes comprised the fourth chapter and showed how individual teachers' pedagogies negotiated curriculum, assessment, gender, sexuality and the emotionality of teaching Health Education.

This section of the chapter has explained and justified the data analysis methods used in this study. It also discussed the themes included in the data presentation chapters. Methodological issues that arose in the course of the research are discussed below.

2.4 Methodological issues

Three methodological issues are discussed in the final section of this chapter. The first concerns criteria for evaluating the truthfulness or trustworthiness (Lincoln & Guba, 1985; Dadds, 2005) of this study. The second two are reflexive accounts of issues to do with the interviews and research ethics.

Credibility and quality

Qualitative researchers have been increasingly concerned with establishing the credibility and quality of their work (Lincoln & Guba, 1985; Seale, Gobo, Gubrium, & Silverman, 2004). In this subsection, criteria for judging the credibility (authenticity and truthfulness) and quality (rigour and cohesion) of the study are examined. The evaluative criteria are based on a list developed by Piantandida and Garman (1999). Smith and Deemer (2000) argue that making judgements about qualitative research on the basis of certain features is inevitable. They emphasise, however, that the list approach should be “open ended” and not “something like an enclosed and precisely specified or specifiable shopping or laundry list” (p. 888). The list that appears below is not exhaustive and its definitions are open to debate. As Smith and Deemer point out, a list is “invariably in one’s standpoint” (2000, p. 888).

My standpoint is consistent with the study’s hermeneutic/interpretive paradigm (Usher, 1996a) and therefore makes modest claims about truth. Louden’s (1991) comments are helpful here. Louden worked within a hermeneutics framework in his acutely observed and reflective study of a year in one teacher’s life. He acknowledged the significance of Gadamer’s (1975) conceptualisation of understanding to his research:

Like other post-positivists¹⁹ Gadamer argues that there is no neutral foundation for understanding. Rather, understanding of events or texts is constructed through the preconceptions we bring to them. There is no prior state of understanding free of prejudices, and no method which can free us from the understanding we bring to each new experience (Louden, 1991, p. xv).

Influenced by these comments I make limited claims to the truth of my account about what the teachers told me. It is an interpretation which rests on my experiences and understandings of the world and is therefore always partial and provisional knowledge (Gadamer, 1975). The aim of this study was therefore

¹⁹ In comparison with positivism, there is more room for doubt in post – positivism though some knowledge claims are proposed as being closer to the truth than others.

not to find the truth but to be as truthful as possible. The following list was useful in establishing the study's credibility and quality. The list is based on criteria for evaluating qualitative research which were developed by Piantanida and Garman (1999).

Questions about the study's credibility and quality are concerned with:

- Integrity (in its architectural sense) – does the structure of the thesis work and is it coherent?
- Vitality – is it meaningful and significant?
- Rigour – is there sufficient depth and are the claims supported by data?
- Utility – is the study useful and professionally relevant?
- Ethics – does the study have ethical awareness?
- Verity – does the study ring true?
- Verisimilitude – does the study present recognizable portrayals?

Each of these quality and credibility criteria is addressed below.

My reflexive disposition is reflected in the transparency of the research process (Seale et al, 2004) and attention to high standards of ethical behaviour. This reflexive disposition, hermeneutic commitment, and discursive analytic framework, work in harmony and with complementary explanatory purpose to form a sound and clearly articulated conceptual framework. This framework is established in Chapters One to Five.

The claims made about contemporary Health Education practice (in Chapters One to Five) are supported by the data presented in Chapters Six to Nine. These data chapters were the result of a meticulous examination of the interview transcripts (a form of content analysis). Consistency (Hammersley, 1992) in the paraphrasing stage of this process was ensured by using another person to work through the transcripts. The findings were professionally significant (D. Hargreaves, 1996) because they illuminate contemporary policy and practice issues in an under-researched curriculum area.

The study 'ings true' because it rests on empirical data which verifies the claims made and because of my professional knowledge as a health educator and scholar. Data presentation was designed to show both aggregated data (Chapters Six to Nine) and individual portrayals (Chapter Nine), thus achieving a recognisable representation of the teachers' experiences.

In the following two subsections on methodological issues, interviewing and research ethics are discussed.

Interviewing

Interviews are not only a common research tool but are also very much a part of our everyday life (Silverman, 1993). The familiarity of the interview needs to be explored and underlying assumptions about the 'eality' it portrays need to be exposed. This was particularly important in this study because just twelve²⁰ one hour interviews formed its empirical base. My reflexive approach to the research study as a whole therefore extended to the principal source of data on which the analysis relied.

Interviewing has never been a neutral activity according to Fontana and Frey (2005). For them, interviewing is "inextricably and unavoidably historically, politically, and contextually bound. This boundedness refutes the whole tradition of the interview of gathering objective data to be used neutrally for scientific purposes" (p. 695). This idea is important for my study because it supports my purpose of generating subjective data and emphasises the non-scientific nature of the enquiry. Two papers in particular have enabled me to problematise the familiarity and neutrality of the interview. I discuss some of the issues I became aware of when I read Bourdieu (1996) and Toll & Crumpler (2004) below.

Bourdieu's writing enabled me to theorise some of the ethical processes which were going on in the interviews I conducted for this study. Bourdieu pointed out

²⁰ Although thirteen interviews took place, one teacher withdrew from the study after reading her interview transcript.

that although the purpose of an interview is different from other social interactions, it is always a *social relation*" (1996, p. 18). So at one level, it is just a conversation, but a conversation which was an intermingling of many dimensions and perspectives.

The quality of the interaction between my self and the teachers I interviewed was very important to me and I was clear that giving them my full attention, a *forgetfulness of self*" (Bourdieu, 1996, p. 24, was of primary importance. Similarly, I tried to minimise the *symbolic violence*" (Bourdieu, 1996, p19) inherent in an interview. *Symbolic violence*" occurs when the interviewer filters the data given to her through her own world view and therefore distorts and symbolically rejects how the interviewee explains their experiences. I was also aware of the difference between the resources of time and literature I had available to me as a teacher educator and what was available to the teachers. Bourdieu talks about the differential capital which needs to be addressed as much as possible, the *market of linguistic and symbolic goods* which is set up in each interview" (1996, p. 19).

What I was not aware of, and which in retrospect I wish I had considered and addressed, were different expectations about the object of the interview. Although I had shared as much as I could at the time about what I thought the purpose of the interview was (to find out about their experiences as Health Education teachers), I did not give the teachers the chance to respond to this or to say what their expectations were. It was therefore not possible to improve the quality of the interaction by *measuring the extent and the character of the distance between the objective of the enquiry as perceived by the respondent and as viewed by the investigator*" (Bourdieu, 1996, p. 19).

Despite the possibility that the teachers and I may have had differing expectations from the interview, we nevertheless had some shared understandings. For Bourdieu, *social proximity and familiarity in effect provide two of the social conditions of 'non-violent' communication*" (1996, p. 20). My professional proximity to those interviewed was an advantage in this study because there was an assumption that I understood some of the problems of

the teachers' practice, such as the low status of Health Education. This shared understanding encouraged —~~pl~~ talk” (Bourdieu, 1996, p. 22) about things which they may not have brought up with an interviewer who did not share the same background. However, there was also a negative side to this, as sometimes I was a little too closely aligned with the study and experienced some discomfort. Bourdieu (1996, p. 21) talks about questioning becoming —in effect a two-handed socio-analysis” when there is a close match of interests and experiences between the interviewer and interviewee and —~~the~~ analyst is herself caught up and examined, much as the person she is submitting to investigation”.

This potential for the interviewer to be positioned by the interview is also explored by Toll and Crumpler (2004). They use Foucault's (1983) concept of pastoral power to guide their exploration of the —~~apa~~parent contradiction between wanting to do good and engaging in an activity that might move from the dangerous to the bad or harmful” (2004, p. 386). Derived from the idea of members of the clergy using power in their care for others, Toll and Crumpler suggested some instances when the workings of pastoral power borders on the dangerous. One such instance is when a discursive effect of the interview is the validation of sharing very personal thoughts and experiences:

From this perspective, the discourse of the interview creates the sense that a *good* interview is one in which something previously hidden is revealed. Thus, telling secrets is not really an option, it is required of the interview. When researchers and participants fail to understand this, when they operate as though the interview is a safe space for the participant to *choose* to tell secrets (or not to), then the effect of the interview may become a bad one (p. 395).

An example of this occurred in the comments of one teacher who had previously described her strained relationships with senior staff. Differences of opinion about Health Education had caused these difficulties. She went on to explain how she had devised a strategy to get what she wanted for the school's health programme:

The year after the bullying issue we had a motivational speaker in and he talked to students. That was all done through the PTA²¹ but with my initial setting it up. So all very political as it were but you just go about it another way, so that it doesn't become something that you can get into trouble from (Andrea, 114-115).^{22 23}

At the time of the interview (late 2003) I recall being pleased Andrea felt safe enough to reveal something of the ways teachers manipulate the system and I had no concept of the interview as a kind of confessional' (Toll & Crumpler, 2004).

Ethical questions raised about the social interaction of the interview were also relevant to the next phase of the research process, interpreting the interviews. Toll and Crumpler (2004, p. 398) claimed ~~that~~ "what we are documenting is not so much about these teachers' professional lives as the way these teachers have been constructed by the interviews".

Toll and Crumpler suggested that one way of responding to this dilemma was to:

...consider the subject of our research to be *our* participation in the research interview. We might examine our desires in developing and conducting interviews, the manner in which our desires are shaped and changed by the interview, the subjectivities we help create, normalize, or reinforce through the interview, and how we are constructed by the discourses of the interviews (2004, pp. 398-399).

The reflexive approach I adopted for the interviews provided opportunities for reflection on my participation in each of the interviews.

²¹ Parent Teacher Association.

²² Pseudonyms have been used for the teachers in this study to preserve their anonymity

²³ The numbers beside the teachers' names refers to the numbered content units in their transcript. The quotes used vary from one content unit to several consecutive units. The method used to code the data was discussed in 2.3.

This part of the section on methodological issues has noted issues about the interviews, specifically ethical issues, the positive and negative effects of professional proximity, and the potential for harm. The last section of this chapter discusses a number of other ethical issues associated with the study, particularly issues of access and the use of the interview data.

Ethical issues

Qualitative researchers are guests in the private spaces of the world. Their manners should be good and their code of ethics strict (Stake, 2005, p. 459).

The ethics of the research proposal for this study were evaluated by a College of Education peer review panel (under delegated authority) against an institutional code of ethics, judged low risk and approval was given for the research to proceed in July of 2003 (see Appendix A). The process of developing my personal code of research ethics, as referred to by Stake, (2005), however, had only just begun.

This reflexive ethical journey began with meeting standard institutional requirements of, for example, informed consent, avoidance of deception, freedom from harm, and confidentiality. Using the principlist paradigm discussed by Cullen (2005), these considerations are mainly —~~con~~cerned with individual rights of participants” (p. 254). Cullen contrasts this approach with the relationships paradigm which focuses on:

...relationships with individuals and groups involved in the research and is context-based, taking into account factors such as culture, gender, ethnicity, community and geographical location. Further, a relationships paradigm adopts a narrative focus and is concerned with continuity and change over time (p. 254).

Cullen points out that although the two paradigms are underpinned by different theories, researchers may use elements from both in reaching ethical decisions

about their research. Both paradigms influenced my research, with the principlist paradigm being more dominant at the beginning of the research. At this early stage I recognised and respected the principles (such as informed consent and protection for research participants) which are the basis for ethical research. I was, however, largely unaware of the potential for “ethical squalor” (Street, 1998, p. 149) that may occur, despite adherence to the principlist paradigm. ‘Ethical squalor’ refers to the concealment of ethical issues that arise during a study.

In hindsight I recognise that for me, the process of gaining ethics approval was largely one of compliance, an exercise in meeting institutional requirements, a means to an end. I attribute my instrumental approach to my inexperience in this kind of research and because I had not begun the fieldwork. There was only one issue that engaged me in these early stages and then only at a relatively superficial level, this was my work as the Ministry of Education contractor for the Beacon project in senior health (Ministry of Education, 2005). A second issue which I should have engaged with at this early stage and failed to do so, was the ethical implications of using knowledge generated from an earlier piece of research on Health Education in New Zealand (my MEd thesis on the development of Health Education in New Zealand, Weir, 2000). It has been part of the reflexive process that now, nearing the end of the study, I have questioned the ethics of using this material and sought advice on the most appropriate way to acknowledge the primary sources and analysis which form a significant part of Chapters Three and Four²⁴.

My participation as a Ministry of Education contractor for the Beacon project for the development of senior health was the source of my first reflexive exercise. I had been the regional supporter for a number of Beacon schools in 2003, at the same time as I was seeking participants for this study. The Beacon teachers I worked with were obviously potential participants, so I sought permission from

²⁴I decided that the use of earlier work was justified as it contributed a valuable dimension to the contextualisation of the study. I have treated the material from my MEd thesis conventionally; that is I have acknowledged the source. Primary sources (from education archives) have been referenced as they appear in the thesis.

the Ministry of Education to include these teachers if they agreed to be part of the study.

After an exchange of correspondence, the Ministry agreed to this request (see Appendix A). One of the assurances I had given the Ministry was that the processes and data from the two investigations would remain separate. Although I tried to avoid data seepage from one environment to the other, I was acutely conscious of the potential for this, even though I had met the formal ethics committee requirements. As Grace comments, such an approach to the ethics of one's research, —demonstrates, once again, how principles of integrity articulated at a formal and theoretical level are compromised in the politics and practice of actual research" (1998, p. 214).

Potential for ethical squalor' is neatly illustrated by two episodes from the early phases of this study. The first had to do with access while the second was one of the participant's withdrawal from the study. In a third example, I explore a less straightforward example when my trustworthiness as a researcher was tested and the power dynamics of research were exposed.

Gaining access to teachers with stories to tell about Health Education caused me some anxiety. Just after I commenced interviewing for the study, two teachers made contact with me and offered to be interviewed off site'. They had found out about the research through colleagues from another school where access had been granted, whereas the principal of their school had denied me access. They were both passionate about Health Education and undoubtedly had very interesting stories to tell. Their enthusiasm for the subject, combined with their location in a school which had a reputation of not valuing Health Education made them attractive prospects. The right of their principal to decline access, however, meant that I could not interview them. They were angry with their principal and somewhat perplexed by my decision not to take up their offer.

The second episode which tested adherence to the ethical parameters of the study involved one teacher's withdrawal from the study. I interviewed thirteen

teachers but analysed twelve transcripts. The thirteenth interview had been transcribed and sent to the teacher for editing and for her consent that her edited material could be used in the study. I did not hear from the teacher for some time after I sent her the transcript and assumed she had simply been too busy to look at the transcript and get back to me. I was very disappointed when she subsequently rang me and told me that she did not want me to use her interview in the study. She admitted to having had doubts about agreeing to participate in the first place and this uneasiness had been confirmed when she read the transcript. It was “~~to~~ painful” she said, and indicated she had moved on from a difficult time in her life and did not want it documented in the study. The loss of any of the interviews would have been of concern but in Alice’s case, I was devastated. Her interview for me was the most memorable as it combined rich data about the history of Health Education in New Zealand with an intelligent and reflective account of the politics and power struggles of curriculum development in a marginalised subject. In addition, it was an intensely personal and moving account of her teaching career. It took me some time to come to terms with her right to withdraw from the study and to exclude her words (which I continued to recall) from the study.

The two examples above caused me some frustration and disappointment as I felt I had lost highly relevant material from the study. The criteria on which to base these decisions were, however, unequivocal – I could not bypass the principal’s denial of access and I had to respect a participant’s right of withdrawal from the study and her wish that her data not be used. In a third example of ethical decision making, there were also criteria on which to base my decisions and I drew on elements of both the ‘principlist paradigm’ and the ‘relationships paradigm’ (Cullen, 2005). The process was, however, different. Although the first two examples were disappointing in that rich data was lost to the study, they were relatively straightforward to settle in an ethical way. The two separate incidents which make up the third example were much more challenging.

In both cases the participants trusted me to make ethical decisions on their behalf. In the first incident, one of the participants returned the transcript to me

in person with the attached form which released the transcripts to me for the purposes of the research (see appendix A) signed and dated. In the course of our conversation she mentioned that she had been very busy and had not had time to read the transcript in its entirety but trusted me to look after her interests.

The second incident demanded a higher level of trust and ethical behaviour. In this case the participant had read and edited her transcript carefully so I was left in no doubt that I could, if I wished, include all the material in the study. There was a considerable weight of responsibility attached to this however, because she had given a very frank account of what had been going on in her school, so there was potential for harm to her as well as the school. There was a note attached to the transcript which acknowledged her candid account and the degree of trust she invested in me. She wrote: —I ~~trust~~ your integrity to protect me”.

The significance of being ethically discriminating about the use of her material was emphasised for me after I read Goodson and Numan (2002). While emphasising the importance of studying teachers’ lives in the workplace, they urge caution and careful attention to ethical behaviour:

But the study of teachers’ lives provides considerable potential for misuse by those administering and seeking to re-structure schooling. The study and, at worse, surveillance of the teacher’s life and work could be of immeasurable use in defining and promoting reforms that are antithetical to many teacher perspectives. The new discourse of sensitivity to the identities of the teacher/deliverers of other people’s intentions is part of the general marketisation and commodification of the professions (p. 275).

I returned to the two incidents outlined above many times in the research as I made decisions about what I could include from their transcripts. The teachers had given their informed consent and so in theory I could use all of their material in the study, but to be truly ethical, I could not. This was because I

believed that their caveats overruled their informed consent. This example serves to illustrate the on-going nature of ethical decision making throughout the research and how all possible dilemmas cannot be anticipated at the beginning of a study. It also illustrates the asymmetrical power relationship inherent in research; these two teachers had effectively handed over their power to me in the belief that I would act in their best interests.

This section on the practical application of ethics to research has shown that it is the reflexive ethical decision making in the researcher's work throughout the study which counts, not simply compliance to institutional codes of ethics.

2.5 Chapter summary

This chapter explained why I have written a reflexive account and how the research questions were developed. The methodological approaches and rationale were explained and justified, specifically the qualitative research paradigm (interpretive/hermeneutic), the toolbox conceptual framework, the significance and use of discourse (and the related theories of subjectivity and agency), and reflexivity. The research methods used in the empirical part of the study were also described and justified. The methods discussed were the interview process and how the transcripts were analysed and presented. In the final part of the chapter, three methodological issues were discussed: a means for evaluating the 'truthfulness' of this study and reflection on two aspects of the methodology (the interviewing and ethical issues).

In the following two chapters (Chapters Three and Four), the study is set within its historical, political, social and educational parameters. These two chapters contextualise the present study by examining the *macro* historical and socio-political discourses (Chapter Three) and the *mezzo* discourses evident as educational policy was put into practice (Chapter Four).

Chapter Three

Context I: Health education's socio-political and historical discourses 1877-2004

The chapter examines socio-political and historical discourses and is organised into seven sections comprising: **3.1 Introduction and chapter overview**; **3.2 Historical factors**; **3.3 Social issues discourse**; **3.4 The effects of social issues and policy discourses on the development of Health Education**; **3.5 Health and education discourses**; **3.6 Neo-liberal discourses**; and **3.7 Chapter summary**.

3.1 Introduction and chapter overview

While their narrations rarely reference history or the global economy explicitly, we have had to situate these men, as they move through their daily lives and narrate their social relations, in the shifting historic sands of social, economic, and political conditions (Weis and Fine 2004, p. xvii).

This thesis argues that contemporary Health Education teaching occurs in relation to economic, social, political and historic contexts²⁵ (Hargreaves 1990; McCulloch, 1992; Openshaw 1995; Pinar, Reynolds, Slattery & Taubman 1995; Lee & Hill 1996; Goodson, 2003). The micro worlds' of schools are shaped both by these contexts and also those that are specific to education. O'Neill (2001) argued that secondary teachers' practice is informed by cultures and traditions developed over a long period of time:

²⁵ Contexts' is used in this instance as these writers in general used non discursive language. Context implies something fixed and unitary; discourse (as discussed in Chapter Two) is the preferred term for this study.

Teachers' personal and collective theories of knowledge (epistemologies), the ways they view their occupational and social worlds (ontologies) and the values they espouse and use as a basis for decision-making (axiologies) are not ahistorical entities. Contemporary practices are embedded in longer standing cultures and politics of secondary schooling in New Zealand (p. 364).

One of O'Neill's findings was that for the teachers in his study (carried out in the mid 1990s) relational discourses remained strong. These discourses had their roots in policy discourses of the 1940s. Enduring discourses such as these were likely to lessen the effects of contemporary official curriculum and assessment discourses. Health education has developed its own discourses over time and these are discussed in Chapters Three and Four. In this chapter, socio-political and historical (macro) discourses are analysed, while Chapter Four examines the influence of policy (mezzo) discourses on Health Education.

This chapter generally follows a chronological structure and uses some contemporary examples to illustrate enduring themes in health education. The chapter examines the socio-political and historical discourses which influenced the development of Health Education from the beginning of state provision of education in 1887 until 2004. It is divided into seven sections with the first (this section) introducing the chapter and giving an overview of its structure and content.

The second section of the chapter briefly discusses two key aspects of New Zealand's early education history relevant to Health Education, and the third section examines social issues discourses. In the fourth section, social issues and policy discourses are discussed in relation to the development of Health Education. In the fifth section, the interrelationship of health and education discourses is explored. The chapter's discursive analysis is completed with a discussion of the influence of neo-liberal ideologies on education.

3.2 Historical factors

There were two aspects of the early years of the state education system in New Zealand that are relevant to contemporary Health Education. These were i) the expectation that schools should take an interest in young people's health, and ii) the development of an academic tradition in secondary schools.

Although there was no written mandate for Health Education until 1920 when concerns about the physical aspects of health prompted the Department of Education to produce a section on *Hygiene and First Aid* in the 1920, *Syllabus of Instruction for Public Schools* (Department of Education, 1920), elements of present day curricular definitions²⁶ of Health Education were clearly going to be the business of schools and teachers. This was because a major function of schooling has always been the provision of a healthy work force. So while there was no formal stipulation that Health Education should take place, the emerging state's requirement for productive citizens meant that attention to physical and social health, as they were conceptualised at the time, was integral to the education system. Policies aimed at optimising individual health for the purposes of social and economic health have been critiqued within a broad theoretical perspective that exposes the state's intentions for education and contrasts these intentions with those that promote education as a good in itself (Codd, 1985; Katz, 1987; Kirk, 1993; Lawson, 1993).

An academic discourse was evident from the early years of state education in New Zealand. Whereas primary schools were established to provide basic education for all, secondary schools were expected to provide an education for a privileged few and were modelled on the academic traditions of England. Such an education would prepare students for what was assumed to be their future roles in society. With the introduction of the free place scheme in 1903, attempts to reproduce the English public system in New Zealand's secondary

²⁶ If Health Education is defined using contemporary holistic descriptors (social, physical, mental and emotional and spiritual together with the values underpinning these interwoven categories), then it can be argued that it has taken place in one form or another since state schooling in New Zealand began with the passing of the 1877 Education Act.

schools were disturbed by an influx of students representing a broader societal base (McGeorge, 1992). Inherited traditions however remained influential, with one of them, the tradition which valued academic subjects over others, being pertinent to this study.

An abiding characteristic of the secondary school environment is the dominance of subjects as a way of organising curriculum (Kliebard, 1987) and the pre-eminence of academic over social goals. A theoretical explanation for the dominance of the academic, based on the work of the British sociologist Basil Bernstein, is explicated in Chapter Five. Here it is sufficient to note the work of Noddings (2005), who claimed that the social issues apparent in the United States have not been adequately addressed because schooling is dominated by academic goals. She argued for an ethic of care as a fundamental principle in education. There were tensions between academic and social issues discourses in this study. In the next subsection, the relationship between a social issues discourse and Health Education is discussed.

3.3 A social issues discourse

This section examines social issues as an on-going discourse in Health Education's development as schools became the focus of official efforts to tackle social issues such as those discussed below.

Addressing social issues through education

There are numerous historical examples of pressures on schools and teachers to address social issues. Anxiety about the lack of moral fibre evident in the behaviour of young people, often aligned with lack to basics rhetoric (see for example Snook, 1990), was a recurrent theme from early on in the history of European settlement in New Zealand. In the early twentieth century it was hoped that the indirect teaching of values through example and a variety of

subjects, including physical instruction²⁷, would address rising public awareness of worrying social issues. Of particular concern was the increasing number of babies born to young women who were not married (Butchers, 1930).

Social issues and adolescence discourses

Anxiety about social issues was often linked in public consciousness with perceptions of adolescence as a vulnerable developmental phase. The social construction of adolescence as a distinct phase between childhood and adulthood is a relatively recent occurrence, although Savage (2007) located the characterisation of this period of life as one of angst and unpredictability in the work of Rousseau and Goethe in the late eighteenth century. The pathologisation of adolescence became apparent during the 1950s with the publication of psychological analyses of the ‘adolescent problem’ such as *Adolescence and the Conflict of Generations* (Pearson, 1958). More recent commentators such as Eckersley (1992) explored the development of the idea of adolescent crisis.

As increasing numbers of adolescents stayed on at school, secondary schools become a primary focus for attempts to address social issues through education. The state’s response to the perceived ‘problem’ is, more often than not, a combination of regulation (through legislation) and education. Public anxiety about the effects of popular culture (such as film) and the state’s response were examined by Shuker (1990) in his work on the development of censorship in New Zealand. He talked about “—concern at the effects of film upon children and youth, and associated calls for schools and the censor to act to prevent the corruption of the innocent” (p. 236). The links between Health Education and legislation are discussed in Section 3.4.

‘Moral panic’ discourses

In this subsection, a moral panic discourse is identified and discussed with reference to an historical example, the Mazengarb Report, and the

²⁷ Character training for example was included in the Department of Education’s *Syllabus for Physical Training in Schools in 1926*.

contemporary examples of 'the obesity epidemic', adolescent sexuality and 'boy racers'.

Heightened anxiety about social issues (and associated perceptions of adolescence as a time of crisis) are perhaps best represented in New Zealand's history by public reactions to media reports and alarm expressed by politicians and other prominent people about adolescent 'depravity' (sexual activity) which allegedly took place in Lower Hutt in 1954. In addition, the 1954 murder in Christchurch of a mother by her daughter and the daughter's friend (the Parker-Hulme case) had caused a moral panic with 'deviant' sexuality being cited as the cause (Glamuzina and Laurie, 1991). The government established the Special Committee on Moral Delinquency in Children to consider these disturbing events and the resulting *Report on Moral Delinquency in Children and Adolescents* (Department of Education, 1954), more commonly known as the Mazengarb Report, was sent to every household in New Zealand. The report became a moral platform for urgent legislation (the Child Welfare Amendment Act, 1954; the Indecent Publications Amendment Act, 1954; and Police Offences Amendment Act, 1954²⁸). This legislation was passed before the select committee established to respond to the Mazengarb recommendations could report to parliament.

The Mazengarb Report was analysed by Soler (1988) according to a sociological model of moral panic used in studies such as those carried out by Cohen (1972) and Hall, Crichton, Jefferson and Robert (1978). Soler expressed some caution about the uncritical use of moral panic models but suggested that the model was useful for analysing "the processes, and agencies which act to identify, highlight, and legitimise public sanctions against juvenile 'immorality' and deviancy" (1988, p. 275).

Elements of moral panic theory such as the effects of media amplification on public perceptions and hurried legislative responses to 'fix the problem', can be detected in contemporary crises such as the so called 'obesity epidemic'.

²⁸ These pieces of legislation are discussed in relation to developments in Health Education later in Chapter Three.

Commentators such as Gard and Wright (2001) are critical of media and scientific preoccupations with the relationship between weight and health and suggest underlying moral and ideological agendas.

Moral panic discourse about adolescent sexuality remains a feature of New Zealand's social fabric. In 2004 the then president of the New Zealand Post Primary Teachers' Association, Phil Smith, wrote an opinion piece headed "In the grip of moral panic" in which he referred to: "the over reaction to proposed (later dumped) legal changes to prosecuting minors who have sex, then the hysteria around the Civil Union Bill and recently an outburst about condoms issued at a school ball" (Smith, 2004, p. 4). In an explicit reference to the New Zealand moral panics of the early 1950s, the columnist Finlay Macdonald (2003) wrote a piece for a national weekend newspaper. Entitled "Shaky moral high ground", Macdonald mentioned a variety of current moral panics but noted that: "pushing all previous moral panics off the front page last week, of course was a supposed scourge of boy racers" (2003, p. 10).

This section has shown that there was a growing concern in the community about social issues during the twentieth and early twenty-first centuries. Community anxiety increased pressure upon secondary schools to be involved in addressing these issues, particularly sexuality. In the following section, the influence of a social issues discourse on health education is demonstrated.

3.4 The effects of social issues and policy discourses on the development of Health Education

In this section, the combined effect of social issues discourses (mainly represented in this section by sexuality) and policy discourses are traced from the 1960s through to the late 1990s. This interplay of discourses was pivotal in Health Education's curriculum development. The subsection considers the reports of the 1970s, challenges for health education development, changes of

policy reflected in government, the development of *Health Education in Primary and Secondary Schools*²⁹ (Department of Education, 1985), the legislation associated with Health Education, and the development of sexuality education programmes in secondary schools.

The reports of the 1970s³⁰

The Ross and Johnson reports (Department of Education, 1973, 1977) were part of a political response to the changing social order in New Zealand during the 1960s and 1970s. They illustrate the inherently political nature of curriculum. Using consultation as a means of acquiring political respectability, the reports provided a defensible platform for planned curriculum initiatives in Health Education (Weir, 2000).

The Ross Report (Department of Education, 1973) named after the chair of the authoring committee, J. A. Ross, who was at that time the Superintendent of Curriculum Development in the Department of Education, was intended as a discussion document. It was circulated in 1973 as *Human Development and Relationships in the School Curriculum*. Ross's interpretation of why the committee had been set up provides insight into the complex issues which successive governments in the 1960s and 1970s were trying to address:

Between 1968 and 1971 many groups and organisations in the community began asking that schools deal with sex education as an answer to social ills and promiscuity. Such groups, writing to MPs, strongly made the point that sex education is part of total development. The Department was caught between these groups and another equally concerned group who believed sex education must remain the task of parents.³¹

The Johnson Report (Department of Education, 1977), named after its chair Garfield Johnson, was the most extensive and significant of a cluster of

²⁹ Henceforth referred to as the 1985 syllabus.

³⁰ This part of the discussion draws on the work undertaken for my masterate – see Chapters One and Two for details of this.

³¹ Curriculum Unit Meetings- Minutes, 1972-1976. ABEP 7749, W4262, Box 2060, 34/1/53, Part 1.

education reports produced in the 1970s. It reinforced the recommendations of the Ross Report and contributed to subsequent initiatives in outdoor education, guidance and special needs. The effects for values education and sexuality education were disappointing for those who had hoped that the report would provide leverage for curriculum change. Looking back, the report appears innocuous but at the time there was much agitation about the smallest portion of the report, the eleven pages which were broadly about values.

Merv Wellington, the Minister of Education responsible for drawing some conclusions from the results of the consultation process, released a much anticipated ministerial statement in 1980 (Weir, 2000). Wellington was well known for his conservative views and there was an on-going worry that he was unduly influenced by groups opposed to sexuality education in schools. Those who had hoped for a mandate for sexuality education were to be disappointed, for in Wellington's view there was insufficient endorsement for change in the area of human development and relationships.

Challenges for health education development

Three issues about Health Education's development that became apparent in the 1970s were: inadequate provision for professional development, issues to do with consultation, and the idea that teaching Health Education could be done by anyone. These issues were also relevant for Health Education's subsequent development.

Adequate professional development for Health Education teachers is a recurrent issue and the role of government departments in facilitating this was signalled early. An awareness that Health Education teachers did not already exist in schools and had therefore to be 'created' was evident in early discussions about curriculum implementation in schools. The Ross Report and the Johnson Report mentioned this absence and it was also noted by the teacher unions (Weir, 2000).

The Department of Education insisted that there should be adequate professional development for those already in schools and that the colleges of education should provide health education courses for their students. Some pre-service health education had been taking place at Otago University's School of Physical Education but this was the exception rather than the rule; most teacher education institutions offered courses only from the mid 1980s (Weir, 2000). On-going issues about access to sustained professional development support are represented in the empirical part of this study.

Issues around consultation were also highlighted. The Department of Education observed that the Ross Report:

...stimulated public discussion and the expression of a wide and conflicting range of opinions. The Department accepts the obligation to continue to take heed of these views and to find ways of implementing them that respects the wishes of both majority and minority groups in society (Department of Education, 1976, p. 14)³²

Community consultation became a requirement for the curriculum (or syllabus as it was then called) which was subsequently developed for Health Education in the 1980s. The comments above foreshadow problems in the consultation process.

Another issue relevant to this study was expressed by Renwick, the Director General of Education in his introduction to *Health Education in Primary and Secondary Schools*. He wrote: —this syllabus is directed at all teachers, as, in a sense every teacher is a teacher of health education” (Department of Education, 1985 p. 6). This statement gives credence to the view that anyone can teach Health Education, that it is just common sense and, as such, contributes to the actuality of low status and marginalisation of Health Education in secondary schools.

³² Report of the Department of Education of 31 March, 1976, in Parliamentary Papers belonging to Information Services, Ministry of Education, Wellington, NZ.

Changes of government reflected in policy

The effect of different political discourses on education policy at this time is exemplified by Wellington's departure from office in 1984 with the election of the new Labour Government. This change in minister was welcomed by members of the Department of Education who were keen to act on the recommendations of the conferences and reports which had urged action in human relationships education. There was huge anticipation of change when Russell Marshall became the Minister of Education in 1984. Helen Shaw, a former secondary school teacher and a key figure in Health Education curriculum developments during the 1980s, described her reaction:

Merv Wellington was cautious and downright antagonistic and when Russell Marshall came it was just a breath of fresh air. It had an immense effect on the Department of Education after having everything we wanted cut back, not just in health but in heaps of other initiatives too. Suddenly it was like the lid that had been screwed on was lifted off with the change of government (Weir, personal communication, 1999).

Shaw's reactions serve to emphasise the way discourses have differential influence, depending on who is in power at the time.

The development of the 1985 syllabus

This part of the chapter discusses the development of a new curriculum for primary and secondary schools, the 1985 syllabus. This development is important because it shows the interplay of policy and sexuality discourses and how, given a favourable political environment, these discourses could be productive.

In April 1980, as one of his responses to the Johnson Report, Wellington had at last authorised his department to begin a review of the primary and secondary Health Education syllabuses which were by now very out of date (the primary syllabus and secondary school regulations had been written in the 1940s). He made it clear that this review was bound by other decisions he had made about the Johnson Report.

The other decisions he referred to had upheld the exclusion of sexuality education from primary schools and endorsed current practices in secondary schools which allowed courses in sexuality education to be offered with the consent of school principals and boards and taking into account the Contraception, Sterilisation and Abortion Act of 1978³³.

As a result of Wellington's announcements, a Health Education project team began work early in 1982. After extensive consultation, frequently acrimonious debate and numerous delays, a new Health Education syllabus for primary and secondary schools was finally approved by Wellington's successor, Russell Marshall and published in 1985. The publication of this syllabus document was very important because it marked the successful outcome of numerous attempts to get an official mandate for addressing social issues in schools.

Policy development for sexuality education

Sexuality discourses had dominated the consultation process for the syllabus. This was because a number of groups and individuals were irate at the possibility of primary schools teaching sexuality education. There was, however, broadly based support for sexuality education programmes in secondary schools from education, community and health groups. Even some of the conservative groups with religious affiliations, such as the Society for the Protection of the Unborn Child (SPUC), were supportive of sexuality education in that it was hoped that sexuality education would reduce the need for abortions (Weir, 2000).

Helen Shaw (the leader of the Department's project team working on the Health Education syllabus) was acutely aware of the political sensitivities involved and was anxious not to be identified with any of the more extreme pressure groups. Reflecting on her work she said:

I guess one of the risks was I had to avoid being captured by the people who were extremely liberal like WONAAC who were giving out condoms

³³ This legislation is discussed in the last part of this section.

over school fences and so on. I couldn't be seen to be pally with a group like that because I could easily have been ostracised by the very conservative groups (Weir, personal communication, 1999).

This comment shows how government employees have to negotiate community discourses (in this case, radical versus conservative view points on sexuality education) as well as those associated with successive governments.

Support for sexuality education in secondary schools was in most cases conditional on the retention of the existing practice of the right of parents to withdraw their child from nominated parts of Health Education programmes. This procedure was given legal status with the passing of the Education Amendment Act in 1985. Under this legislation, primary and secondary schools were required to consult with their communities every two years about their Health Education programmes. The Act outlined the consultation required for the implementation of sexuality education programmes for senior primary and secondary schools. The legislation also gave school principals and governing bodies the right to scrutinise the content of sexuality programmes before they could be taught to students. This legislation was significant as it formalised the principle of partnership with parents and community which had developed over several decades. It was also a way of addressing the issue of parental rights which had hitherto been a barrier to curriculum development (Weir, 2000). This and other legislation affecting Health Education is discussed in the next subsection.

Legislation and Health Education: 1945-2001

Health Education stands out from other school subjects because of the development of legislation and policy designed to control sexuality education³⁴ teaching. In the last part of this section on social issues and policy discourses and their effects on Health Education, the legislation affecting Health Education

³⁴ The term 'sexuality education' has replaced sex education since the 1990s. Sexuality education is favoured because it includes all the dimensions of well-being – physical, social, emotional, mental and spiritual. Sex education is more likely to refer to just the physical dimensions. Sexuality education is the preferred term in this thesis.

is considered. This legislation reflects the political sensitivity of Health Education because of controversies over sexuality education (Clark, 2001; McGeorge, 1977; Openshaw, 1985; Snook 1980,1990; Weir 2000). The legislation is also significant because it had the potential to create anxiety and confusion for schools and teachers.

The major legislation affecting the teaching of health education and, particularly, sexuality education were as follows: the 1945 Revised Health Education Syllabus for Primary Schools; the 1954 Amendment to the Police Offences Act; and the 1978 Contraception, Sterilisation and Abortion Act (and the repeal in 1990 of Section 3 of the same Act). A further piece of legislation (the Education Amendment Act of 1985) mandated community consultation for Health Education, required Board of Trustee approval of the content for sexuality education programmes (later revoked), and upheld the right of parents to withdraw their children from sexuality education programmes. This legislation was modified in 2001 with every (state) school required to implement all aspects of the 1999 curriculum, including sexuality education. The right of parents to withdraw their child, however, remains. Wyness (1997), commenting on similar legislation in England (the 1993 Education Act), notes that although sexuality education is a compulsory part of the curriculum and therefore requires the commitment of teachers: —the Act also appears to undermine these efforts in that it strengthens the rights of parents to exclude their children from this component of the curriculum” (p. 107). The implications of New Zealand legislation for sexuality education were long lasting and are explained below.

Similarly, one major influence on the teaching of sexuality education was the revised syllabus, gazetted in 1945. In this syllabus, the expectation for Health Education was similar to the 1929 syllabus for primary schools but for the first time sexuality education was mentioned, but excluded from primary schools – all in the same phrase. It stated: —there is no place in the primary school for group or class instruction in sex education” (Department of Education, 1945). This phrase dominated discussions about sexuality education in primary schools for decades and by implication indicated that secondary schools could teach sexuality education. In addition to the 1945 syllabus, a second major

influence on sexuality education was the controversial Contraception, Sterilisation and Abortion Act of 1978. Much of the controversy and confusion arose from varying interpretations of Section 3 of this Act. The legislation allowed designated people, including teachers (as part of a human development and relationship programme and with the permission of the principal and governing body of the school), to give contraceptive education to those under the age of 16 in schools³⁵.

Schools struggled with the application of the Act to sexuality education. A major problem was the inhibiting influence of previous legislation (the Amendment to the Police Offences Act of 1954)³⁶ which made it an offence to instruct or persuade young people to use contraception. The Department of Education, in consultation with groups such as the teacher unions, produced guidelines to help interpret the Act but confusion and anxiety remained. The overall effect of the legislation on contraception was to create an uncertain climate for sexuality education.

The combined effects of this legislation and the earlier Amendment to the Police Offences Act of 1954 were long lasting, despite the eventual repeal of Section 3 in 1990. Examples of the longevity of the effects of the legislation on sexuality education include a 1996 study of sexuality education provision for Years 7 and 8 in a provincial area of New Zealand. In this study, Blakey and Mold (1996) noted confusion about the contraception information teachers could provide. In a more recent example, a pre-service secondary student told me that on a teaching placement in a state secondary school she had been informed by a Health Education teacher that she could only indicate the range of contraceptive devices available but could not teach students about their use (Weir, personal communication, 2006b).

³⁵ For a detailed discussion see Snook, (1980).

³⁶ The Amendment to the Police Offences Act (1954) was one of the pieces of legislation associated with the Mazengarb Report (Department of Education, 1954).

The development of sexuality education programmes in secondary schools

There were some advantages in working within this confusing legislative framework. Historical evidence suggests that teachers did not merely respond to official expectations but initiated programmes for sexuality education based on their understanding of the needs of students in their communities (Weir, 2000). Teachers in secondary schools were therefore able to initiate their own programmes because of ambiguous legislation which allowed for a variety of interpretations of what was acceptable in a secondary school sexuality education programme.

An additional factor in the development of these programmes was that they took place in more benign times than the present. This observation is supported by a general agreement that teachers both in New Zealand and other countries had considerable autonomy in determining curriculum content during the 1970s and 1980s (see for example, McCulloch, Helsby & Knight, 2000 and Goodson, 2003). Goodson, writing about the English experience, notes that the historical conditions of the period from the mid 1940s until the 1970s (such as an emphasis on the public sector, and the pursuit of social justice) saw the growth of considerable professional autonomy. In these circumstances, change was more likely to be generated and managed by those working in and with schools (teachers and professional education groups), rather than policy makers working from the centre (Goodson, 2003).

By the 1980s, secondary schools, unencumbered by the primary proscription and working within a broad non-prescriptive climate, had developed school based initiatives which included sexuality education in a variety of site based life skills and social education programmes (Weir, 2000). Evidence of the opening up of secondary education to subjects which were additional to the academic canon is provided by a Department of Education 'baseline survey' undertaken in the late 1970s. Under the heading 'Innovation and Relevance' among the new subjects and courses (such as social education and family life education) "about a third of the schools were offering Health Education at the junior level and a significant number up to Form 5" (Department of Education, 1981, p. 177).

In this section, strands of social issues discourses (mainly represented by sexuality) and policy discourses were traced from the 1960s through to the late 1990s. This interplay of discourses was a major influence on health education's development. The subsection considered the reports of the 1970s; the challenges arising from policy development in health education, the changes of government that were reflected in policy development, the development of the 1985 syllabus, the legislation associated with health education, and the development of sexuality education programmes in secondary schools. In the next section, the relationships between health and education discourses are examined.

3.5 Health and education discourses

Health Education is a mix of discourses (sometimes harmonious and sometimes discordant) from both the health and education sectors. In this section, the intermingling of health and education discourses is shown through an examination of health and education sexuality discourses, the education sector's response to the HIV crisis of the late 1990s, the involvement of outsiders in health education and the influence of indigenous and World Health Organisation discourses.

Health and education sexuality discourses

A predominantly health sector discourse of reproductive health and an education discourse that involves more complex views of sexuality and sexuality education are considered in this part of the subsection. These discourses are relevant because it was evident that some teachers in this study were influenced by a reproductive health discourse.

Reproductive health discourses are concerned with pregnancies and infections. In New Zealand, Tasker (2001, p. 10) noted that the health sector was very

concerned with: —high levels of teenage pregnancy and sexually transmitted infections (STIs) compared with other OECD countries”. In Britain where health education does not have a separate curriculum, but is located in the cross-curriculum themes, national health strategies such as the 1988 *Healthy Schools Initiative* which is part of *Our Healthier Nation* (Harrison, 2000) stressed the detrimental effects of early pregnancies for teenage girls and the dangers of STIs. The 1992 British Government White Paper, *Health of the Nation* (HMSO) (Wyness, 1997) proposed ways to halve Britain’s teenage pregnancy rates.

The state has economic reasons for being interested in reproductive health. Schools provide a means of reaching large numbers of people for sustained blocks of time and also opportunities to use individuals to carry the desired health messages back to families and communities (Tones, Tilford, & Robinson, 1990). In the late 1990s, the British government linked high rates of teenage pregnancies to diminished academic accomplishment and lessened potential for participation in the national economy (Alldred, David, & Smith, 2003).

The state’s interest in sex was emphasised by Foucault (1978) when he noted the emergence in the eighteenth century of —a new technology of sex”:

Through pedagogy, medicine and economics, it made sex not only a secular concern but a concern of the state as well; to be more exact, sex became a matter that requires the social body as a whole, and virtually all its individuals, to place themselves under surveillance (p. 116.)

The state’s interest in reproductive health can be theorised using Foucault’s analysis of the workings of disciplinary power (Middleton, 1998) and can be applied to the —administrative surveillance and regulation” (p. 7) of among other things, —abortion, contraception and sexual information” (p. 8). Reproductive health discourses were used by teachers in this study and were also evident in the reported views and actions of others such as public health nurses.

A potential tension in sexuality education is between a public health discourse (a strand of health discourse) and a moralistic discourse (Johnson, 1996).

Here, the need to provide up to date knowledge about the biological aspects of sexuality can come into conflict with traditional views about sexual relationships. Thompson (1993) sums up the conflicting aims which have their origins in different discourses:

Should school sex education be used as an opportunity to communicate knowledge and skills to enable young people to make informed decisions or should it be used as an opportunity to impose a prescriptive model of sexual and personal morality? (p. 220).

Put another way, there can be subtext to providing young people with knowledge for it is argued that knowing the facts about human reproduction will encourage young people to make sensible choices about sexuality, that is, they will refrain from sexual intercourse (Fine, 1988). Tensions between moralistic and public health discourses were evident in this study.

Some New Zealand Health Education resources offer explicitly theorised views of sexuality and sexuality education. The ontological and epistemological assumptions of the senior Health Education resource *Social and Ethical Issues in Sexuality Education* for example are different from those which underpin other Health Education resources. The content and approaches in *Social and Ethical Issues in Sexuality Education* suggest that sexuality is the site of deeply embedded ideologies and values about individuals and society. This critical approach is radically different from the claims Thompson (1993) made about England's school 'sexeducation' programmes:

Historically the evolution of public policy around sexuality mirrors wider anxieties concerning nationhood, social change and social stability. Historians have shown that the origins of school sex education lie in the moralist and eugenic concerns around the breakdown of the family, the changing role and expectations of women, the purity of the race and the differential birth rate between social classes. The aims of school sex education have never been to help young people have satisfying and fulfilling sexual relationships (p. 221).

A number of the teachers in this study were familiar with *Social and Ethical Issues in Sexuality Education* and were therefore aware of critical sexuality discourses which had the potential to expose some of the above ideologies.

In this part of the section, sexuality discourses have been discussed. These discourses broadly belong to two discursive fields: the health sector (with a primary interest in reproductive health) and the education sector that is likely to have a more complex and critical view of sexuality. The teachers in this study drew on both discursive fields.

HIV/AIDS and Health Education

In this part of the section, the education sector's response to the HIV 'crisis' of the late 1990s is used to illustrate a combination of discursive influences and also the way the discourses 'travel' from one sector to the other. This 'travelling' occurs because of the professional development processes funded by the health sector. Provisions for professional development therefore enabled people from both sectors to meet and exchange ideas. The significance of this example is that in this case, education discourses reflected health discourses that included both reproductive health discourse strands (such as an emphasis on managing an infectious disease) and also questions about societal values and attitudes.

New Zealand's situation seems to have been unusual because there appears to have been less emphasis on disease management than was the case in Britain. Halstead and Reiss (2003), for example suggest that the arrival of AIDS was instrumental in the revival of a major aim of sexuality education in Britain – a reduction in the STI rates which had diminished in importance since antibiotics could be used so successfully against them. In Britain, "there was a flood of HIV/AIDS education packs for use in schools" (Halstead & Reiss, 2003, p. 148) as 'public health pragmatism' (Thompson, 1993) was brought into play.

The health discourses reaching the education sector in New Zealand seem to have been different. Davis and Lichtenstein (1996) for example, liken the arrival

of AIDS in New Zealand to other major infectious diseases such as the 1918 influenza pandemic and note the wide ranging effects of such diseases. They go on to argue, however, that the social impact of AIDS was something markedly different from previous epidemics:

AIDS has raised questions about some of our fundamental values and has forced onto the public agenda issues and topics that have long been either suppressed, dormant or simply ignored. These include matters of sexual culture and sexual orientation, issues of injecting drug use and sex work and basic human rights (p. 222).

These critical discourses were shared with the education sector through professional development. One aspect of New Zealand's response to the HIV/AIDS 'crisis' was a Department of Health funded national teacher development project which began in 1992. The project was led by Gillian Tasker a tertiary health educator and later principal Health Education writer for the 1999 curriculum. Tasker argued that the influential "scientised transmission pedagogy" of sexuality education was an inadequate model and advocated a "critical or emancipatory constructivist approach" which "necessitated a transformative teacher development process" (Tasker, 2001, p. 44).

Prior to Tasker's project 'transmission pedagogy' seemed to have prevailed in some of the schools which had implemented their own programmes aimed at increasing secondary school students' knowledge of AIDS. Milne's 1990 study of three Hamilton secondary schools which taught lessons on AIDS makes it clear that the programmes in two of the schools were "predominantly knowledge based" and also made the point that "efforts were made to address students' attitudes towards homosexuals" (Milne, 1990, p. 89).

The scope of the national project was much broader, for in addition to increased understanding about AIDS transmission and prevention, it emphasised the importance of:

...the provision of learning opportunities to critically reflect on the attitudes and values of the communities and society to which the

students belong, especially in relation to heterosexism and homophobia, and to identify ways they can support themselves and others in situations involving intolerance and discrimination (Tasker, 2001, p. 48).

The Department of Health's HIV/AIDS teacher development project provided an impetus for sexuality education as teachers who participated returned to their schools (Tasker, 2001). The experience also exposed teachers to a range of views drawn from discourses about disease prevention and management and more critical discourses that encouraged critique of entrenched attitudes and values.

Health education and 'outsiders'

A significant feature of Health Education's history has been the involvement of community and national groups. In addition to helping shape the curriculum and resource material (as described above), they have also been involved in teaching Health Education. These outsiders bring their own discourses to Health Education. The health sector is strongly represented in this group and so health sector discourses were embodied by people who worked with or supported teachers.

The interest of outside groups was evident from the early years of New Zealand's education system. McGeorge (1977) mentioned several organisations which were successful in gaining access to primary and secondary schools. They included the White Cross League (sexuality education in senior primary in the early 1900s) and the Temperance Movement (championed by George Fowlds, Minister of Education in 1906). Other examples were the Church of England Mothers' Union, the Family Planning Association and the Marriage Guidance Council (sexuality education in secondary schools in Christchurch, Wellington and Auckland during the late 1950s and 1960s). The Department of Health advocated for sexuality education in schools and some intermediate schools used Health Department officers to teach sexuality education outside of school hours during the 1960s (Weir, 2000). Outside providers have been involved in teaching Health Education in

recent years (Tasker, 2004a). A number of individuals and health groups from outside of education have also contributed to key resources³⁷ to support learning at senior secondary level. These groups include the Alcohol Advisory Council of New Zealand, the Mental Health Foundation and the New Zealand Police. Outside providers have also been involved in health education in other countries. In England for example, Hamblett (1994) recommended that external agencies should be used in health education. Outside organisations might include “medical and nursing professionals, Relate (formerly the Marriage Guidance Council), the Family Planning Association, the fire prevention service, police and drugs squad officers”. (p. 30).

The work of outsiders in health education provided some interesting questions to follow up in this study; in particular, what effects would the discourses they embodied have on pedagogy? Indigenous health discourses and those that originated in the work of the World Health Organisation (WHO) were of particular interest because they challenged existing powerful discourses. Indigenous and World Health Education discourses are discussed in the last subsection.

World Health Organisation and indigenous discourses

In New Zealand, as in other ‘developed’ countries, prevailing health discourses stemmed from an Enlightenment inheritance from the eighteenth century that stressed the separation of body and mind. This binary discourse was largely unchallenged until the latter half of the twentieth century when alternative discourses began to emerge. These alternative discourses came from both local and global sources. In New Zealand, discourses from Māori sources emphasised the integration of mind and body and the role of community in the restoration of health to individuals (for example, Durie, 1994, 2001). At about the same time similar discourses were emerging through World Health Organisation channels.

³⁷ The use of these resources is discussed in Chapter Six, Section 6.3.

The World Health Organization's major contribution to the conceptual development of health began with the definition of health as being —state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity” (World Health Organisation, 1946). This has continued through a series of influential conferences and reports which culminated in the most widely known initiative, the *Ottawa Charter for Health Promotion* (World Health Organisation, 1986). The WHO's 1946 definition gave credence to broad holistic definitions of health already present in indigenous world views, and signalled a radical departure from previous discourses about the health of individuals and society. The Ottawa Charter emphasised individual and community empowerment through the development and exercise of individual skills, but at its core was the call for political and social action. Tones (1992), for example, comments on the role of advocacy (a strategy identified in the charter) in the enhancement of health. Advocacy involves —the process of lobbying by relatively powerful people or groups on behalf of others who are disadvantaged or lack power in one way or another” (p. 34).

Indigenous and global discourses about health, particularly those derived from the WHO, have had a major influence on the way health is conceptualised in New Zealand. Health is now more likely to be characterised as holistic and aimed at individual and community empowerment, with less emphasis on individual health behaviour change and more emphasis on the development and implementation of policies which challenge structural inequalities.

Alongside these contemporary health discourses, however, the ‘medicalisation’ (Illich, 1977) of health continues with scientific and expert knowledge dominating lay and non-scientific knowledge. ‘Medicalisation’ therefore remains a powerful influence on public consciousness. A further discursive tension is between the individualism of neo-liberalism (expressed as accountability for one's own health) and social justice discourses that emphasise collective responsibility and are aimed at addressing social and economic inequalities.

The last part of this section has referred to new discourses emerging from the health sector (indigenous, holistic, social justice) during the 1980s and 1990s. There were discursive tensions as these new discourses did not replace the old

and powerful discourses, such as the supremacy of science and the notion of health experts'. A further source of tension is suggested by the oppositional discourses of individualism and social justice. A question to investigate in this study was how the teachers made sense of their work within these conflicting discourses.

In this final section of this chapter, the effects of neo-liberal discourses on education are discussed.

3.6 Neo-liberal discourses

The changes in curriculum and assessment which took place in the 1990s reflected the power of neo-liberal discourses to influence policy during this period. These discourses stressed the power of the market to improve the economy and, through this, individual living conditions. They proposed a diminished role for the state in the economy and in public and personal life (Olssen, Codd, & O'Neill, 2004).

At first, the ascendancy of neo-liberalism fuelled radical changes in economic structures and processes but in the second term of the Labour Government (1987-1990) education was also targeted. The results were the sweeping administrative changes (often referred to by the umbrella terms of reforms' or restructuring') which occurred in New Zealand after the publishing in 1988 of the Picot Report named after the chair of the taskforce responsible for the report, businessman Brian Picot (Picot, 1988). The radical changes in education policy in New Zealand and other countries seemed to be associated with a growing lack of confidence in the state's ability to manage deep seated economic crises and social fractures. In this environment, education was targeted as both a source of the problem and a means to ameliorate it (Smyth, 1989). The resulting changes to teaching have been extensively documented in New Zealand (for example, (Codd, 1994, 1999; Codd, Harker, & Nash, 1990;

Grace, 1990; Snook, 1996, 2000; Sullivan, 1994, 1998, 2000) and other countries (for example, Ball 1994; Campbell & Neill, 1994; Hattam, Shacklock, & Smyth, 1997; Helsby 1999a; Smyth, 2001, Troman, 1996).

Hattam et al. (1997) described the contemporary work environment (created by these changes for teachers in Australia) as one characterised by intensification. This is a theory about the increasingly demanding yet unsupported nature of teachers' work, which originated in the work of Larson (1980) and was later developed by Apple (1986). Teachers were now recast as "competent practitioners or technicians", there was "increased surveillance", critical debate was discouraged and "discourse about education and social justice" was discarded (Hattam et al., 1997, pp. 228-229). In this environment, teachers were assumed to pursue self interest rather than social justice or professional goals (Codd, 1999).

Since 1999, there have been further shifts in educational discourses. Codd (2005, p. 194) was of the opinion that: "Strongly influenced by discourses of economics, educational accountability has shifted away from a focus on inputs and process and onto a focus on outcomes and products". Within the curriculum discourse of Health and Physical Education, teachers are now charged with producing healthy people (Tinning & Glasby, 2002).

O'Neill (2005) argued that aspects of earlier discourses of teaching have been modified and reassembled with the purpose of developing a new discourse, that of the "responsible teacher" (p. 119). In this new discourse, an emphasis was placed on teachers and schools meeting the needs of particular groups:

... diverse students, those with special needs and those at risk of educational underachievement or failure within their schools. The official Ministry of Education mantra now is that in the 1990s, assessment became an unwieldy blunderbuss; the responsible teacher, in contrast, is expected to use assessment purposively (p. 119).

The burden of obligation to improve education for all students has therefore shifted from the state (through structural change) to individual teachers. For teachers this meant increased pressure on them to come to terms with curriculum and assessment initiatives.

Teachers and students are subject to the official gaze of others. Middleton (1998) extended the disciplining of individual bodies to propose ways students and teachers are —categorized, classified, or otherwise known” (p. 6). For teachers, ways of being known include assessment by state organisations such as the Educational Review Office (Middleton, 1998). In the period covered by this study, teachers also came to be known through government professional development contracts associated with current discourses such as ‘literacy’ and the NCEA. There were also contracts which had a Health Education focus and aimed to address social issues, for instance the use of drugs and mental health. In addition, Ministry of Education initiatives such as the promotion of senior Health Education (one of the ‘Beacon School’ projects (Ministry of Education, 2005) discussed in Chapter Four) were potentially another way of disciplining through privileging expert knowledge and permitting evaluation of teachers in relation to this expert knowledge.

3.7 Chapter summary

This chapter examined the socio-political and historical discourses which influenced the development of Health Education from the beginning of state provision of education in 1887 until 2004. Two aspects of New Zealand’s early education history that were relevant to Health Education were the expectation that schools had a role to play in improving the health of their students and the development of an academic tradition in secondary schools. The links between political and popular concerns over social issues (arguably a media construction, particularly in recent years) and Health Education were demonstrated through an historical approach. The combined effect of social

issues discourses (mainly represented by sexuality) and policy discourses were traced from the 1960s through to the late 1990s. This interplay of discourses was shown to be important for Health Education's curriculum development. The intermingling of health and education discourses was shown through examining health and education sexuality discourses, the education sector's response to the HIV crisis of the late 1990s, and the involvement of 'outsiders' in health education. The emergence of indigenous and World Health Organisation discourses was also discussed. Indigenous and WHO discourses were to have significant effects on the curriculum development that took place in the mid 1990s. The chapter's discursive analysis was completed with a discussion of the influence of neo-liberal ideology on education.

Two major policy developments which invited responses from Health Education teachers – a new curriculum and the inclusion of Health Education in the National Certificate of Educational Achievement (NCEA) – are discussed in the following chapter.

Chapter Four

Context II: Policy into practice for Health Education: 1985-2004

The chapter considers policy discourses of curriculum and assessment in the period 1985-2004 and some effects of policy on teachers and pedagogy. The chapter comprises: **4.1 Introduction and chapter overview** – explains how this chapter builds on the previous chapter and provides an overview of Chapter Four's structure; **4.2 Curriculum discourses in Health Education**– curriculum development with a focus on the 1999 curriculum; **4.3 Assessment discourses in Health Education** – assessment in Health Education and the significance of the National Certificate of Educational Achievement; **4.4 The effects of policy on teachers and pedagogy** and **4.5 Chapter summary**.

4.1 Introduction and chapter overview

Chapter Three analysed the socio-political and historical discourses which influenced the development of Health Education. Chapter Four builds on the macro discursive analysis of Chapter Three to examine educational policy as it was put into practice across the education system in the period 1985-2004. Health Education curriculum and assessment discourses (particularly from 1999) are the focus for this chapter. In the following chapter (Chapter Five) discursive tools that helped the analysis of the teachers' micro worlds are discussed: discourses of pedagogy, sexuality, gender and emotionality.

The chapter begins with a section that focuses on the development and characteristics of the 1999 curriculum. A significant point of difference from

past development was the grouping of three previously separate curriculum areas into one curriculum area. Other issues with implications for this study were the effects of political discourses on curriculum development and the blending of health and education discourses. A discursive comparison of the two curriculum documents (the 1985 syllabus and the 1999 curriculum) completes this section.

In the second section, the introduction of an assessment discourse, the National Certificate of Educational Achievement (NCEA), is discussed. This development is important because inclusion in this assessment framework signalled a new pedagogical discourse. Health Education was now part of a national qualification matrix as well as a subject which contributed to personal and community health. This assessment development introduced two dimensions to the study which needed investigation: the creation of a 'new' Health Education subject – senior health that was assessed by the NCEA, and the related potential to change perceptions of Health Education as a low status curriculum area that was generally restricted to junior secondary level³⁸.

In the third section, the effects of policy discourses (particularly assessment) on teachers and pedagogy are examined through literature from New Zealand and other countries affected by similar educational discourses. As there is a scarcity of research about Health Education teachers' experiences of policy, examples from other curriculum areas are used. In this fourth section the following are discussed: teachers' differing responses to policy changes, the effects of formal assessment on pedagogy, the NCEA and curriculum construction, professional development associated with policy changes, and the Beacon project.

The main purpose of this thesis was to find out how the participants in this study made sense of curriculum and assessment policy and how these understandings affected their practice and well-being. The three sections on curriculum, assessment and the effects of policy on teachers and pedagogy are

³⁸ Health Education is compulsory to Year 10 in New Zealand secondary schools. Senior health refers to Years 11-13.

therefore important because they explain the policy discourses which informed the teachers' practice in the period under investigation. They are also relevant to the theoretical discussion of pedagogy which takes place in Chapter Five and foreshadow the empirical data set out in Chapters Six to Nine.

4.2 Curriculum discourses in Health Education

The political and policy issues relating to the development of the 1985 syllabus were considered in the previous chapter. In this section, the development of the 1999 curriculum is the main focus and is examined through a discursive analysis of the effects of combining three previously separated learning areas, the effects of political discourses, and the effects of blending health and education discourses. Following this analysis, the approaches and content of both curriculum documents are examined and comparisons between the two are made. This comparison was made because the 1985 syllabus had the potential to influence practice for some time and also to show that the 1999 curriculum represented a mix of old and new discourses.

Introduction

The New Zealand Curriculum Framework³⁹ (Ministry of Education, 1993) provided the umbrella policy for the 1999 curriculum. The NZCF was a product of neo liberal discourses that were influential at this time. (These discourses were discussed in Chapter Three as part of the macro analysis for the study.) In line with new government policy, curriculum development was now contracted out. In 1995, the Christchurch College of Education won the contract to write the national curriculum statement for the Essential Learning Area of Health and Physical Well-being that had been identified in the NZCF. Gillian Tasker (Health Education) and Ian Culpan (Physical Education) from the Christchurch College of Education were the principal writers.

³⁹ Henceforth referred to as the NZCF.

A combination of previously separated curriculum areas

The NZCF placed Health Education within one of the seven Essential Learning Areas specified in the document. Physical Education and Home Economics (mainly food and nutrition education) were also placed within the same Essential Learning Area. All three curriculum areas had previously had their own curriculum documents, so this was a radical departure and likely to have a significant effect on teachers.

According to Lind (1997), who was a member of the Ministry of Education's Policy Advisory Group, his group's task of developing policy specifications for the Minister of Education, and therefore the brief for the writers of the national curriculum statement, necessitated: —an integration of the best of the current Health Education Syllabus (Department of Education, 1985), Home Economics Syllabus (Department of Education, 1989) and Physical Education Syllabus (Department of Education, 1987)” (p. 3). This new arrangement appears to have been unique to New Zealand and Australia. Tinning (2004, p. 242) pointed out that this grouping —seems to be a peculiarly Australian and New Zealand initiative'. In the UK, USA and continental Europe, Health Education is separated from Physical Education. Physical education teachers in these countries may or may not teach Health Education”. The implications of this structure are examined in the next part of this section and a theoretical discussion of this integration occurs in Chapter Five.

The tensions created when previously separate curriculum areas are placed together is inevitable and hard to resolve. The effect of grouping Health and Physical Education together and calling Physical Education physical well-being' in the NZCF was noted by Scratchley (1999):

This caused immediate concern for physical educators who saw this move as a threat to the very essence of their subject. They feared that Physical Education as a subject was being redefined in terms of health. Lobbying by physical educators resulted in the Ministry of Education retaining the learning area as health and physical wellbeing but determining that the

curriculum statement to schools would be renamed health and physical education (p. 219).

The retention of the name Physical Education was clearly very important. The significance of language use and its relation to discursive practices can also be surmised from the comments of Stothart (2000) when he noted that in 1993 the previously combined professional association New Zealand Association of Health, Physical Education and Recreation (NZAHPER) became Physical Education New Zealand (PENZ). According to Stothart, the main reason for the change:

...was the view that recreation professionals had formed their own professional body and health educators were in the process of doing the same thing. It was argued that the specific focus of Physical Education would strengthen the professional organisation and provide increased benefits to members (2000, p. 7).

The three subject study organisations associated with the 1999 curriculum – Physical Education New Zealand (PENZ), New Zealand Health Teachers' Association (NZHTA) and Home Economics and Technology Teachers' Association of New Zealand (HETTANZ) – continue to hold separate conferences and produce separate resources and publications.

From a traditional Physical Education perspective (one that privileges scientific and sports discourses) the 1999 curriculum presented challenges. The presence of new socially critical health discourses such as advocacy (discussed in Chapter Three) in blended Health and Physical Education curricula were potentially unsettling for teachers who positioned themselves within certain Physical Education discourses. Writing in 1997 of the Australian experience, Kirk, Macdonald, and Tinning (1997) argued that the dominant social justice discourse of the new curriculum — may be in tension with the individualistic, masculinist, and performance orientations characteristic of the pedagogy...of human movement studies” (pp. 293-294).

The comments of an experienced head of a Health and Physical Education department in an Australian school illustrated the effects of combining Health and Physical Education for some teachers: —HPE teachers are often the interface between kids and their parents in matters relating to personal development in general and sexuality education in particular” (Tinning, 2004, p. 243). Tinning suggested that:

...for teachers who are interested primarily in teaching about sport and physical activity, this expectation to teach personal development and Health Education might be a serious challenge to their notion of what their job as a HPE teacher might be (2004, p. 243).

Recent New Zealand reports suggested that those who teach in the Health and Physical Education area did not have opportunities to develop a shared pedagogy. An Educational Review Office (ERO) report on the New Zealand curriculum noted that many Health and Physical Education teachers in secondary schools did not have experience in teaching both Health and Physical Education (Education Review Office, 2001).

In New Zealand, tensions between Health and Physical Education are still apparent. A reference in a 2006 paper by the principal Physical Education writer for the 1999 curriculum document, Ian Culpan, referred to his initial unease about bringing Health and Physical Education together in the same curriculum statement:

Culpan (1996/97) asked the question whether the MOE was trying to redefine Physical Education in terms of health, by grouping Health Education and Physical Education in one curriculum statement, or whether it was simply a convenient way to group complimentary subjects. Stothart (2004) believes that Physical Education within the school curriculum is not secure and is in danger of embedding itself so deeply into Health Education that fundamental elements of —robust kinaesthetic pleasure or gross muscular movement will be lost” (Culpan, 2006, p. 16).

These on-going discursive tensions recorded in the literature suggested that teachers in the study would also have encountered these tensions as they made conscious or unconscious decisions about positioning.

The effects of political discourses

The politics of curriculum development are discussed in this section. According to Ball (1994), production of policy as text involves both documents (in this study, the development of Health Education curriculum and assessment documents) and people: those who develop the documents, those who write the documents and those who read them:

...we can see policies as representations which are encoded in complex ways (via struggles, compromises, authoritative public interpretations and reinterpretations) and decoded in complex ways (via actors' interpretations and meanings in relation to their history, experiences, skills, resources and context) (p. 16).

The development (or encoding) of New Zealand's two Health Education curriculum documents had three characteristics in common: controversy and delays, little change between the draft documents and the final versions and the influence of a small number of key people. Each of these have relevance because they all had the potential to affect the Health Education curriculum discourses which are available to the teachers in this study. These three characteristics and likely effects on teachers are considered in this next part of the section on curriculum development.

There were echoes of the unexplained delays of the 1970s and 1980s in Tasker's accounts (1996/97, 2004a) of the development of the 1999 document. Work on the document began in 1995 and after consultation, the final document was released in 1999. There was then a two year transition period before it was gazetted (became official policy) in 2001. Tasker (1996/97) reported that the process was long and difficult because of the complexity of the task, frustrating delays, and the challenges of a small but vociferous number of conservative

groups expressing their concerns about the document, particularly the sexuality education component.

A range of individuals and organisations from the fields of health and education were consulted (as they had been for the 1985 syllabus); and again, as in the earlier document, there were unexplained delays between the completion of the draft curriculum statement and its release. Tasker commented that:

...speculation about the delay included issues of teacher workload, the low status of this curriculum area in the hierarchy of essential learning areas in a 'back to basics' climate of calls for a stronger focus on literacy and mathematics; and, since 1996 was an election year, the politically sensitive nature of the content such as sexuality and spirituality (Tasker, 2004, pp. 208-209).

According to Tasker a change of Ministry of Education staff associated with the contract accelerated the process, and the draft document was eventually released for further consultation and trialling early in 1998.

The delays and controversies which characterised the development of the 1999 curriculum meant an extended period when teachers were in a 'curriculum vacuum'. The 1985 syllabus document was the only official curriculum in existence, but teachers knew it would soon be redundant. Thus there was considerable latitude for teachers as they made decisions about their day to day practice in the period between the gazetting of the 1985 syllabus in 1989 and the gazetting of the 1999 curriculum in 2001.

Development of the 1999 curriculum shares a second characteristic with the 1985s syllabus – there were no major changes as a result of feedback on the draft document. Tasker (2004, p. 209) comments: —Responses to feedback largely involved verbal refinement, structural and layout changes and the addition of another key area of learning entitled, 'Body Care and Physical Safety' (p. 209).

This second characteristic suggests two possibilities: firstly that the majority of teachers endorsed the document, or secondly and more likely given the period of rapid change to many aspects of their work, that they had neither the opportunity nor inclination to be engaged in the final stages of the curriculum's development. If the latter was the case, this would also have contributed to conditions that favoured teacher agency in their day to day practice.

A third characteristic of the politics of curriculum development with relevance to this study is the potential influence of a small number of 'experts' in the Health Education field. This is important because of the possible effects these 'expert discourses' may have had on teachers. An important issue is that of access to opportunities to 'make meaning' about these new ideas through professional development. A further consideration is the degree to which these ideas became part of teachers' practice.

The professional trajectories of a number of those involved in the development of the 1985 syllabus (Weir, 2000) and the 1999 curriculum is a reminder that the number of key players (aside from education officials) in the New Zealand educational environment is small, and it must be assumed that these key players have a significant effect upon policies. The influence of a few key people on policy development is noted by Tuffin (2002). In 1993, the same year as the New Zealand Curriculum Framework was published with its brief description of the 'Health and Physical Well-being Key Area of Learning', Ian Culpan (subsequently the principal Physical Education writer for the 1999 curriculum) was asked by the New Zealand Qualifications Authority (NZQA) to chair an Advisory Group for the Health and Physical Well-being Key Area of Learning. Gillian Tasker (a colleague from the Christchurch College of Education) also became a member of this Advisory Group. Tuffin (2002, p. 68) observes that Culpan and Tasker: "went on to develop a key association with the Ministry in the subsequent curriculum statement".

Tasker was working on her doctoral thesis (an exploration of students' experience of an HIV/AIDS sexuality education programme and the implications for teaching and learning in Health Education) concurrently with her role in the

curriculum contract. It is not surprising that Tasker's research had a significant effect in shaping the new curriculum (and subsequent resource and professional development). She acknowledged this influence on the curriculum in her thesis:

As principal writer I benefited from the insights gained through my parallel work on this thesis. I was concerned to ensure that the document was designed to facilitate a personally liberating pedagogical process and to provide a sound philosophical base for the development of classroom programmes in all Health Education contexts, including sexuality education (Tasker, 2001, p. 194).

Tasker's exposure to new theories through her academic work concurrent with her work on the curriculum contributes helps explain the document's philosophical basis. Of relevance to this study was how the discourses Tasker was referring to were reflected in the teachers' understandings of the curriculum.

It can also be surmised that Culpan (in his role as principal Physical Education writer for the curriculum and who worked at the same tertiary institution as Tasker) was exposed to the literature informing Tasker's views. Regardless of a mutual sharing of research, literature and ideas, both of the principal writers would have read and discussed the literature review (Shaw, 1994) commissioned by the Ministry of Education's Policy Advisory Group. Tasker was also a key figure in the development of the Health Education subject study organisation, the New Zealand Health Teachers' Association (NZHTA) and Health Education conferences. In her analysis of the discourses in New Zealand's Health Education curriculum, Tuffin (2002, p. 69) argued that —Culpan's and Tasker's involvement throughout the curriculum development process forms one of the key conditions in the choice and use of curriculum discourses”.

Since the 1980s Health Education curriculum discourses have been influenced by a small number of people who participated in curriculum development at a

national level. Of interest in this study was whether these expert discourses were part of the discursive resources drawn on by the teachers in this study.

Effects of blending health and education discourses

A blend of health and education discourses was a further characteristic shared by the 1999 curriculum and the 1985 syllabus. Both documents, and especially the 1999 curriculum, were influenced by the World Health Organisation (WHO) discourses examined in Chapter Three. One of the discourses associated with the WHO was the New Public Health⁴⁰. This discourse emphasised the social, economic and political determinants of health. Banfield and Brown (1996) noted the influence of this discourse on the South Australian Health and Physical Education curriculum document (Australian Education Council, 1994). Similarly, writers in New Zealand revealed health discourses evident in the 1999 curriculum document. Liggins (1997), for example, explored the overlapping discourses of health and education at the time the draft curriculum statement for the 1999 curriculum was being written. Tuffin (2002) examined the language of the underlying concepts stated in the 1999 curriculum (hauora, health promotion, socio-ecological approach, and attitudes and values) through the lens of health promotion.

New Public Health discourses were evident in both curriculum documents but were more apparent in the 1999 curriculum and subsequent senior assessment documents. The relevance for this study was how these discourses influenced the pedagogical decisions made by the teachers.

A comparison of the 1985 and 1999 curriculum documents

A discursive comparison of the two curriculum documents completes this section on curriculum development. It was important to examine both the 1985 syllabus and the 1999 curriculum in terms of discourses because of the implications for the teachers in this study. For the long serving teachers the 1985 syllabus was relevant to their day to day decisions about teaching. The

⁴⁰ Old Public Health was mainly concerned with infectious diseases and ways to control them eg., vaccination and sanitation. The New Public Health was more concerned with recurring diseases and used a range of methods (including health promotion) to try to alter people's behaviour (Dew and Kirkman, 2002).

1985 syllabus was also relevant to the less experienced teachers, because it was the only curriculum in place during the protracted period until the 1999 curriculum was published and finally gazetted in 2001. The influence of the 1985 syllabus can therefore be said to be long lasting. The 1985 syllabus is also important because it represents the social issues and political discourses of previous eras which were carried through into the 1999 curriculum.

Two points are made in the following part of this section on curriculum development. The first is that there were discursive similarities between the two curriculum documents, and the second is that the 1999 curriculum was less prescriptive than the 1985 syllabus. Both documents drew on the following discourses: a needs-based discourse that emphasised that school health programmes should be designed with community input and aim to meet local health goals; holistic discourses, although spirituality was only explicit in the 1999 document; community health discourses, and social issues discourses.

Social issues discourses were more explicit in the 1999 curriculum than in the 1985 syllabus and there was much more emphasis on a collective, socially critical stance that contrasted with healthism (Crawford, 1980) or individual accountability. Health education aims within this individualistic discourse targeted individual behaviour change and were more apparent in the 1985 syllabus than in the 1999 curriculum. In the 1999 curriculum document, a critical viewpoint is located in all four underlying concepts but particularly in the socio-ecological perspective and health promotion. Whether this aspiration has been achieved is questioned by Evans, Evans, Evans, and Evans, (2002), who drew on the work of Gard and Wright (2001). With reference to a —culture of weightism” (Evans et al., 2002, p. 203) they stated:

Even in countries such as Australia and New Zealand where a more critical edge is to be found within the curriculum of PE, sport and health, the actions of teachers and policymakers still seem wrapped in an ideology of healthism designed to make children and young people fit and thin (p. 203).

This comment suggests the resilience of individualistic discourses in both New Zealand and Australia and a tension within the curriculum and for teachers.

In the 1999 curriculum, social issues discourses were signalled in three out of the seven⁴¹ Key Areas of Learning: mental health (which included drug education), sexuality education, and more recently, as ‘obesity’ was identified as a social problem, food and nutrition. Ian Culpan (the principal Physical Education writer) noted that the Ministry of Education brought forward the development of the curriculum document. He suggested that this decision: “was largely related to questions raised in Parliament about the alarming rates of suicide, sexually transmitted diseases and alcohol-related problems among New Zealand youth in comparison with other so called developed societies” (Culpan, 2004, p. 230).

The main point of difference between the 1999 curriculum document and the 1985 syllabus was that the 1999 curriculum was much less prescriptive than the 1985 curriculum. This meant there was more freedom for the teachers to develop and justify their own interpretations of the curriculum. The philosophical assumptions of the 1999 curriculum were clearly signalled in its literature review and in the writings of Tasker (2004a) and Culpan (2004).

The ontological, epistemological and axiological assumptions of the 1999 curriculum can be detected in the literature review commissioned by the Ministry of Education to guide the writing of the curriculum draft. The first section of the literature review for Health Education was entitled “Post modern curriculum” in which the “trends are growing points for further development” and “teacher’s role is facilitative and reflective, rather than predominantly instructional” (Shaw, 1994, p. 2). Drawing on the work of Doll (1989), Shaw wrote:

Curriculum design needs to encompass the major conceptual changes of its time. At present, the relatively stable predictable concepts of

⁴¹ The other Key Areas of Learning were body care and physical safety, physical activity, sports studies, and outdoor education.

Newtonian modernism are being replaced by more open systems, based on complexity and transformative change. Thus the essentially reductionist view of pre-set ends, resulting from discrete, quantifiable and linear units of learning as the components of a cumulative curriculum, is no longer tenable for effective learning (1994, p. 2).

This extract from the literature review, which was referred to as the curriculum was developed, makes clear that knowledge development was open and contestable and that there were implications for the teacher's role.

In this part of the section on curriculum development, the two points of relevance for the teachers in this study were the influence of a social issues discourse and the new 'post modern' discourse.

This section of the chapter has provided an analysis of curriculum policy as it was put into practice in Health Education. This section is important because it has discussed political, social and educational discourses relevant to this study. These discourses were relevant because the teachers in this study drew on them to make meanings about their work. Some of them also drew on assessment discourses. In the following section, Health Education assessment discourses are discussed.

4.3 Assessment discourses in Health Education

In this section the National Certificate of Educational Achievement (the NCEA) is described and implications for Health Education's inclusion in this qualification system are proposed. The implications discussed in this section are: the creation of a 'new' subject, and the relationship between assessment and subject status. The effects of the new assessment discourse are considered in the following section (4.3) where they form the major part of a discussion on the effects of policy changes on teachers and pedagogy.

In 2002, the NCEA replaced existing national secondary qualifications. The NCEA is a standards based qualifications system that was the most recent attempt to depart from the norm-referenced assessment methods of previous qualifications systems (Alison, 2007). Health Education had been included in one of these attempts, the development of unit standards in the mid to late 1990s. (New Zealand Qualifications Authority, 1998)

Opportunities for Health Education to be taught at senior levels were enhanced by its inclusion in the subjects which could be assessed through a combination of unit and achievement standards which make up the NCEA. Students who met the standard' in unit standards were awarded a pass' but their pass' in achievement standards may also have met requirements for merit' or excellence'. The idea that unit standards are inferior to achievement standards is persistent (Hipkins, Vaughn, Beales, Herral, & Gardiner, et al 2005) so the choice of standard (unit or achievement) by the teachers in this study was of interest.

Assessment and subject status

Health Education's 2002 inclusion in the NCEA was potentially a catalyst for change in its subject status because it gave Health Education the opportunity to prove its academic respectability. The changing status of secondary school subjects and the effects of these changes have been documented by numerous writers including Ball (1987), Ball and Lacey, (1995), and Goodson (1981, 1983, 1988). As Paechter (1993) has pointed out, most of these changes have taken place over a long period of time: —the long micro and macro political manoeuvrings on the part of practitioners” (p. 350). Health Education's elevation to a formally assessed subject at senior levels via NCEA was a rapid process, in contrast to its slow evolution as a subject in primary schools and at the junior level in secondary schools.

Formal assessment is one of the markers of subject status and also appears to be a motivating factor for students. One of the pressures noted by teachers of sexuality education in an English study carried out by Alldred et al. (2003), were —issues of discipline“(p. 86) in a non-assessed subject. The perception of

Health Education as a non-academic' subject was highlighted in a 1998 New Zealand study in which a sixteen year old student explained that she had missed out on a lot of sexuality classes as I was in brainy' classes so we did more academic' things while the others attended health classes" (Elliot, Dixon, & Adair, 1998, p. 2).

Possibilities for progressing Health Education as a senior academic subject were welcomed by tertiary Health Educators (Aldridge, 2000; Tasker 2004a). Writing in 2004, Gillian Tasker was optimistic that the qualification reforms" (p. 218) signalled an era of expansion for Health Education:

A qualification structure for Health Education is being developed through NCEA achievement standards at Years 11-13 comparable to all other traditional subjects. There is now a legitimate pathway for students who wish to take Health Education as a full subject in the senior school. In the current economic climate, qualifications count, especially since Health Education now leads to a myriad of career pathways; the health world is diverse, incorporating psychology, social work, teaching, the police force and any of the service industries (2004a, p. 218).

It was apparent from Tasker's comments that there was great enthusiasm and anticipation at a national level. It remained to be seen if this enthusiasm was shared by teachers.

Differences in the status of health and Physical Education

The pursuit of academic credibility by proponents of traditionally marginalised or lower status school subjects such as Art and Physical Education in England was noted by Goodson and Marsh (1996). Physical Education had already followed this path in New Zealand as one of the group of subjects which, until 2002 (the beginning of the NCEA), had contributed to senior norm-referenced academic' qualifications (School Certificate, Sixth Form Certificate and University Bursaries). Perceptions of Physical Education as an academic subject were enhanced by these historic associations with academic qualifications.

In the NCEA system, Physical Education as a former ‘bursary subject’ had an advantage over Health Education in the hierarchy of subjects, as it was automatically included in the ‘approved list’ of subjects for admission to university and students could also sit a Physical Education scholarship examination. A major set back for the recognition of health as an academic subject was the exclusion of Health Education from the ‘approved list’⁴² of entrance subjects for university. Health Education was also not included in the list of scholarship subjects⁴³.

The creation of a ‘new’ subject

The new discourse for Health Education, that of standards based assessment, which as in other subjects —operates with the force of a de facto curriculum” (Locke, 2004), effectively created a ‘new’ subject. Changes to subjects such as an alteration in their status or the creation of ‘new’ subjects affect teachers’ practice and well-being. Ball and Lacey (1995) noted the effect of new subjects as follows:

...the existing patterns of preferment are disturbed, and new struggles and disputes develop. Changes like these threaten certain teacher interests and advance others. New career opportunities open for some, and existing avenues are closed down for others (p. 96).

Another recent ‘new’ subject, Technology, provides some parallels with Health Education. In a recent study, Jones and his colleagues indicated that subject expansion was a complex and contested matter in secondary schools. Their national study of the implementation of the Technology curriculum in New Zealand revealed that secondary teachers, despite benefiting from purpose built facilities, were restricted by structural issues such as —timetable constraints, management decisions or lack of enthusiasm on the part of former home economics and wood/metal teachers” (Jones, Harlow & Cowie 2004). Health Education teachers in this study were also limited by these sorts of constraints.

⁴² The hard boundaries of the ‘approved list’ have subsequently softened and Health Education, Technology and Dance were, at the recommendation of the New Zealand Vice Chancellors’ subcommittee on entrance, added in 2006.

⁴³ Letter to principals from the New Zealand Qualifications Authority, 18 July 2003.

In this section the NCEA has been described and the effects of Health Education's inclusion in this qualification system have been suggested. The main predicted effect, and one which was enthusiastically embraced by some Health Education experts, was that the subject's status would be improved and full programmes in senior Health Education would be offered in schools. The effects of Health Education's inclusion in the NCEA for the teachers that were part of this study are considered in Chapter Seven. The effects of an NCEA discourse on pedagogy are also described in Chapter Seven. In the next section, literature on the effects of policy change (particularly assessment) is discussed.

4.4 The effects of policy on teachers and pedagogy

In this section the effects of policy discourses (particularly assessment) are examined through literature from New Zealand and other countries affected by similar discourses. It is argued that reactions to teachers' experiences of curriculum and assessment change were diverse, contingent upon their individual circumstances and may change over time. Following a discussion of the significance of power relations and differing responses to curriculum and assessment, the effects of assessment policy are examined because they have application to this study. The Beacon School project (an attempt to lift the profile of Health Education and to provide requisite professional development) is discussed in the final part of the chapter.

Differing responses to policy changes

The new opportunities for curriculum expansion in health through the NCEA assessment system became part of existing political struggles in schools. Schools are complex networks of power and teachers negotiate meanings about their practice within groups and across groups where power exists. Ball (1994) emphasised —interpretation and creativity” (p. 19) in the acting out of policy, and asserted the significance of power:

Power is multiplicitous, overlain, interactive and complex, policy texts *enter* into rather than simply change power relations: hence, again, the complexity of the relationship between policy intentions, texts, interpretations and reactions (p. 19).

The effects of power thus had implications for the teachers in this study as they tried to make sense of changes in assessment policy within the existing power relations in their schools.

Teachers' reactions to the curriculum and assessment discourses are not uniform (Acker, 1999). Acker (1999), writing with reference to the educational changes in Britain in the late 1980s and early 1990s, noted that although related, there is "no simple correspondence" (p. 181) between these policy changes and changes in teachers' work, for teachers respond to imposed reform creatively with a certain amount of agency (ability to take individual action), rather than mechanically and as victims of forces beyond their control" (p. 181).

Tyack and Cuban (1995) and Helsby (1999a) also emphasised that there was a two way process going on in curriculum and assessment policy implementation. Helsby (1999a, p. 13) described this process as an: "interplay of imposed structural changes with the active agency of teachers in accommodating, ignoring or adapting such changes within particular contexts and cultures of schooling". O'Neill (2001) argued that responses to imposed curriculum and assessment change by a group of New Zealand secondary teachers and curriculum leaders were "greatly contingent upon the constraints and opportunities provided by their unique circumstances" (p. 353).

Hargreaves (2005) built on the work of those such as Lortie (1975) who had drawn attention to the significance of the different life stages and career trajectories of teachers. Hargreaves (2005) focused his account on the influence of these factors on teachers' reactions to change. McCulloch et al. (2000) also stressed that teachers' responses to changing conditions were determined by a number of factors, including "age, gender, work experience,

teaching subject, departmental culture, career stage and ambitions, the school ethos, their teaching schedule, and their personal and professional confidence” (p. 113). A number of these aspects, such as work experience and career stage are relevant to the empirical data in this study.

How teachers respond to the multiple demands and tensions of changing times can also be discussed in terms of individual resources. In her study of high schools that had restructured in the United States, Little (1995) noted that in absorbing the many new demands and developing a place to stand, teachers:

...turn to resources that are in a powerful sense internal and individual: their own education and professional training, the sense of competence and confidence that experience engenders, the passions and pleasures that wed individuals to what and how they teach (pp.174-175).

Personal life experience was also relevant as the content of Health Education is arguably more personal than that of other subjects. As Hargreaves said (1999, p. 2) “the matters closest to our hearts, our organising frameworks of thought and action, inevitably spring from our own trajectories and the lives and experiences grounded within them”.

Experiences of the far-reaching policy changes in New Zealand and in other countries were therefore not uniform, and it was also possible that their reactions changed over the course of time. Interviews with secondary school teachers in England in 1999, for example, suggest a reduction in the power of the National Curriculum to adversely affect teachers’ sense of professional independence. There was also an indication that in some instances, teachers had responded to policy changes by seeking development opportunities (Helsby, 1999a).

Health Education’s inclusion in the National Certificate of Educational Achievement (the NCEA) was a significant policy change which affected some of the teachers in this present study. Their reactions are examined in Chapter Seven. In the next part of this section, literature and empirical studies concerned with effects of formal assessment are considered.

The effects of formal assessment on pedagogy

While becoming part of a formal assessment system such as the NCEA has advantages such as changing perceptions of subject status, there may be disadvantages such as those noted by McCulloch et al. (2000). They suggested that in England:

Commonly used terms such as 'assessment-led' curriculum and 'teaching to the test' are indicative of the potential importance of assessment systems in determining the shape of the school curriculum and the nature of teachers' work. The widespread abandonment of the eleven-plus examination, for example, was often associated with innovation and curriculum development in primary schools (p. 74).

In Health Education, the way teachers were able to respond to the needs of students and their communities in the junior school and non-assessed senior classes may have been affected by the constraints of the NCEA.

Research with New Zealand primary and secondary Health Education teachers, undertaken by Barlow (1990) within the framework of the 1985 syllabus, was relevant to the study. Barlow (1990) noted the importance of teaching based on community consultation and teachers' resistance to externally imposed objectives and assessment. Barlow reported that:

Some teachers interviewed found that teaching by objectives, especially in Health Education, is meaningless and they indicated strong desires to 'control' the curriculum *in consultation with their local community*. There is a strong resistance by teachers against political directives for health assessment and evaluation because a) local (health) contexts can vary in their requirements and b) these approaches *de-skill* teachers and de-value their professional judgement (p. 343).

Barlow's New Zealand research suggested tensions for teachers if they positioned themselves within both an NCEA discourse and a community or 'needs based' discourse. Another avenue of enquiry suggested by Barlow's

research was the effects of senior assessment on junior health pedagogy, for there were signs in the study that NCEA was affecting the conceptualisation and assessment of junior subjects. Official approval of this change in practice was revealed in findings of a recent Education Review Office (ERO) report on 'good practice' in the teaching of sexuality education. In one of the schools selected as an example of 'good practice', the report commented that:

There was an expectation that teachers would follow a set procedure to analyse student achievement data in senior health classes, particularly in the sexuality-related standards for NCEA. Specialist health teachers took this practice to the junior classes and collected achievement data from all classes. The teachers analysed the data for trends and patterns and used the findings to evaluate and inform future planning (2007, p. 69). Another possible effect of adopting NCEA for Health Education is what Little (1993), in relation to the curriculum reforms which were taking place in the United States at the time, referred to as —pressures for fast-paced implementation” (p. 140). The pace and intensity of change saw an —attempt to reduce conceptual and practical complexities in the interests of a fast-paced implementation” (p. 140). These comments gave an insight into the time constraints and anxiety associated with the professional development for the implementation of the NCEA.

Assessment tensions encountered by teachers were described by Craig (2004) in her analogy of two 'dragons (of accountability) feeding. The first dragon had assessment as central to the curriculum, the second dragon, according to Craig, sought a more authentic approach to curriculum. Craig noted that in the first dragon story, —some things fall in perilous danger of being lost altogether: the arts and other interactions necessary for sustaining the life of the mind and human development in community” (2004, p. 1240). How teachers managed this tension is examined in Chapter Seven.

A further tension with relevance to this study was also indicated in Barlow's 1990 New Zealand study. This was the difficulty of 'measuring Health Education goals. Barlow found that: —Most teachers interviewed recognised a major feature of Health Education noted in the literature review. Namely, that

Health Education outcomes are usually long-term and are difficult to quantify with reliability” (Barlow, 1994, p. 343). Long term goals referred to in this study were mainly to do with sexuality and drug education.

As argued in the previous section, teachers’ reactions to policy discourses were likely not to be uniform. Rex and Nelson (2004) revealed this in their account of how two high school English teachers in the United States responded to high stakes testing. Their study showed that the personal beliefs, values and experiences unique to each teacher influenced attitudes towards assessment:

For both teachers, their commitment to their students as whole people and to the trajectory of students’ lives beyond schooling came through strongly. Test performance and subject matter were not primary. Student welfare as survivors and achievers in the “real” world was foremost. They would shape curriculum, test preparation, and pedagogy to serve that important end (2004, p. 1317).

An example of how individuals responded differently to assessment systems is recorded in a New Zealand account. The effects of the NCEA on one Health Education teacher were documented by Fitzpatrick and Locke (2008). Their work highlighted the dilemmas teachers face, for alongside some negative effects of the NCEA, there were also some perceived benefits:

Dan’s passion for a critical approach to Health Education is undermined by inadequate moderation, increased workload, and the dissection of health content into separate, unrelated standards – all unfortunate by-products of the NCEA. All the same, Dan witnesses his students gaining better results under this system, one in which he can better contextualise assessment tasks to link with the cultural worlds of his students (p. 95).

Despite NCEA problems such as the fragmentation of knowledge and poor moderation procedures, teachers are likely to see advantages to being part of the NCEA. This is because in the teachers’ “reading” of assessment texts they could see opportunities —to allow for the pragmatic advance of their quest for

curricula and credentials to meet the general educational needs of every person” (O’Neill, 2001, p. 370).

The NCEA and curriculum construction

A further avenue of enquiry for this study was consideration of the effects of NCEA discourses on how teachers conceptualised curriculum. Teachers’ curriculum knowledge is affected by a number of factors including personal subject background and teacher education in tertiary institutions (Locke, 2004). In a New Zealand study, Locke argued that the NCEA had become another highly influential factor in the development of this knowledge.

The extent to which teachers of English in New Zealand were active participants in developing curriculum discourses was examined in Locke’s study. He noted that —~~a~~ large part of their body of expertise is related to subject knowledge” (p. 25). This knowledge was gained through tertiary experiences and modified by discourses working in their schools and embedded in official documents and teaching materials. Locke argued that —~~the~~ NCEA, has added another powerful determinant to the construction of secondary curriculum” (2004, p. 26). Teachers of senior Health Education have diverse subject backgrounds compared with established subjects such as English. There being no obvious agreement on the subject knowledge teachers should bring to senior Health Education, teachers were therefore more vulnerable to having a curriculum imposed on them (such as the one created by the NCEA) than teachers who come with more distinct and widely recognised subject backgrounds.

A further factor pertinent to senior Health Education, was the degree to which teachers felt capable and proficient about their curriculum and assessment knowledge and expertise. An Australian model of curriculum development⁴⁴ (developed by the Board of Senior School Secondary School Studies), involving teachers of senior Health Education, was critiqued by Glasby (2000). Her study of the three year pilot phase of the development of the senior syllabus in Health Education, in which assessment was fundamental, was based on her

⁴⁴ In Victoria and Queensland Health Education is offered as a senior school subject which contributes to university entrance qualifications.

observations of the conferences and meetings attended by teachers over a three year period and interviews carried out with the teachers over this time. She observed an imbalance of power relations as the teachers were —continually positioned in asymmetrical power relations with Board agents in a range of contexts within the pilot process” (p. v). Although teachers had opportunities to —challenge or reorient what was considered legitimate knowledge” (p. v), they were constrained by their desire to be recognized as competent: —but they came to construct themselves as competent allied with their constant fear of being judged incompetent, served to limit their ability to challenge the process of legitimating knowledge” (p. v). Professional development for the implementation of the NCEA was the equivalent context to Glasby’s Australian example. One of the outcomes of this study was an analysis of teachers’ responses to the professional development for the implementation of NCEA.

Professional development associated with policy changes

In New Zealand, professional development was offered at each stage of the NCEA implementation (Level One in 2002, Level Two in 2003, and Level Three in 2004). Training for the implementation of NCEA was particularly significant for Health Education teachers who by and large had less experience in formal assessment than colleagues who taught in subjects with a more extensive formal assessment history. In the late 1980s and early 1990s, if Health Education was assessed at all, it was likely to be a combination of student self-evaluation and teacher evaluation. In some cases, community and family evaluations were also sought. Some health teachers in secondary schools were also experimenting with criterion-referenced assessments (Barlow, 1990).

Research carried out by Locke (2004) on the effects of the curriculum and assessment reforms on English teachers in New Zealand noted strong reservations about the new system and tensions associated with the NCEA training days. Commenting on the teachers’ experiences of the NCEA training which took place in 2000-2001, Locke wrote:

In general, though, the dissent was suppressed by the need to get on with it and by the fact that the facilitators were subject advisors and fellow teachers known to the participants. —“Don’t shoot the messenger,” they appeared to say (2004, p. 24).

Teachers’ responses to the NCEA professional development are discussed in Chapter Seven.

Professional development for the NCEA and the Beacon Project (discussed later in this section) were part of a new policy discourse of pressure for teachers to undertake professional development. Learning is inevitable for teachers as they move through different phases and situations in their careers. Prior to the reforms of recent decades, however, such learning was likely to be self-directed by teachers (McCulloch et al., 2000). Teachers in this study talked about self directed learning such as professional development on social issues topics, especially sexuality and drug education. The rewarding experiences reported by a number of teachers in this study contrasted with a critique of professional development in the United States advanced by Little (1993):

Compared with the complexity, subtlety, and uncertainty of the classroom, professional development is often a low intensity enterprise. It requires little in the way of intellectual struggle or emotional engagement and takes only superficial account of teachers’ histories or circumstances. Compared with the complexity and ambiguity of the most ambitious reforms, professional development is too often substantively weak and politically marginal (p. 148).

The teachers’ experiences of self directed professional development are discussed in Chapters Six and Nine.

Making choices about what should be learned (which included opting out of professional development if teachers were comfortable with their teaching) was, however, no longer an option. As a result of changes to curriculum content and

assessment, teachers had no choice but to be involved. McCulloch et al. (2000) noted that:

The complex of changes in England in the past fifteen years is so extensive and so well policed (by SATs, appraisal, Ofsted inspections and the operation of quasi-markets, for example) that a non-learning response has scarcely been viable (p. 80).

A recurring theme across the literature in Health Education (and particularly sexuality education) was the importance of having teachers who have relevant tertiary qualifications and training (Coates, 1993; Education Review Office, 1996; Hamblett 1994; Tasker, 1996/97, 2004a). One of the problems with the desire for relevant qualifications and training was that it was not clear what constituted relevant tertiary qualifications for Health Education (the range of tertiary qualifications and training of the teachers in this study is a case in point). The provision of conceptually sound senior Health Education through to Year 13 then relied upon Health Education teachers being involved in professional development. Tasker (2004a, p. 218) noted that the —Ministry of Education has made a substantial contribution to provision of both written resources and professional development opportunities for practising teachers since the release of the final document in 1999”. One of the opportunities for professional development was the Ministry of Education’s Beacon Project.

The Beacon project

The Beacon Schools’ Project was established to address the absence of expertise in senior Health Education and a number of other senior secondary school subjects including Home Economics, Social Studies and Technology. In addition to building up teachers’ curriculum and assessment knowledge and skills at senior level, there appeared to be an attempt by Health Education and Home Economics curriculum leaders to promote these curriculum areas as academic subjects. Under the heading of ‘Beacon for excellence’, the first paragraph of a front page feature in the New Zealand Education Gazette of 5 May 2003 stated, —Health education and home economics have struggled to be

recognised as conventional academic subjects at senior secondary level, but a new project developing schools as ‘centres of excellence’ in these subjects is hoped to turn that around” (Ministry of Education, 2003, p. 1).

In the same feature article, Gillian Tasker signalled that Health Education was changing in the upper levels of the secondary curriculum and that schools should take notice:

Some schools see it as a timetable filler with a little of sex and drug education and that’s about it. At the senior level Health Education has a very strong sociological focus and takes a much broader, bigger picture view. It also promotes critical thinking skills (Ministry of Education, 2003, p. 1).

Beacon Schools were identified on the basis of current or potential capacity for leadership in the nominated subject. Health Education and Home Economics were amongst the first to receive funding and guidance as part of the Beacon Project. The project for Health Education and Home Economics began in 2002 and ran over four years. Physical Education (the third subject in the Health and Physical Education learning area of the 1999 curriculum) was one of the last subjects to benefit from the Beacon School Project. Anecdotal accounts of reactions to this late inclusion suggest that Health Education teachers, who did not identify with Physical Education aspirations, were of the opinion that it was the result of lobbying by those who felt Physical Education was ‘missing out’ on support and funding.

A summary report written for the Ministry of Education in 2005 provides a snapshot of the participating Beacon Schools. The review was based on data from milestone reports prepared for the Ministry of Education and interviews with thirty two people associated with the project.

The teachers and professional leaders were strong advocates for their subject’s relevance. They saw their subjects as developing skills and

understandings through making important connections to young people's lives" (Ministry of Education, 2005 p. 5). These strong claims, which attested to the subjects' worth, were made by teachers and supported by professional leaders and student data. A number of implementation issues for senior Health Education and Home Economics were also reported. Implementation issues concerned gender issues, some resistance to assessment for Health Education, a belief that Health Education should be available to all students and not just those who opted to take it as a formally assessed subject, negative perceptions of other staff, and questions about the sustainability of these two subjects at senior level. These issues, with quotes from the summary report (Ministry of Education, 2005), follow.

A "gender imbalance" (p. 6) in Health Education and Home Economics classes was mentioned:

The Professional Leader for Health Education and Health Education teachers noted that frequently there is a lack of strong role modelling by male teachers to support Health Education. Such teachers are influential because they either teach at junior levels of the school or assist with subject choices. Health education is seen as an easy subject with no status and no interesting or relevant issues for boys (p. 6).

The comments of teachers and principals revealed some resistance to assessment in Health Education. One of the criteria for becoming a Beacon School for Health Education and Home Economics was student assessment against achievement standards. Those interviewed pointed out that "senior classes tended to consist of 'less academic' students" (p. 6) and "some principals and teachers questioned the value of assessing Health Education through achievement standards or unit standards and described a mismatch between the demands of assessment and the abilities, needs and interests of the students" (p. 6). It was also noted that every senior student (not just those who selected senior health as an NCEA option) would benefit from Health Education, with some participants expressing the view that Health Education for

all at senior levels would be more beneficial than the Beacon School model” (p. 6).

It was felt necessary to address the negative views of Health Education held by other staff. It was suggested that the view that Health Education was not an academic subject resulted from ~~a~~ lack of understanding of the curriculum and the links with the work force” (p. 9). Negative perceptions ~~—~~ ~~de~~ as barriers to the subject’s credibility and reduced the amount of support available to them (p. 9). Hostile reactions from teachers in other subject areas who were nervous about the impact of ~~—~~ ~~th~~inner spread of students across the curriculum” (p. 10) were reported and it was believed there was gate-keeping’, particularly by career advisors and deans” (p. 9). Teachers suggested that whereas principals were prepared to run small classes in academic’ subjects, they were ~~—~~ less willing to sustain ones perceived as less academic” (p. 10).

The sustainability of Health Education and Home Economics at senior secondary level was also addressed in the report and is illustrative of the organisational and attitudinal constraints on the development of new senior school subjects. Principals pointed out the difficulties of supporting new subjects, such as ~~—~~ ~~th~~ resource implications of the increasing variety of subjects at senior level, a mismatch between the current staffing and the number and nature of teachers needed for new’ subjects and the effects of increasing timetabling complexity” (p. 10). Principals also noted the potential impact if the sole Beacon specialist (where only one teacher taught senior Health Education) left the school.

The Ministry of Education summary report (2005) provided a snapshot’ of the participating Beacon Schools. This snapshot of the Beacon School Project is important because it shows that regardless of the quality of professional development, there were significant barriers for the implementation of senior Health Education.

4.5 Chapter summary

This chapter examined educational policy as it was put into practice across the education system in the period 1985-2004. Health Education curriculum and assessment discourses (particularly from 1999), were the focus for this chapter. A significant point of difference from past developments was the grouping of three previously separate areas into one curriculum area. Other issues with implications for this study were the effects of political discourses on curriculum development; the blending of health and education discourses, the on-going influence of the 1985 syllabus and the similarities and differences between the 1985 syllabus and the 1999 curriculum.

The significance of Health Education's inclusion in the National Certificate of Educational Achievement (NCEA) was considered. This development was important because inclusion in this assessment framework signalled a new pedagogical discourse and had the potential to change perceptions of Health Education as a low status curriculum area that was generally restricted to junior secondary level. The effects of policy discourses (particularly assessment) on teachers and pedagogy were also examined through literature from New Zealand and other countries affected by similar educational discourses. Variation in teachers' responses to policy changes was noted and the possible effects of formal assessment on pedagogy were also discussed. The relationship between the NCEA and teachers' 'meaning making' about curriculum were considered and the chapter concluded with a discussion of the professional development that was associated with policy changes.

In the following chapter (Chapter Five), discursive tools that helped the analysis of the teachers' micro worlds are discussed: discourses of pedagogy, sexuality, gender and emotionality. Together, Chapters Three to Five make up the 'toolbox' which facilitated the analysis of the empirical data.

Chapter Five

Power and knowledge, gender, sexuality and emotionality

This chapter completes the theoretical toolbox for the study. It presents a theoretical framework which, combined with the discursive approach of Chapters Three and Four, provides the means to address the research questions. Thus in Chapter Five, tools for the analysis of the teachers' micro worlds are discussed. The major theoretical tools were found in the work of Bernstein (1971, 1996) and this discussion makes up the first half the chapter. In the second half of the chapter, theories about gender, sexuality and emotionality are considered in relation to teaching Health Education. The chapter comprises: **5.1 Introduction; 5.2 Power and knowledge; 5.3 Sexuality and power in Health Education; 5.4 Gender in Health Education; 5.5 Emotionality in Health Education; and 5.6 Chapter summary and key points for investigation.**

5.1 Introduction

The aim of Chapters Three and Four was to identify the key elements of the context in which contemporary Health Education teaching (Chapters Six to Nine) takes place. However, in order to provide explanations for the actions of the teachers in the study, both individually and as a group, a sharper focus on their pedagogy was also required. The theoretical 'toolbox' (Ball, 2005) for this study is thus completed in Chapter Five with the addition of a discussion of teachers' work in terms of discourses of power and knowledge, power and sexuality, gender and emotionality. In combination, Chapters Three to Five

make available tools for a robust interrogation of the interview data and consequent deep analysis of the teacher narratives.

The work of Basil Bernstein dominates this chapter because his theories make up a very significant element in the toolbox and, equally, a major part of the data presentation and analysis (Chapters Six and Seven). Bernstein offered important conceptual tools with which to explore power and knowledge in contemporary discourses of Health Education curriculum, pedagogy and assessment. The writing of other theorists and researchers is used to complement and extend the theoretical frame derived from Bernstein's work: sexuality, gender and work on the emotions of teaching. In each part of the chapter I have drawn on a small number of theoretical and empirical studies, discussing these in depth, rather than provide a broad overview of the literature. This toolbox provides the coherent theoretical framework for the analysis of the teacher accounts in Chapters Six to Nine. The chapter concludes by summarising Chapter Five and also summarises the key points arising from Chapters Three to Five. These points informed the analysis and organisation for Chapters Six to Nine, the data presentation chapters.

5.2 Power and knowledge

Introduction

Given the discussion in Chapters Three and Four, I expected the teachers' accounts would reveal: (i) concerns about the low status of Health Education and (ii) the complication of sharing an essential learning area of the New Zealand curriculum with Physical Education. Goodson's work (e.g., 1983) on the politics of school subjects had been helpful in this regard, however, it was Bernstein's theories particularly which enabled me to consider ways of connecting the teachers' accounts with some general principles of pedagogy. These principles helped me to analyse their accounts in a way that did justice to the complex and challenging nature of their work.

Bernstein's theories have been 'works in progress' as he elaborated on his initial thesis and tried to make his writing more explicit and useful over time. Bernstein's seminal paper *On the Classification and Framing of Educational Knowledge* published in 1971 was extended and elaborated in later writings (e.g., 1996). The purpose of the publication in which the 1971 paper appeared was significant for it marked a new way of looking at curriculum. Writing in 2006, the book's editor Michael F.D. Young recalled: "The primary purpose of that book was to unmask the ideological assumptions of the official curriculum and to argue that it always expresses some interests" (2006, p. 21).

Critics of Bernstein's work such as Walford (1995) argued that his writing was obscure and difficult to apply empirically in educational research. I argue that Bernstein's theories are abstract rather than obscure and need to be applied to particular contexts in order for them to have practical relevance. Accordingly, in each of the subsections below, the relevance of his theories to this study are explained. The subsections are as follows: Power and its effects on curriculum and pedagogy; Classification and framing of knowledge; A change of knowledge code; Bernstein's principles applied to curriculum, pedagogy and assessment; The effects of changes in knowledge codes; The effects of new knowledge codes; 'Commonsense' and 'uncommonsense' knowledge; and Section summary.

Power and its effects on curriculum and pedagogy

From a preliminary reading of interview transcripts, it became evident that power was affecting the practice of teaching Health Education. Bernstein's explanatory principles, particularly those of classification and framing, opened up ways to understand power and its effects on teachers by explaining ways in which school knowledge is selected, structured, transmitted and valued.

Bernstein (1971, 1996) argued that investigation of principles of communication provided a means of analysing why some forms of discourses are privileged over others and how this domination is sustained. This is part of a bigger

argument about the means by which social inequalities are transmitted. The question which has driven his work over three decades was restated in 1996:

How does power and control translate into principles of communication, and how do these principles of communication differentially regulate forms of consciousness with respect to their reproduction and the possibilities of change? (Bernstein, 1996, p. 18)

In the context of this study, the central question was therefore to find out how teaching was shaped by official curriculum and assessment discourses.

Bernstein's preoccupation with making the workings and effects of power less opaque is echoed in the work of Foucauldian scholars in education. For example, Olssen (1999, p. 176) emphasises that —Foucault's point is that modern power is *centreless*, located neither in the State nor in any other single source". This conceptualisation of power implied that in schools it is not sufficient to envisage power as invested in powerful individuals such as principals and heads of departments — the —terminal forms power takes" (Foucault, 1978, p. 92). Rather, scholars are urged to go beyond the idea of power residing in individuals and ask questions about the domain of power — how it is manifested in institutions such as schools and what effects it has. Bernstein's theories about the operation of power in the selection and transmission of knowledge permit this kind of examination to take place in terms of teachers' work.

Bernstein argued that cultural reproduction theory (namely, that schools have a central role in replicating inequalities) did not in itself provide a sufficiently robust means to examine what was happening when educational discourses become the conduits of power relations into schools. Bernstein attempted to address this absence through developing some principles which facilitated an examination of *how* the inequalities of the social world external to the school were both produced and reproduced within schools.

To achieve this aim, Bernstein developed a typology of knowledge codes as a means of exposing and exploring the principles which mould the message systems of formal education; that is, the message systems of curriculum, pedagogy and evaluation. These message systems were defined by Bernstein (1971) as:

Curriculum defines what counts as valid knowledge, pedagogy defines what counts as a valid transmission of knowledge, and evaluation defines what counts as a valid realization of this knowledge on the part of the taught (p. 47).

A purpose for this study therefore was to investigate how the teachers positioned themselves and how they were positioned, in relation to official curriculum and assessment discourses. In the following subsections, a way of exploring the official message systems of curriculum and assessment (Bernstein's principles of classification and framing) is described and then applied to the 1999 curriculum and the NCEA.

Classification and framing of knowledge

In Bernstein's analysis, power and control are inextricably linked; power establishes the nature of relations between different discourses while control constructs what is legitimate communication within discourses. Bernstein's principles of classification and framing allow an examination of the way power separates and regulates educational discourses within curriculum structures and thereby affects the day-to-day practices of learning and teaching.

Classification refers to the relationship between discourses, —the metaphoric structuring of space” (Bernstein, 1996, p. 26) and framing refers to what can be said and by whom (what constitutes legitimate communication). This idea of control through communication was also used by Ball (1990) with reference to Foucault, when Ball talked about discourses as being —about what can be said, and thought, but also about who can speak, when, where and with what authority” (p. 17).

Bernstein made a distinction between two kinds of knowledge codes or curricula – ‘collection’ and ‘integrated’. In a collection code curriculum, each content element or subject is strongly bounded and closed off from other subjects and is characterised by strongly framed pedagogy, such as grouping students according to perceptions of ability, and a teacher dominated pedagogy. By contrast, the components in an integrated code curriculum are separated by indistinct boundaries and pedagogy is weakly framed with more emphasis on group work and relational interaction between teachers and students. Bernstein argued that a weakly classified model “is highly vulnerable because communications from the outside are less controlled” (1996, p. 25).

The concepts of classification, framing and knowledge codes were helpful in analysing the pedagogical tensions inherent in the 1999 curriculum document taught by teachers in this study. In the following subsection, the 1999 curriculum is analysed using the collection and integrated knowledge codes.

A change of knowledge code

The 1999 curriculum was an integrated knowledge code because it brought together Health Education, Physical Education and “aspects of Home Economics” (Ministry of Education, 1999, p. 6). These three subjects had historical identities based on different development paths and policy documents, but from 1999 were linked through four over-arching ideologies – the 1999 curriculum’s underlying concepts of hauora, health promotion, the socio-ecological perspective, and attitudes and values. Thus the 1999 curriculum brought about a change in the degree of ‘insulation’ between Physical Education, Health Education and Home Economics.

Bernstein’s development of *recognition rules* and *realization rules* were helpful as a way of analysing the fraught discursive field for secondary school teachers initiated by the release of the 1999 curriculum. For Bernstein, “recognition rules regulate what meanings are relevant and realization rules regulate how the meanings are put together to create legitimate text” (Bernstein, 1996, p. 32). The three separate curriculum areas each carried a range of what had

previously been relatively stable meanings, but it was inevitable that in putting them together, some of these meanings would come to have less weight as realization rules came into play. Historically, career paths and pedagogical experiences of Physical Education and Health Education teachers had been different. A further complication was that Health Education also fitted into integrated codes, which are additional to the 1999 curriculum model. In this study, for example, aspects of Health Education were integrated with Religious Education and Science. The variety of integrated codes would imply major barriers in the realisation of an inclusive school based legitimate text'.

The integrated code of the 1999 curriculum opened up possibilities for new thinking and ways of doing things; in this sense, Bernstein's idea of a —~~potential~~ discursive gap" (1996, p. 44) was helpful. A discursive gap occurs when meanings have not become confined to a specific context: —~~if~~ these meanings have an indirect relation to a specific material base, because they are indirect, there must be a gap" (1996, p. 44). There will be tensions and contradictions in attempts to realise the latent possibilities of this gap, for power inevitably comes into play and increasingly, as Bernstein (1996) pointed out, it is the state which has a significant role in determining the kind of discourse which is created.

In this study, the idea of a discursive gap' was useful when looking for signs of a new integrated Health Education, Physical Education and Home Economics discourse which showed that shared practices were being created, and in turn, were creating a new discourse. If it was not developing within schools, then it could be argued that there was more opportunity for discourses to be imposed from the outside by government organisations such as the Ministry of Education.

Bernstein's principles applied to curriculum, pedagogy and assessment

Not only were Health Education teachers grappling with the 1999 curriculum during this study, they were also coming to terms with novel assessment and credentialing requirements in the form of the NCEA. Understanding the complex

relationships between curriculum, pedagogy and assessment discourses was central to the analysis of teachers' work in this study. In this subsection these complex relationships are explored using Bernstein's work.

Bernstein built on the idea of the relative strengths of boundaries as a distinguishing feature between collection and integrated curricula to theorise the role of classification and framing across the mechanisms by which formal knowledge functions: through curriculum, pedagogy and evaluation.

Classification is about boundary strength and therefore the distance or proximity between different knowledge contents. Classification is crucial to understanding how knowledge is divided, how decisions are made about what should be learned and who should teach and learn particular content. In other words, classification is very useful for interrogating assumptions about curriculum.

Framing is useful for analysing power relations within learning, that is, its pedagogical characteristics. The strong framing typical of collection codes is realised through tightly controlled knowledge transmission (i.e. teaching). In strongly framed collection codes, visible power resides mainly with the teacher and —the educational relationship tends to be hierarchical and ritualised and the pupil seen as ignorant with little status and few rights” (Bernstein, 1971, p. 58). The weaker framing characteristic of integrated codes encourages student agency: —there is a shift in the balance of power, in the pedagogical relationship between teacher and taught” (Bernstein, 1971, p. 60).

Outsiders are sometimes invited into secondary schools to teach aspects of Health Education, particularly at the junior secondary level. This is unusual for secondary school subjects and contributes to Health Education's weak classification and framing. This characteristic was evident in this study and had implications for teachers and students.

Bernstein suggested that in addition to changing —the nature of the authority relationships by increasing the rights of the taught” (1971, p. 61) a characteristic of —relaxed” (1971, p. 61) frames is the increased presence of both teacher and student: the relaxed frames —can also weaken or blur the boundary between

what may or may not be taught, and so *more* of the teacher and the taught is likely to enter this pedagogical frame” (1971, p. 61). There is potential for expanded pedagogical relationships when frames are relaxed. This relationship might involve a level of commitment that extends beyond a formal role-based relationship. Weak framing was a characteristic of the teaching described in this study, particularly in junior Health Education.

In the Health Education needs based‘ discourse of the 1999 curriculum, there is an assumption of student agency. If the NCEA system was used at senior level, there was likely to be less emphasis on student agency. This was because the NCEA constituted a strongly classified and framed knowledge code (a collection code) which shifted power back to the teacher. In comparison with junior Health Education, the NCEA offered a degree of certainty about what should be taught and also required technical knowledge of how the system worked. These changes favoured the development of more hierarchical and rule governed relationships.

In an integrated code, there is no obvious ~~temporal~~ cohesion” (Bernstein, 1971, p. 65) of principles for assessment. This is because of what Bernstein calls ~~the~~ deep structure of knowledge, i.e. the principles for the generating of new knowledge” (1971, p. 61) which are likely to be introduced early on in the student’s schooling. This is evident in the 1999 curriculum as young children are encouraged to learn about the different dimensions and interrelationships inherent in the concept of hauora‘ (well-being), learning which is subsequently assessed at senior secondary level.

Bernstein suggested that an integrated code may privilege the evaluation of ~~dispositional~~ attributes” over ~~cognitive~~ attributes” (Bernstein, 1971, p. 66) This has the potential to expose students to regulation and control. The complexity of such assessment in Health Education, which lacks the ~~temporal~~ cohesion” (1971, p. 65) of a collection code and inevitably has a strong emphasis on student and teacher attitudes and values, was present in this study.

The effects of changes in knowledge codes

In this study, the knowledge code changes initiated by the 1999 curriculum document were being worked through in schools. The teachers in this study had to make sense of curriculum and assessment discourses in relation to existing strongly and weakly framed curriculum areas (subjects). Bernstein's collection and integrated knowledge codes provided ways of analysing organisational and relational tensions inherent in the new curriculum and assessment discourses.

The integrated code of the 1999 curriculum was in contrast to the organisational culture of secondary schools, because schools are generally organised around strongly framed (collection knowledge code) learning areas. This characteristic is shared by other countries. Tracing the development of school subjects in England, Goodson and Marsh (1996, p. 12) commented: "—inspite of the many alternative ways of conceptualising and organising curriculum the convention of the subject remains supreme. In the modern era we are essentially dealing with the *curriculum as subject*". Siskin (1990) also noted the significance of the subject department in determining teacher conceptions, practice and outlook on teaching.

The 1999 curriculum was an example of an integrated curriculum. In integrated codes, previously separated knowledge and ways of teaching can form the basis of a new discourse as teachers negotiate the possibilities and constraints of a novel environment (Mac an Ghail, 1994). This possibility was weakened for the three curriculum areas because integration was not reflected in the departmental organisations evident in this study. In other words, no new integrated departments were set up and the teachers belonged to existing departments such as Physical Education or to the more recently established and lower status Health Education departments. This organisation was not conducive to the development of pedagogy based on shared values and also raised resource issues. Ball and Lacey (1995) contend that "—departments compete with one another for control of time, personnel, fiscal resources, territory, students, and —oice" within policy making" (p. 96). In this study there was evidence of competition between Health and Physical Education

departments and internal competition if Health Education teachers were based in Physical Education departments.

Classification was useful in exploring further reasons for relational and organisational tensions. Classification –always has an external value because it is concerned with relations. But classification can also have an internal value” (Bernstein, 1996, pp. 28-29). Internal classification can refer, for example, to the informal or formal nature of the way a classroom is set up, with strong classification being linked to specialised spaces. Health Education can have both strong and weak internal classification. Some Health Education classes take place in dedicated rooms (that is, specialised spaces) and are often marked by being set up in informal ways. Health Education is, however, often taught in borrowed rooms which are set up as specialised spaces for other subjects. As a result such rooms are strongly classified for the host subject but weakly classified for Health Education. There is also the contrast for pupils and teachers of teaching spaces dedicated to teaching Physical Education (e.g., the gymnasium) that are strongly classified for Physical Education.

Bernstein also mentions classification by dress and posture; here again there is strong internal classification with those who teach Physical Education often wearing clothes which identify them as Physical Education teachers while those who teach Health Education and other subjects wear different clothes and bear themselves in different ways. Compounding this divergence between Health and Physical Education are the different clothes students wear to Physical Education classes and in sports teams. The explicit physicality of Physical Education, a further contrast with Health Education, is illuminated by Bernstein’s definition of text: —anything which attracts evaluation, and this can be no more than a slight movement” (Bernstein, 1996, pp. 32-33).

Bernstein (1971) argued that the organisation of knowledge into tightly bounded subjects, a collection code, sets up conditions whereby power is concentrated in the hands of a few, that is the heads of departments who work closely with the principal. Senior staff members therefore have strong horizontal working relationships (as they liaise with their senior colleagues) in addition to strong

vertical relationships within their subject. In comparison, junior staff tend to relate vertically within their subject department but are less likely to have strong work relationships across the school. Junior staff develop a sense of belonging and subject loyalty through their social interactions within their subject area and because of the symbolic space between them and other subject areas. Of relevance for this study was the concentration of power in and across collection code subjects (and to senior staff) and potential barriers to teachers developing loyalty to a weakly classified curriculum area such as Health Education.

In comparison with the collection code, the integrated code has the potential to weaken the strength of subject based loyalties as teachers work together on educational projects, and —~~to~~ administration and specific acts of teaching are likely to shift from the relative invisibility to *visibility*” (Bernstein, 1971, p. 62). There is greater scope for power sharing in an integrated code, compared with a collection code, because power is more likely to be dispersed and not coalesce around a senior head of department who has strong links with the principal. The operation of power (in the delineation of this new knowledge code and the establishment of its difference from other subjects) and control (whose voice will be heard) will be most visible in the early days of an integrated curriculum. The workings of power, though perhaps less visible, will continue to affect an integrated code, because —~~with~~ weak classification there is a reordering of specialised differentiation and this can provide a new social basis for consensus of interest and opposition” (Bernstein, 1996, p. 25). Teachers working in an integrated code have greater opportunity to exercise agency because power is dispersed.

The code changes signalled in the 1999 curriculum document created the possibility of shifts in the organisation and allocation of power and had implications for the socialisation of teachers. The effects were potentially unsettling as teachers tried to construct new subjectivities (or cling to old ones) and competed for time, space and resources (Mac an Ghail, 1994). As Bernstein suggests: —~~it~~ is no wonder that deep-felt resistances are called out by the issue of change in educational codes” (1971, p. 63).

A further matter of interest was anticipated links between the socialisation of students as well as teachers into subjects and the associated subject loyalty and identity conferred by this socialisation. In this regard, Bernstein suggests that “the subject becomes the linchpin of the identity” (1971, p.56) and that:

Any attempt to weaken or *change* classification strength may be felt as a threat to one’s identity and may be experienced as a pollution endangering the sacred. Here we have one source of the resistance to change of educational code (p. 56).

The bringing together of Physical Education, Health Education and aspects’ of Home Economics into the 1999 curriculum is an example of a change in classification strength by a weakening of boundary strength. This led to a “disturbance of existing authority structures, existing specific educational identities and, concepts of property” (Bernstein, 1971, p. 59) and was evident in the teachers’ accounts.

Bernstein suggested that in order for an integrated code to be successful it requires an explicit and elaborated “ideological consensus” (1971, p. 64) and it may involve “resocialisation” (p. 65) if teachers have previously been socialised by a collection code. Within the integrated code there is potential for discomfort and disturbance as teachers resocialise. This internal disarray is likely to be in contrast to the official outward shape of the discourse, which is separated from other collection or integrated codes. Thus the 1999 curriculum classified three previously separated curriculum areas into a one learning area and separated it from other learning areas, but this created tensions within the boundaries of the learning area: “Externally, the classificatory principle creates order, and the contradictions, cleavages and dilemmas which necessarily inhere in the principle of a classification are suppressed by the insulation” (Bernstein, 1996, p. 21).

There were two additional collection code discourses which teachers drew on when constructing meaning and practising Health Education: NCEA and

professional development for Health Education. These two knowledge codes are discussed below.

The effects of new knowledge codes

Both the NCEA and professional development to accompany official curriculum implementation are examples of strong framing and classification. The NCEA relays messages of strong framing through national policy, training and monitoring; professional development relays messages of strong framing and classification through pedagogy and resources. An important distinction within professional development, however, was that resources and professional development, particularly for senior levels, were sometimes funded by the Ministry of Health rather than the Ministry of Education. Thus education discourses intermingled with public health discourses in these resources and associated professional development⁴⁵.

Both NCEA and professional development can be viewed as ways of constructing —legitimate text” (Bernstein, 1996, p. 32). That is, they set up the ‘recognition’ and ‘realisation’ rules for what curriculum areas are and are not. An interesting finding during this study was evidence of the influence of these two additional collection codes on the ‘meaning making’ and practice of Health Education. There were two particular areas of interest. The first was how non-assessed senior Health Education and junior (Years 9 and 10) Health Education, both of which were outside the NCEA system, were affected by NCEA discourses. The second was the separation of Health Education, Physical Education and Home Economics in the NCEA. Each of these curriculum areas were strongly framed and classified by having separate standards and separate professional development.

This subsection on the effects of changes in knowledge codes has shown the organisational and relational tensions which teachers had to negotiate as they

⁴⁵ For example, a key senior resource for NCEA health is *Social and ethical issues in teaching sexuality education: A resource for Health Education teachers of year 12 and 13 students*. This resource was funded by the Ministry of Health and was only available to teachers who attended the three day professional development courses. Teacher release and travel was funded by the Ministry of Health.

came to terms with the 1999 curriculum and the NCEA. The overall impression is one of confusion and contradiction. The teachers' individual and collective reactions to changes in knowledge codes are presented in Chapters Six and Seven.

In final subsection, Bernstein's theories on commonsense' and noncommonsense' knowledge are discussed. These theories helped in the analysis of the pedagogies reported by the teachers and also helped explain Health Education's non-academic status.

'Commonsense' and 'uncommonsense' knowledge

Health Education is the only subject in the New Zealand curriculum for which consultation with the community is a legal requirement⁴⁶. Health Education is therefore opened up to everyday' knowledge through the incorporation of local community, cultural and family knowledge. This characteristic contrasts with the specialised academic content and language of other curriculum areas. The selection and valuing of such knowledge and its implications for schools, teachers and students is usefully discussed using Bernstein's principles of classification and framing.

Bernstein used classification and framing to explore the relationships between educational or uncommonsense knowledge" and the commonsense knowledge, everyday community knowledge, of the pupil, his family and his peer group" (1971, p. 58). Weak framing suggests that there will be a shift in power relations within classrooms when the banking model' (Freire, 1972) is less evident. Freire used the analogy of banking' to describe the transmission of teacher knowledge to students: Instead of communicating, the teacher issues communiqués and makes deposits' which the students patiently receive, memorize, and repeat" (1972, p. 47). In this banking model, educational or school knowledge is privileged over personal and social knowledge. Weak classification between commonsense or non-educational knowledge and educational knowledge suggests: a change in what counts as having knowledge, in what counts as a valid realization of knowledge...and so changes

⁴⁶ The origins of this requirement are discussed in Chapter Three.

in the structure and distribution of power and in principles of control” (Bernstein, 1971, p. 63).

In this study, an area of interest was the extent to which commonsense knowledge was valued, particularly in junior Health Education classes where there was no system of national assessment. Valuing of commonsense knowledge had implications for power dynamics and control in classrooms. There were also implications for perceptions of status because uncommonsense knowledge is “not ordinary or mundane, but something esoteric which gives special significance to those who possess it” (Bernstein, 1971, p. 58). Bernstein suggested that weak framing is often associated with those students who do not flourish in an academic environment and is therefore a means of controlling “deviancy” (1971, p. 58). Indeed, the status of students within a school may be judged according the kinds of knowledge they engage with. So, for example, Paechter (2001) argues that:

...students may be classified and curricula differentiated according to the degrees to which non-school knowledge has been incorporated into the learning situation, measured on a scale according to which the more non-school knowledge a student acquires, the less ‘able’ he or she is perceived to be (p. 169).

For Health Education there are serious implications: firstly that Health Education is perceived as ordinary, everyday and not included in “official pedagogic communication” (Bernstein, 1996, p. 38); and secondly that Health Education classes might be the repository for students and teachers who are ‘ordinary’ and lack academic ability.

The separation of ‘other-world’ knowledge and ‘real world’ knowledge as the premise on which formal education should be founded was also questioned by Dewey (1939) and Young (1971). Young was intrigued by the way some knowledge received an educational endorsement and other knowledge did not. Drawing on Gramsci’s idea of hegemony (the potential for domination by some discourses to the extent they become unquestioned), Young encouraged

scholars to look at the reasons why some —~~the~~ knowledge available to certain groups becomes ‘school knowledge’ or ‘educational’ and that available to others does not” (1971, p. 28).

Debate continues about what kind of knowledge should be emphasised in educational institutions. Young (2006), for example, drew attention to some limitations of everyday knowledge:

The primary but not only purpose of educational institutions is to take people beyond their everyday knowledge and enable them to make sense of the world and their lives and explore alternatives; the purpose of educational institutions is not to celebrate, amplify or reproduce people’s experience (p. 22).

In the NCEA there is a shift from the experiential knowledge valued in junior classes to a more conceptual knowledge. There is also variation in this, however, and again Bernstein’s work was useful. Bernstein’s attempts to uncover the class dimension of schooling, also represented in the writings of Apple (1990) and Nash (1990), were helpful in analysing the unit standards/achievement standards debate in Health Education. There is an interesting example of framing within NCEA, with unit standards deemed to be ‘easier’, more straightforward and therefore more suitable for ‘less able’ students. Unit standards, by comparison with achievement standards, are perceived to be more practical and less conceptual. It could therefore be argued that unit standards are more grounded in the everyday world of students.

The drive to attain academic recognition has meant that teachers have been encouraged to offer achievement standards rather than unit standards; a criterion for becoming a ‘Bacon school’ for example was the use of achievement standards. Achievement standards, particularly those at Levels Two and Three, appear to have been constructed for the ‘middle class’ as a certain kind of knowledge is privileged, one that is more likely to be ‘recognised’ and ‘realised’ by students from middle class backgrounds, that is, where there is a ‘strong classification between home and school’ (Bernstein, 1996, p. 34).

The inclusion of Health Education within the NCEA system has the potential to alter perceptions of its non-academic status. This is in contrast to Britain where Health Education is one of a number of cross-curricular themes that attempt to address personal and social health. In Britain the dominance of strongly framed and high status subjects which are part of 'high stakes' assessment has put pressure on the holistic, 'real life' or non-academic dimensions of secondary schools and created tensions and ambiguities for teachers (Power, 1996).

In this sub section classification and framing were used to analyse what counts as knowledge in Health Education. Important concepts were commonsense and uncommonsense knowledge. These concepts were helpful in explaining Health Education's status and also curriculum and assessment tensions.

In this major section, Bernstein's theories about how power works in the selection and teaching of knowledge have been applied to Health Education. The concepts of classification, framing and knowledge codes were used to analyse tensions in Health Education curriculum and assessment discourses. These concepts helped explain tensions in the integrated knowledge code of the 1999 curriculum and in the inclusion of Health Education in the NCEA system.

Although curriculum and assessment were very important discourses for this study, there were other discourses that influenced the teachers' work. In the remainder of the chapter, the following discourses are discussed: sexuality and power, gender, and emotionality.

5.3 Sexuality and power in Health Education

In this section a Foucauldian perspective on power is used to analyse sexuality. This was because sexuality as a form of power was evident in the study. There are two subsections: power and the body, and power and sexuality.

Power and the body

For the purposes of this study, a Foucauldian perspective offered a way of examining how power works in schools. From this perspective, the body is identified as a primary location for the implementation of power (Foucault, 1980). The effects of these discourses are not likely to be uniform for wherever power is present, resistance is also possible:

Just as the network of power relations ends by forming a dense web that passes through apparatuses and institutions, without being exactly localized in them, so too the swarm of points of resistance traverses social stratifications and individual unities (Foucault, 1978, p. 96).

Middleton (1998) used Foucault's work to analyse the disciplinary effects of past and present sexuality discourses in life history work with teachers. She countered a gloomy view of teachers and students subdued by "the hegemonic weight of New Right conservatism and technocracy" (1998, p. 3) and argued that there are "always oppositions, alternatives, resistances and creativities" (1998, p. 3). In this study there was evidence of pedagogical agency within the sexuality discourses apparent in the data.

Schools (their architecture, layout and structures) and schooling (the social processes involved in teaching) yield abundant examples of power being worked out through 'disciplining' bodies. Furthermore, Health Education is concerned with the health of individuals and society and therefore provides an additional dimension through which to explore power as it is exercised over bodies. The disciplining of individual bodies and attempts to manage population processes such as the birth rate are included in the term 'bio-power' (Foucault,

1978). Connections between disciplining the body and controlling populations through reproductive health discourses were discussed in Chapter Four.

Surveillance of the many events which make up a school day is one of the more obvious ways that power operates. Movement by students and teachers is one example of the effects of the panoptic gaze (the all-seeing eye) which in the prison setting produces —a state of conscious and permanent visibility that assures the automatic functioning of power” (Foucault, 1977, p. 201). Time in secondary schools is segmented and teachers and students have to be in certain places at certain times – in the staff room, in class rooms, in specialised teaching spaces such as the gymnasium, and not in other places at certain times. Movement outside officially designated times is regulated and elaborate systems for tracking and reporting have been developed.

In recent years, fears of exposure to claims of harassment (e.g., Jones, 2001) have added to the pressure to remain visible so movement is restricted to places where teachers and students can be seen by others. Teachers and students are both under surveillance so power is mobile. Drawing on the work of Biklen (1995) who argued that teachers as well as students are affected by regulations, Middleton (1998, p. 27) noted that —the bodily disciplining of teachers and their students are interdependent”. The significance for Health Education teachers is that sexuality education is part of the curriculum so there are particular challenges for them.

Within classrooms there are a variety of body centred rituals which emphasise power relationships. These include seating arrangements (who can sit with whom) and what dress is deemed appropriate (for staff and students). Posture including how students sit (leaning back on chairs is discouraged) is read and may be corrected. In contrast to an emphasis on formal seating, Health Education pedagogy encourages flexible seating and grouping arrangements, even in junior classes where surveillance is often most evident.

Power and sexuality

Middleton highlighted the centrality of sexuality in Foucault's research of "disciplinary power across the separate but intersecting professions and institutions of modern societies" (1998, p. 7). Foucault (1976) identified an obsession with sexuality in schools in the eighteenth century. A controlling discourse was expressed through structures, organisation and management techniques. This discourse "was largely based on the assumption that this sexuality existed, that it was precocious, active, and ever present" (p. 28). Foucault claimed that since the eighteenth century, the sexuality of young people has become "an important area of contention around which innumerable institutional devices and discursive strategies have been deployed" (p. 30).

The opening up of new power dynamics within schools through bringing sexuality into the official curriculum exposed historically located tensions between sexuality and schooling (Youdell, 2005). Youdell noted the work of Epstein and Johnson (1998), and commented: "It has been argued that schools and sexuality are constructed as fundamentally discrete and that the people who populate schools – students and teachers – are constructed as intrinsically non-sexual" (p. 251). The relevance for this study was that sexuality discourses were in the main confined to classrooms.

Inconsistent messages concerning sexuality, bodies and education (that is, denial that sexuality has anything to do with education, while intensively monitoring students and teachers' bodily practices) remains a feature of schooling (Sikes & Everington, 2003). Thus:

On the one hand, they have tended to be consciously and deliberately ignored, yet at the same time, denied as having anything legitimate to do with teaching and learning, which are seen to be about the mind. On the other hand, however, there is a whole raft of rules, regulations and sanctions – applying to teachers as well as to pupils – concerning dress, demeanour and relationships that is apparently there to check any intrusion of sex into the academe (Sikes & Everington, 2003, p. 396).

The relevance of opening up the curriculum to include sexuality education was that senior staff in a number of schools where the teachers worked appeared anxious about sexuality. Anxiety about sexuality therefore could be a constraint but it also presented possibilities because senior staff did not want to engage in discussions about sexuality education.

A significant disciplining mechanism is associated with a normative discourse of heterosexuality which remains strong in schools despite challenges in recent years (Connell, 1995; Epstein, 1996; Kehily, 2002; Mac an Ghail, 1994). In his study of the role of schooling in shaping sexual identities, Mac an Ghail (1994, p.163) reported that —since — reflecting that in wider society — pervaded the whole of the formal curriculum, serving to reproduce and legitimate dominant heterosexual hierarchies”. Compulsory heterosexuality (Rich, 1980) provides the ideological basis for the surveillance and discipline of both students and teachers.

The development of —legitimate spaces in the curriculum” (in Health Education and other subjects) during the 1990s (Middleton, 1998, p. 14) presented opportunities for students to use sexual language and to discuss issues such as homosexuality. These new conditions sanctioned a school based sexuality discourse which students could use to regulate teacher behaviour.

Middleton gave the example of a woman teacher at a boys’ school who described how students used homophobic language in an attempt to regulate her appearance” (1998, p. 14). As Middleton states with reference to her data:

Through Foucauldian lenses, power indeed shows up as —capillary,” as it flows through all parts of the school’s —corporate body”. All individuals channel power: Students and teachers police each others’ outward appearance, deportment, and behaviour, although it is the teacher who officially has power over the students (1998, p. 21).

This example serves to illustrate the way power can affect pedagogical relations. The implications for students and teachers are shown in the data presentation chapters, particularly Chapter Nine.

The discussion in this section has provided another theoretical tool for this study of teaching. This section has used power as a lens through which to examine discourses of the body and sexuality. Power over bodies (both students and teachers' bodies) was shown to be a feature of schooling with particular relevance for those who teach sexuality education. In the following section a discussion of gender adds a further tool. This discussion adds another dimension to this multi-layered study of Health Education teaching.

5.4 Gender in Health Education

Introduction

In this section, the significance of gender theory for this study is argued. Gender is defined and its explanatory work in this study described.

My experience of Health Education is that it is strongly associated with female teachers (and when Health Education becomes optional in the senior school, female learners). I suggest that this association is part of the gendered configuration of the present day social world and is therefore deeply embedded in schools. The gendered configuration reflects —society that has dominant ideas about the correct way to be male and female. This produces a gender order where some ideas are seen to be better and more right than others” (MacNaughton, 1998, p. 166). However, as Connell (2002, p. 3) points out, —Recognizing the gender order is easy; understanding it is not”.

The toolbox for examining teachers' accounts of their work in Health Education was incomplete without an explicit articulation and theorisation of gender. This was missing from the work of Bernstein and Foucault. This is not to say their theoretical principles have not been used to question assumptions about gender. Foucault's work on the decentred nature of power and the disciplining of the body have obvious application for gender studies, and perhaps more surprisingly, Bernstein has been used by a number of feminist writers (e.g.,

Arnot, 2001). It was, however, the work of other theorists which provided the clear articulation of gender theory I was looking for.

Connell's work (1985, 1995, 2002) was used as the starting point for exploring the gender discourses emerging from the interviews. I used Connell because of the relevance of his theoretical and empirical work to education, which is a specific site of power-knowledge struggles. Connell (1985, p. 3) argued that "gender relations" were as important as class relations in the shaping of education and the lives of teachers". The importance of the gender lens for analysing institutions such as schools was strongly supported by Acker (1989, p. 1) who "was puzzled by the gender divisions within teaching but also because their existence is so taken-for-granted".

Connell's work on gender helped the analysis of the gender discourses which emerged in the interviews. These discourses were very important because they affected who taught and who studied Health Education when it became an optional subject at senior secondary level. Gender discourses also affected Health Education pedagogy.

What is 'gender'?

Gender is the structure of social relations that centres on the reproductive arena, and the set of practices (governed by this structure) that bring reproductive distinctions between bodies into social processes (Connell, 2002, p. 10).

For the purposes of this study, Connell's definition of gender is used because it incorporates the "reproductive arena" (2002, p. 10), that is "a historical process involving the body, not a fixed set of biological determinants" (1995 p. 71); social dimensions of gender; and the idea that gender is constituted in everyday practices – "constructed in interaction" (1995, p. 35). Connell's way of looking at gender is useful as it acknowledges the body and also the social shaping of that body in a mutually reinforcing and continuous process – "bodies are

addressed by social processes and drawn into history without ceasing to be bodies” (1995, p. 48).

Gender discourses are embedded in the content and pedagogy of Health Education, particularly sexuality education, and this has changed over time. Although new discourses have begun to influence sexuality education, there is still considerable emphasis on bodies and things being done to bodies to make them safe or unsafe (the physical dimension of sexuality education remains a prevailing discourse). Social relations and practices therefore have a very strong relationship to bodily processes, particularly those of girls and women, in the ways sexuality education is currently taught.

How the teachers in this study positioned themselves in relation to gender discourses affected their teaching and had particular relevance to sexuality education.

Gender theory and its importance as an analytical tool

Examination of Connell’s work since 1985 shows a continuing emphasis on the importance of looking at gender as a way of exploring underlying principles of social interaction, such as that which takes place between Health Education teachers and their students. The following work by Connell and others on gender theory helped illuminate social processes involved in teaching Health Education and also essentialist discourses.

According to Connell (2002), gender theory serves to highlight:

...relationships, boundaries, practices, identities, and images that are actively created in social processes, come into existence in specific historical circumstances, shape the lives of people in profound and often contradictory ways, and are subject to historical struggle and change (p. 27).

Connell’s theories about gender therefore provided a very useful reference point for examining the teachers’ accounts of their engagement in social processes

and how they negotiated these “relationships, boundaries, practices, identities, and images” (2002, p. 27).

Connell (2002) noted the extensive and lengthy preoccupation of research with ‘sex difference’ studies which purport to show that the psychological makeup of women and men is different. A popular version of ideas of difference between men and women is that women have superior verbal abilities. Connell (2002, p.51) argued that “language use is situational, and is shaped by relations of power” (p. 51) and that there are “no broad differences in verbal ability”.

The argument that characterises women as ‘nurturing’ or ‘emotional’ emphasises essentialist perceptions of masculinity and femininity which accentuate biological differences and deny the influence of social discourses. The dominance of essentialist discourses may privilege some ways of doing and being over others. Acker (1999, p. 107) for example, noted “some elements of self sacrifice, guilt, and self-blame, reflecting the mothering subtext” in her study of women primary school teachers over a period of ten years. Essentialist discourses limit possibilities for both teachers and students.

Zembylas (2005) asserted the importance of a non-essentialist view of the emotions of teaching:

Acknowledging the politics of emotion encourages both men and women to articulate their emotions and develop alternative emotional expressions that challenge oppressive ideologies. For example, the argument that characterises women as “nurturing” or “emotional” easily becomes a position of constraining expectations that privileges men and excludes women from particular social positions (p. 19).

The present study found evidence of this ‘oppressive’ ideology in the dominance of an essentialist gender discourse.

Binary interpretations are not useful in explaining the mixture of personal qualities and characteristics which males and females bring to teaching (Acker,

1999). Acker (1995, p. 85) argued that —competitive comparisons are unhelpful”, instead suggesting that —we can usefully examine how both men’s and women’s ways of operating are influenced by prevailing conceptions of masculinity and femininity and by their experiences in a world where gender is a key organising principle”.

Aspects of general gender theory which have been discussed in this subsection are applied to schools in the following subsection.

Gender in schools

Connell was breaking new ground in his 1985 study when he argued for scrutiny of the gender regime‘ in schools: —the way they institutionalise gender relations, handle questions of sexuality and sexual identity, encourage particular forms of femininity and masculinity and discourage others” (1985, p. 138).

In 2002, Connell highlighted the patterns of gender in organisations, the *gender regime* of an institution” (2002, p. 53). He argued that gender regimes are embedded in broader social patterns and that an examination of these regimes involves scrutiny of relationships as they are enacted in daily life: —Gender is always something that is done; and done in social life, not something that exists prior to social life” (p. 55). Each of the teachers in this study did gender‘ in their day-to-day work with teachers and students. The ways they did gender‘ were influenced by dominant gender discourses including the prevailing gender regimes of their schools.

Gender, power and school subjects

In this subsection, literature on the effects of gender discourses on teaching are considered. The gender effect on curriculum was documented in work carried out in the early 1980s. Measor (1983, 1984), for example, demonstrated that students were aware of the differential status of subjects and that relative status is associated with gender. This gendered hierarchy is also noted more recently by Kenway and Willis (1998):

...the dominance of masculine values and knowledge reinforces what many students already know, that those subjects most associated with

the masculine are to be valued over those most associated with the feminine (p. 73).

The connections between gender and power/knowledge were made explicit by Paechter (2006). While acknowledging the pioneering work which theorised the relationship between power, knowledge and curriculum in the early 1970s, and the work of subsequent writers such as Goodson (1983), Paechter contended that the “—inevitable connection between gender, power and curriculum” (2006, p. 75) has largely been ignored in curriculum studies.

Viewed through a gendered lens, an enduring subject hierarchy which can be traced back through many years, remains. It is a curriculum which “—emphasises and gives status to those subjects which are associated with reason and rationality, with abstractness, and, therefore with masculinity” (Paechter, 2006, p. 79). Those subjects associated with the body, such as Health Education and Home Economics, therefore have a lower status than those associated with disembodied knowledge.

Paechter (2006) also pointed out a class dimension to the embodied/disembodied subject hierarchy:

Subjects associated with the body, then, are also associated in school with working-class, “—lessable” and disaffected students, performing an essential service (from the school’s point of view) in keeping these students from inhibiting or interfering with the smooth running of more academic areas (p. 81).

In this study, teachers reported having challenging students “—dumped” in their senior classes.

Paechter noted the “—gendered traditions” within “—embodied marginal subjects” (2006, p. 81). Health education is not part of the national qualification structure in the United Kingdom. Physical Education is, however, part of this structure and is strongly gendered, with almost twice as many males as females selecting

it as an examinable subject (*The Guardian Newspaper*, 2003, as cited in Paechter, 2006, p. 81). Paechter pointed out that no one cares that gender remains a dominant discourse in low status subjects:

Middle-class students do not study them anyway, once they are no longer compulsory, and they are of no importance for entry to the more elite forms of higher education. These are working-class subjects for working-class students, areas with so little leverage in power/knowledge terms that are left to carry on with a gender divided curriculum which would be considered an anathema in a higher-status area (2006, p. 83).

Social relations are influenced by the intermingling of power/knowledge and gender. Those who teach the high status masculine subjects are likely to be better resourced and structurally advantaged in comparison with low status subjects. The rewards conferred upon these teachers give them a social edge in personal interactions. Staff room interactions may not be so pleasant for those who teach marginal, body related subjects" (Paechter, 2006 p. 84).

In this section, gender discourses have been shown to have influenced perceptions of subject status. These perceptions affected both the work and the well-being of the teachers in this study.

Gender and emotionality

Emotion as a discourse of teaching is explored in the last section of this chapter, but here it is dealt with in relation to gender. Emotional discourses featured in the talk of the female teachers and were less evident in the accounts of the two male teachers in this study. This is because of a prevailing discourse which equates emotion in teaching with a feminine (and therefore less powerful) discourse and does not allow for the actual diversity of masculine and feminine positionings that are available" (Davies, 1989, p. 112).

Lingard and Douglas (1999) extended Hochschild's (1983) theory of emotional labour (the discord that results from the conflict between the outward display of role-appropriate emotions and true feelings, often associated with service

industry occupations) to claim that as a result of restructuring, “women bear the brunt of emotional labour within these new structures” (Lingard & Douglas, 1999, p. 92). Using Lyotard’s (1984) concept of ‘performativity’, Lingard and Douglas (1999) argued that the requirement to ‘perform’ in a ‘managerialist’ dominated environment, which demands quantifiable outcomes in line with state policy directions, has had “gendered impacts” (p. 63). In this performative environment, ‘middle managers’ and teachers (many of them women) “carry the burden of the emotional fall-out of these restructured, leaner and meaner, outcomes focused educational systems” (p. 4). This burden was apparent in the accounts of some of the women teachers who were very committed to developing Health Education in their schools.

Apart from the single-sex girls’ school in this study, the senior management of the other eleven schools was dominated by men. The gender dimension of this study showed that the women teachers (and the women they talked about) in most cases felt excluded from school policy making groups but carried emotional burdens associated with decisions made by these groups.

‘Doing emotion’ in Health Education

Characterisations of Health Education as a feminine subject (that is a subject frequently and stereotypically linked with women) does provide a legitimate space for ‘doing emotion as doing gender’ (Shields, Garner, DiLiane & Hadley, 2006) for women can be officially engaged in emotional work with their students precisely because health is associated with a feminine nurturing discourse.

Madeleine Grumet’s analysis of the silences and tensions in the spaces between women’s private and public spheres is helpful in exploring this gendered phenomenon. Grumet (1988) argued that women should bring together the two domains of private and public in their teaching and, through an historical lens, asserts:

We have burdened the teaching profession with contradictions and betrayals that have alienated teachers from their own experience, from

our bodies, our memories, our dreams, from each other, from children, and from our sisters who are mothers to those children (p. 57).

Grumet argued for a reclamation and reformulation of women's work for "When we attempt to rectify our humiliating situation by emulating the protectionism and elitism of other professions" we subscribe to patriarchy's contempt for the familiar, for the personal...for us" (1988, p. 58).

The women in the study may not have been consciously reclaiming women's work, but rather enacting a way of teaching that seemed appropriate for teaching Health Education. It may also have been because they chose to position themselves according to discourses of femininity recognised and rewarded in their schools. Beliefs about femininity and the way these shaped the social practices of Health Education teachers was therefore a productive avenue of enquiry.

Gender theory was outlined in this section and its inclusion in the toolbox for this study was justified. Gender was defined and its explanatory work in this study was described. Essentialist discourses were signalled as being of particular relevance to this study and assumptions about gender were linked to sexuality education pedagogies. The effects of gender discourses on perceptions about subjects were made and connections between gender and emotion were noted.

The next section of the theoretical framework considers recent studies on the role of emotions in teaching and suggests how these are relevant.

5.5 Emotionality in Health Education

In this section the final explanatory tool, that of emotionality, is discussed and its significance for the study is argued. A survey of recent literature on the emotions of teaching is followed by an explanation of its relevance for Health Education. In the last part of this section, a typology of emotions (Hargreaves, 2001) is described. This typology was useful in analysing the emotional discourses in this study.

Research and theory about the emotions of teaching

Stress and the emotions associated with stress have been linked to the rapid changes in education which have taken place in the last thirty years.

Hargreaves (1998, 2001) welcomed the recognition and exploration in recent years of the emotional dimension of teaching as it helped counter the technicist research associated with education ‘reforms’. Technicist research is usually funded by governments and is concerned with the ‘effective’ implementation of predetermined goals in curriculum, pedagogy and assessment.

Goodson (2003, p. 67) suggested that attention to personal and emotional responses to change —are symptoms of a growing awareness of the absences that sit at the heart of the predominantly technical and managerial paradigms of educational change and reform” Lingard and Douglas (1999, p.89) argued that —demands to achieve more for less within a funding cuts culture, can also have substantial emotional effects on teachers”. Work by Carlyle and Woods (2002) emphasised the need for collective accountability for the stress suffered by teachers. In New Zealand, work by Manthei and Gilmore (1994) and more recently by Harker, Gibbs, Ryan, Weir and Adams (2003) supported anecdotal evidence that teachers in all sectors were experiencing high rates of stress.

Stressful emotions were not necessarily associated with policy change, however, Acker (1999, p. 115) pointed out that in her longitudinal study of British primary school: —teachers taught under circumstances that made it

difficult and often left them feeling angry and frustrated. These circumstances predated the additional stresses usually credited to government policy from 1988 onwards". A question for this study was therefore to what extent were stressful emotions caused by policy discourses?

Teaching has an intrinsic emotional dimension as well as the cognitive dimension and the two are intertwined and present in all teaching situations. Boler (1999) explored the inevitable coupling of education with emotions; Noddings (1992) stressed the significance of caring; Goleman (1995, 1998) talked about 'emotional intelligence'; Woods (1996, p.6) argued that teaching is frequently "expressive and emergent, intuitive and flexible, spontaneous and emotional"; and Acker (1999, p.182) referred to a "caring script" in teaching. Moore and Atkinson (1998) have also noted the contribution made by studying the emotional aspects of teaching to understanding what is going on in classrooms.

If teachers adopted one of two "overlapping orientations to students' emotional worlds" (Kenway & Willis, 1997, p. 82) that is, they adopt a 'therapeutic' rather than an 'authoritarian' orientation, then it is argued that their students' lives and emotions will be highly significant to their teaching. Equally, some teachers, regardless of the subject they teach, will favour the authoritarian approach which "either downplays or ignores the emotions, the psyche and students' positionality, treating them as cognitive, rational units" (Kenway & Willis, 1997, p. 136). In contrast, Hall (1998) described the personal cost to teachers who take a therapeutic stance or in role terms engage in pastoral care, whether as part of their assigned role or, ideally as every teacher should, and argues for attention to 'self care'.

All teachers draw on emotional discourses but this is perhaps more evident in Health Education. The reasons for this and effects on teachers are discussed below.

Emotionality in Health Education

In this subsection, a strong emotional discourse is located in Health Education. This is because teaching as an ‘emotional practice’ (Hargreaves, 1998) is pertinent to the ‘real life’ content of topics covered in Health Education. The possibilities suggested by the Health Education curriculum add powerful emotional and personal dimensions to the educative aims of the subject. Studies undertaken in Australia and New Zealand indicate that there is a level of relational engagement between teachers and students in health education topics which is unusual in secondary schooling. Research by Rowling (1996) on the teaching of the health education mental health topic ‘grief and loss’ in two Australian secondary secular schools alerted her to the “use of self disclosure by teachers as a teaching strategy” (p. 282). Rowling argued that the positive effects of teachers using personal experiences outweighed any possible negative effects. She reported that teachers in the study thought that using personal experience was natural, and contrasted teaching academic subjects with teaching the grief and loss topic:

Their day-to-day work is about finding ways to help young people understand academic topics. Teachers in the research schools stated that in their personal development type of lesson they were trying to teach about life, so they naturally went to their own life experiences for examples, to make it concrete (p. 282).

Rowling’s (1996) study suggested that in the case of topics such as sexuality and drugs, moral and legal ramifications meant that teachers were less likely to share personal experiences. There was evidence of close connections between teachers’ personal experiences and their teaching. In some cases, teachers reported direct links in their teaching.

The emotional effects associated with teaching Health Education in New Zealand secondary schools have been documented by Munro (2000), Munro and Price (2001), and Munro and Ballard (2004). The issues and tensions that were identified included inadequate time to develop a trusting class climate, tension with regard to teacher boundaries with students, and uneasiness about

the ability of some Physical Education teachers to teach Health Education. In their study of four women secondary teachers who taught sexuality education, Munro and Ballard (2004) raised important questions about how those who teach sexuality education can be supported. The women were described as “reflective practitioners who felt responsible, accountable *and* vulnerable teaching this aspect of curriculum, which evokes personal issues for them as well as their students” (p. 88).

A discourse of ‘self care’, which has been widely applied to those involved in the caring professions, can be linked in Health Education to an awareness of what might be uncovered for the teacher in a teaching episode; for example, finding out something in relation to themselves in a sexuality education lesson. Moore (2004) developed the discourse of self care through referring to the work of Anna Freud. According to Moore, Freud argued “~~that~~ teachers have a *duty* to attempt to understand their own actions and reactions in order to avoid possible negative consequences on their pupils of a failure or refusal to do so” (p. 145). Middleton (1998, p. xvii), however, cautioned that “confessional’ pedagogies can be voyeuristic”. Such pedagogies raise a number of ethical problems about pupil-teacher relationships and are pertinent to this study.

In this subsection, implications for the emotional aspects of Health Education pedagogy have been suggested. In the next subsection, a typology of emotions (Hargreaves, 2001) is presented as a useful conceptual framework for this study.

Emotional geographies

Hargreave’s (2001) conceptual framework of ‘emotional geographies’ provided an explanatory platform for analysing the emotional discourses which featured in the interviews for this study. Hargreaves argued that teaching is “inextricably emotional – either by design or default” (1998, p. 1057) and expanded his work on teaching as an ‘emotional practice’ (1998) to argue for a more comprehensive and contextualised approach. One result of this expansion was the development of emotional geographies of teaching, “a conceptual

framework' ...that addresses how teachers' emotions are embedded in the conditions and interactions of their work" (Hargreaves, 2001, p. 1058).

Hargreaves used the emotional geographies framework to analyse data from a study of the emotional dimension of teaching and changes in education which was carried out in Canadian primary and secondary schools in the late 1990s. The framework is proposed on the basis of distance or closeness and comprises:

...the spatial and experiential patterns of closeness and/or distance in human interactions and relationships that help create, configure and color the feelings and emotions we experience about ourselves, our world and each other (2001, p. 1061).

The emotional geographies framework was valuable as it went beyond the —sacred—to include the —profane realm of unsettling and darker emotions in teaching" (2001, p. 1057). Hargreaves pointed out that there are relatively few studies which have addressed this —underlife" (p. 1058) of teaching, particularly those which address the emotional impact of changes to teachers' work in the past two decades.

Examples of work which illuminate this 'underlife' of teaching are studies by Little (1996), Jeffrey and Woods (1996), and Troman (2000). In the context of the restructuring of schooling in the USA in recent years, Little (1996) studied teachers' experiences of heightened emotionality and linked these to career disruption or career risk. Against the backdrop of major changes in schooling Jeffrey and Woods (1996) considered the emotional impact of an Office for Standards in Education (OFSTED) inspection of an English primary school. Troman (2000) examined the phenomena of low trust and its negative impact on collegial relationships and teachers' physical and emotional health. Though not an empirical study, it is worth noting a critique by Codd (2005), who lamented the replacement of a culture of trust with a culture of mistrust and the effects of this culture change on teachers.

The emotional geographies framework was also helpful because it encouraged analysis which went beyond the obvious; that could instead show that emotion is present in all personal interactions in schools, that Health Education is a subject that arguably has a greater emotional dimension than most subjects, and that attention to the emotional dimension of teaching is worthwhile. Hargreaves (2001) advocated scrutiny of the broad conditions of teaching in which the emotions sit, and asked how they have been shaped:

Emotions are integral to teaching. Yet this means more than advocating less rationalization and more passion in teaching and more than cultivating more caring dispositions or greater emotional intelligence among teachers. We also need to understand why teachers' emotions are configured in particular ways in the changing and varying organisational life of schools (p. 1075).

The five emotional geographies identified by Hargreaves (2001) were sociocultural geography, moral geography, professional geography, physical geography, and political geography. Each had illuminative potential for analysing the data generated in this study. In the overview that follows, they are described and their relevance to this study explained.

Sociocultural

The degree of congruence between teachers and their students and teachers and the communities to which their pupils belong can be examined from a sociocultural perspective. Factors such as age, ethnicity and class can create emotional distance or closeness. Sociocultural distance/closeness in this study has to do with community, and is particularly relevant because of the policy expectation that health teachers will be close to their communities. The policy device through which this takes place is community consultation.

Moral

Hargreaves (2001, p. 1066) argued that "emotions are moral phenomena" because they are prompted by and coalesce with our purposes. On the basis of his Canadian study, he argued that "moral closeness with and support from students, parents and colleagues, and administrators reinforces teachers' sense

of purpose and is a source of positive and energizing emotion for them” (2001, p. 1067). In contrast, moral distance can result from teachers feeling that there are restrictions on the enactment of their purposes or that there is a disjunction between their purposes and those of others. In this study, there were instances of both moral distance and closeness.

Professional

Hargreaves suggested that —bureaucratic regulation and classical professional aspirations conspire together to distance teachers from those around them” (2001, p. 1069). In a similar vein, Zembylas (2005) used the concept of emotional labour (Hochschild, 1983) to point out the tensions which may come into play as part of a school’s emotional regime. —For instance, the demand of professionalism as the skill to react emotionally to colleagues in a particular way, rather than with spontaneity, suggests that ultimately emotional labour is a necessary part of the work of teachers” (Zembylas, 2005, p. 44). In this study there was some ambiguity around the teachers’ professional distance with students.

Physical

Positive and meaningful relationships are much more likely to develop if people meet at regular intervals, for as Hargreaves (2001, p. 1070) says: “We cannot know or understand people we rarely meet; nor can we be understood by them in return”. The amount of time available for Health Education and timetabling arrangements for junior classes were of concern to some of the teachers in the study. One reported problem was that infrequent contact with students meant that it was difficult to build positive teacher /student relationships.

Political

Emotions are political because they transcend the personal and are strongly connected to —people’s experiences of power and powerlessness” (Hargreaves, 2001, p. 1072). The significance of the thinking in terms of emotional politics for this study was that teachers talked about their emotional responses to situations which involved power. These situations included interactions with senior staff and also when some of them were learning about the NCEA system.

Teachers experienced a mix of “power and powerlessness” (Hargreaves, 2001, p. 1072) as they drew upon assessment, professional and personal discourses in order to come to grips with the formal assessment requirements for senior Health Education. This was in contrast to a degree of comfort and competency expressed about the pedagogy of junior Health Education.

In this final section, the emotional dimensions of teaching have been discussed and their significance for the study have been argued. A survey of recent literature on the emotions of teaching was followed by an explanation of its relevance for Health Education. In the last part of this section, a typology of emotions (Hargreaves, 2001) was described. This typology was a useful tool for discussing the emotional discourses in this study.

5.6 Chapter summary and key points for investigation

The major part of this chapter was concerned with Bernstein’s theories about how power works in the selection and shaping of knowledge. His concepts of classification, framing and knowledge codes were used to analyse Health Education curriculum and assessment discourses. These concepts helped explain tensions in the integrated knowledge code of the 1999 curriculum and in the new knowledge code created when Health Education became part of the NCEA system. The principles of classification and framing were also helpful in exploring the relationship between ‘commonsense’ knowledge and ‘uncommonsense’ knowledge.

In the second part of the chapter, further theories with explanatory value were introduced. These were concerned with sexuality and power, gender theory, and theories about the emotional dimension of teaching. The discursive effects of power and sexuality in schools were shown to be particularly relevant for Health Education teachers. Gender theory was also shown to be a useful

theoretical tool. The relevance of an essentialist discourse was signalled as important and assumptions about gender linked to sexuality education pedagogies. The effects of gender discourses on perceptions about subjects were also made and connections between gender and emotionality were noted. In the last part of the chapter, theories about the emotions associated with teaching were discussed and applied to Health Education teaching. Finally, a typology of emotions was proposed as a useful way of considering emotional discourses.

The issues raised in Chapters Three to Five are summarised below:

- The origins of contemporary Health Education discourses;
- The effects of Health Education's weak classification and framing for junior health/non-NCEA health;
- The effects of the change to an integrated knowledge code (the 1999 curriculum);
- The effects of Health Education's inclusion in the NCEA system;
- The effects of the ways teachers positioned themselves in relation to sexuality discourses;
- The effects of the ways teachers positioned themselves in relation to gender discourses;
- The ways teachers positioned themselves in relation to the emotional discourse of Health Education teaching; and
- The capacity of teachers to exercise agency.

These issues informed the analysis and organisation of Chapters Six to Nine, the data presentation chapters.

Chapter Six

Health Education curriculum and pedagogy

In this chapter the four data chapters are introduced and their significance for the thesis is explained. Chapter Six (this chapter) is then introduced and its inclusion in the study explained. The chapter consists of: **6.1 Introduction to the data chapters; 6.2 Issues based curriculum and pedagogy; 6.3 Groups that contributed to Health Education knowledge; 6.4 The non-prescriptive nature of the 1999 curriculum; 6.5 Permeable curriculum boundaries with other curriculum areas; 6.6 An internally contested curriculum; and 6.7 Chapter summary**

6.1 Introduction to the data chapters

The four data chapters present a layered analysis of the interviews. Chapters Six and Seven illustrate selected aspects of the work of Bernstein (1971, 1996), particularly the way power operates to define what is valued as knowledge in schools. The main concepts of Bernstein pertinent to Chapters Six and Seven are classification (the degree of insulation between areas of knowledge) and framing (the way power operates within a knowledge code). Chapter Eight is concerned with gender and emotionality in Health Education pedagogy, and Chapter Nine illustrates how individual teachers' pedagogies negotiated curriculum, gender, sexuality, and the emotionality of teaching Health Education.

Chapter Six illustrates the weak classification and framing of non-NCEA assessed contemporary secondary school Health Education. An important theme in this chapter is that of internal contestation. Through this theme, pedagogical tensions are explored drawing on Bernstein's concept of an integrated code curriculum (see Section 5.2). Unless otherwise indicated, the teachers' accounts used in this chapter refer to junior health classes and non-NCEA assessed senior Health Education classes.

6.2 Issues based curriculum and pedagogy

This section illustrates health education's weak classification and framing in relation to the outside world through examples of an enduring discourse in health education, its attempts to improve both societal and individual health⁴⁷. In addition to illustrating this enduring discourse, the teachers' accounts also show how some teachers got involved in health issues beyond the classroom. Some difficulties of assessing an issues based curriculum and applying skills to outside contexts are also discussed in this section.

Health issues motivate past and present curriculum and pedagogy

Health education's historical development as a subject which addresses current issues is reflected in the stories of a number of the older teachers in this study. Judy⁴⁸ cited the inadequacy of students' skills to manage the societal issues they encountered as one of the reasons she had been keen to teach Health Education. The curriculum gave her the means of addressing these needs. Anna (a former nurse) explained that a primary motivation for becoming a teacher was the hope that she could do more for young people's health through education than merely treating the results of poor health: —I saw that education was the way to break a cycle and patterns" [Anna, 20]⁴⁹.

⁴⁷ See Sections 3.3 and 3.4.

⁴⁸ Pseudonyms have been used for the teachers in this study to preserve their confidentiality.

⁴⁹ The numbers beside the teachers' names refers to the numbered content units in their transcript. The quotes used vary from one content unit to several consecutive units. The method used to code the data was discussed in 2.3.

A description of the beginnings of health in one school in the mid 1980s illustrates the way health needs and educational needs were grouped together in an ad hoc manner and the initiating role taken by the school's guidance counsellors:

We used to call it Life Focus and it wasn't called health for a very long time and within that group it was really the guidance team that were doing all that sort of thing so the bullying was put in with the time management skills and the bit on smoking and a bit on alcohol.

[Andrea,5]

Contemporary programmes also reflected this needs based approach. The Health Education programmes operating in Alana's school in 2004, for example, were also designed on the basis of needs identified within the school:

We started with the needs; like a bullying unit because there was quite a bit of bullying. We introduced a sexual abuse, family violence unit because the counsellors were seeing students and those students were coming with those issues in their lives. [Alana, 39]

Mental health was signalled as a major concern. Poor mental health was portrayed by some teachers as an issue of national importance and one which had an impact on students' educational opportunities. There was evidence of a shift to a more holistic conception of health. It was suggested, for example, that the mental health of students was becoming as significant as their physical health.

Poor food choices and physical inactivity were criticised by a number of the teachers who had Physical Education backgrounds. Anna, who came from a nursing background, was also concerned that today's children had too many unhealthy eating options compared with previous generations. A mixture of poor fitness levels, unhealthy weight gain and negative body image for girls were expressed in Pat's comments about the incoming students at her school:

By the time they come into secondary schools it's too late, they're starting to pile on the weight, the girls are starting to become worried about their bodies being seen and all the rest of that and we're producing a generation of stiffies. [Pat, 75]

Some teachers used their own experiences (commonsense knowledge)⁵⁰ of health issues in their teaching. Michael, for example, talked about "bringing up a bit of life history that I think it would be important for them to know" [Michael, 192], and Nicole admitted to perhaps being too candid at times, but nevertheless justified this approach:

I'm really honest and open with kids again probably too much so at times. I mean I don't tell them the gory details of my life or anything but I'm really open about the fact that I don't have everything sorted. [Nicole, 168]

Teachers spoke of an approach to knowledge which allowed for a variety of perspectives that would meet student needs and cover the curriculum. It was felt teachers could go into the depth if there was student interest, and students were sometimes given considerable latitude about what they wanted to cover:

Many times like students are entirely running the whole thing. Sometimes it's directed or suggested but it's not always me up there saying —Ok, this is what we're looking at today and our aim is this". Sometimes in Health Education your aim or how you got to some point has nothing to do with what you started out with in the lesson, whereas I couldn't really say that's what happens in Science. You can go off on a few tangents in health that aren't necessarily getting you off track or teacher distraction sort of thing. They're all things that still have some links somewhere that's actually useful in your lesson. [Liz, 64]

⁵⁰ For Bernstein's (1971) concepts of commonsense and uncommonsense knowledge see Section 5.2.

In this extract, Liz made the point that Health Education pedagogy is different from that of Science.

The characteristics of the community in which students live and the necessity of crafting something which was relevant for these students were mentioned. Nicole noted that the students in her school had different needs in comparison with the students from another school in the region that drew students from a struggling community. Nicole argued for “completely different work, different approaches”. [Nicole, 116].

The perception that student needs determined topics within a broad curriculum direction emerged also in Michael’s accounts of working in a low decile⁵¹ school. Michael stated that he had one theme for the year. —“My theme this year is what is a healthy body? That’s all there is” [Michael, 195]. His references to planning reflected this responsive and flexible approach: —“I’d say three out of five of my health lessons I’ve probably planned and two would be well, maybe we need to look at this today” [Michael, 174].

Some teachers noted that in health there is always a possibility that there will be something in the lesson which will resonate with students and these moments should be managed sensitively. Here Paul talks about the importance of giving students time to express their views. This example is interesting because the class he was talking about was a senior NCEA class⁵²:

I just found that you know you’d start things off and then it’s a sort of subject that you can’t say —“Oh no, I don’t want to deal with that right now, no we’re only spending ten minutes on this” when you’ve got kids who are really passionate and want to say stuff. I think it’s better to just

⁵¹ In New Zealand, decile ranking is used for prioritising funding. It is based on socio-economic measures of school communities. Schools are ranked from one (the lowest) to ten (the highest).

⁵² In general, learning in senior NCEA classes was reported to be more pressured than for junior classes (and non NCEA assessed senior classes) because of the need to get through assessment tasks. The constraints on pedagogy for those who taught senior health that was assessed by the NCEA are reported in Chapter Seven.

let it flow rather than say —No'm sorry you know we've done our ten minutes now we've got to move on to number two".[Paul, 62]

The fluid and responsive styles of teaching that were reported in this study presented some assessment dilemmas. The challenges of assessing an issues based curriculum such as Health Education are discussed in the next part of this section.

Assessment tensions

In the following section, tensions in assessing health are described using data from Judy and Pat. These teachers were two of the most experienced teachers and had strong views on assessment. While other teachers also talked about assessment, it was mainly in relation to senior health that was part of the NCEA system⁵³. While not therefore representative, Judy and Pat's comments were included because they suggest a number of assessment tensions to assessing a curriculum which aims to improve individual and social health. The following were talked about: assessment did not fit with the aims of the subject, it was difficult to assess attitudes and values, and the lack of validity in assessing behaviours when they are removed from their 'real life' contexts.

Pat was uneasy about the current assessment as it applied to both Health and Physical Education and indeed gave disenchantment with assessment as one of her reasons for dropping Physical Education. Pat felt that assessment detracted from the subject's rationale: —My heart's not really in this assessment stuff and I think it's possibly been to a certain extent detrimental to the subject and to the purpose of the subject" [Pat, 135].

Judy was adamant that only factual material and skills should be assessed, and values and attitudes should be excluded. She also advocated for an approach that would encourage students to express their feelings, but that these should be ignored in the assessment process with only skills being evaluated:

⁵³ Health assessed by the NCEA system is discussed in Chapter Seven.

I think that they should be able to express their feelings but they shouldn't be penalised or rewarded for that. I mean that's just part of the process. I think it shouldn't be something that is marked or given any particular value over using it. Skills can be marked but nothing else can. [Judy, 58]

Pat reflected on the nature of Health Education and how it differed from other subjects:

To me one of the hardest things about health is that you're dealing with some of the core stuff about living but yet you're being asked to try and assess it as if it was mathematics. [Pat, 100]

For Pat, health dealt with core issues about living and this conception did not fit well with the universality of assessment.

Challenges to classroom based knowledge

Skills learned in the classroom were intended to address health issues both at school and outside school. Nicole talked about the realities of trying to apply classroom skills to the 'real world' in her supermarket example:

In our school but also in society you know, it's not role modelled and the whole business of "Tell someone how you feel". I had tried out that example of "If you are in the queue at Pak n Save and the women with the two kids pushes in front of you and you say "Excuse me that makes me feel ahhh when you push in front of me" and they said they'll get one of two responses, one will be play the child card "I'm really busy and I've got to get my children out of here" and the other will be "Bo off, I don't care". [Nicole, 163]

This example illustrates the difficulty of applying Health Education assertiveness skills to the social worlds outside school. According to Nicole, the hierarchical structures of schools also mitigated against the skills she was teaching:

I think that's actually quite a big thing that challenged us, the theory of, you know conflict resolution with people above you in the hierarchy, sensitive conflict resolution with people above you in the hierarchy, I don't think they've had the lessons, you know someone hasn't taught them. [Nicole, 165]

The practical difficulties presented in real life situations (particularly situations involving sexuality) were also mentioned by some teachers:

I always try to tell them that it was safer sex, not safe sex because I mean when you watch kids using condoms and just using them in here they don't know which is the right way or the wrong way. There's a knack to them really in putting them on and you take an embarrassed kid who can't talk about issues in the dark where they're going to do it behind a bush and are they going to get it on right? You know the damn bush is likely to prick it before they get it on. [Anna, 155]

Equipping students with accurate knowledge and appropriate skills did not guarantee that those young people who were sexually active would apply this knowledge. Judy recalled her disappointment about an event that had happened after a sexuality unit:

We'd just done, **we'd just done**, it must have been alcohol and sexuality at Year 10 and there was a party on and these kids, Year 10 kids, so they would have been fifteen or fourteen, they went out and one of the girls got absolutely wasted and was involved in sexual activity, and ended up pregnant. [Judy, 120]

The potential for classroom based knowledge to be challenged in the school and community has been shown in these examples. In the last part of this section, teacher involvement in school health issues is discussed.

Health issues outside the classroom

Some teachers believed that their Health Education roles extended beyond the classroom and were active in what they considered to be school health issues. Three examples from a range of health issues talked about were i) a school wide initiative to promote student mental health, ii) a health promotion activity aimed at improving student nutrition, and iii) a debate about drinks in the school canteen.

Some teachers mentioned health promotion activities that involved their whole schools. Judy, for example, commented on a school initiative in mental health promotion (a site based initiative based on a World Health Organisation concept). She reported that the initiative —helps meet the NEGs and the NAGs, a safe environment and all that sort of stuff” [Judy, 26]. It was apparent that Judy saw the initiative as a way of meeting national educational and administrative guidelines (the NEGs and the NAGs) in addition to addressing the mental health issues faced by young people.

Another school wide initiative concerned food. Toni talked about her long term interest in nutrition and suggested that poor nutrition had an adverse effect on educational achievement. She felt that a food programme she had developed at a previous school was the most important health decision she had made in her career. Toni, who claimed not to be ‘political’, involved her students in a school wide health promotion activity. One result of this activity was that Toni came into conflict with the woman who managed the canteen. The friction centred on the woman’s contract which meant she sold a range of ‘unhealthy’ products such as chips, lollies, pies and fizzy drinks, and limited amounts of ‘healthy’ food such as filled rolls. Toni described the conflict as a “huge battle” [Toni, 77].

Another teacher, Liz, who also had a nutrition background, was annoyed she had missed a staff briefing when a proposal to replace regular carbonated drinks with the diet version was raised. Liz was concerned that the diet variety was just as bad as it contained artificial sweeteners. Although surprised that most of the staff agreed with the proposal, Liz acknowledged that the staff was looking at the issues from a behavioural point of view rather than a nutritional

point of view. With the support of a number of the home economics trained teachers on the staff who understood the nutritional issue at stake, Liz managed to get the decision over-turned.

Life issues continually overlap with school discourses and contribute to a complex classroom environment. Addressing issues such as mental health was not neatly confined to Health Education, as Jane found out when she was confronted with the reality of threatened suicide in the middle of her appraisal by her Head of Department (HOD):

Unfortunately I had a girl in my class who was quite suicidal in my PE class, had gone back to the changing rooms earlier and written a note so I was in the middle of dealing with that and the class found out about the note and were picking on her. [Jane, 126]

In the above section, examples of the issues based nature of Health Education were presented. This enduring discourse affected classification and framing strength in health as it legitimated ‘commonsense knowledge’ and involved school and community discourses. In addition to illustrating an enduring discourse, the teachers’ accounts also show how some teachers got involved in health issues beyond the classroom. Some difficulties of assessing an issues based curriculum and applying skills to outside contexts were also discussed in this section.

Another factor that weakens framing and classification strength for Health Education (particularly non-NCEA assessed health) is the participation of non health specialists in contributing to health knowledge. In the following section, the participation of these groups is recorded.

6.3 Groups that contributed to Health Education knowledge

This section documents the groups that some of the teachers reported as taking an interest in Health Education. The groups were as follows: senior staff and

Boards of Trustees, staff members who did not teach Health Education, people from outside the school, and teachers for whom Health Education was either not their major primary teaching role or who were perceived as not being committed to Health Education.

Senior staff and Boards of Trustees

Boards of Trustees (the governing bodies of schools) and senior staff members were reported to have been involved in decisions about Health Education. The two examples that follow are indicative of the way power operated in Health Education.

Nicole recounted that in the context of what had been personally a difficult year, for the first time her principal had insisted that the health programme be approved by the school's Board of Trustees.

This year with all the upsets, one of the funny things was that the boss started to say —“the legal requirements have changed so that now you have to get things signed off by the Board of Trustees”. I think you always did. I don't think there is any change there at all and prior to this year it's always been the —“We don't know what you're doing but we don't really want to know as long as it's going along okay”. And I thought this is quite interesting that he suddenly thought we've actually got to sign it off and —“I'd like you to come and talk about it”. [Nicole, 37-39]

As the health coordinator at her school, Judy kept in contact with the Board of Trustees but hers was a somewhat different experience from that of Nicole. Judy had expected to report to the Board of Trustees because she was the health coordinator (the person with overall responsibility for health education) and saw her accountability in terms of her annual report to the Board:

If we were trying a new initiative or we wanted to try something different I always let the Board know because it seemed to me that if any flak was going to occur it would probably go to the Board. [Judy, 52]

Although clearer about her relationship with the Board of Trustees, Judy was nonetheless conscious of the need to keep the Board of Trustees informed in case there was criticism or complaint about what was occurring in health.

The consultation⁵⁴ meetings at Andrea's school were a possible source of tension with senior staff members because of concerns about the impact of issues that might be raised:

The number of admin' who turn up at things you're not expecting them to turn up to and change things completely like the fact every two years we need to go out and speak to our community and ask them how they view health courses and things like that, it's sort of well —Do't say that because you might get some issues raised there or people being uncomfortable with that". [Andrea, 21-22]

Clearly Andrea felt that the presence of senior staff had an inhibiting effect upon her facilitation of community consultation. In the next subsection, the participation of non-Health Education staff in discussions about Health Education knowledge is described.

Staff members who did not teach Health Education

Some teachers talked about instances where non-Health Education teaching staff contributed to the definition of Health Education knowledge. The health promoting school concept in Judy's school provided the forum for staff to discuss health issues. Judy talked about staff discussions on such health related matters as sexuality, bullying, gender and discipline issues.

While Judy applauded the involvement of all staff in the discussions about health issues, she expressed some disquiet. She was, for example, concerned that other teachers did not understand the purposes or pedagogy of Health Education:

⁵⁴ For the origin of community consultation for Health education see Section 3.4.

Sometimes these people think that just by providing the information we are actually giving the kids licence to attempt or try to experiment or whatever and I don't agree with that, I don't think that necessarily happens. [Judy, 49]

She also had misgivings about the reactions of some staff when school health issues were raised in terms of her non Health Education colleagues' values and beliefs: "We have some people who are quite, very Christian in their beliefs and there were tensions when you are discussing whole school issues" [Judy, 28].

Jane was, however, encouraged by the opinions of some of her colleagues about Health Education. Jane reported that several people on her staff had recognised that students' needs could be met in Health Education and that the subject also provided a means of students accessing support. The next subsection shows the influence of people outside the school on Health Education knowledge.

People from outside schools

Parents and extended family, community support agencies; an outside provider of Health Education, public health nurses who worked in schools and a police education officer contributed to Health Education knowledge in this study.

Parents and extended family were invited to contribute to Health Education knowledge through community consultation and in one case through work students were doing in class. Community consultation was mentioned by some teachers. Jane, for example, talked about the consultation meeting on sexuality education she had run for her school's Pasifika community. Michael encouraged his students to ask their parents about topics which had been raised in class. Michael also let parents know that their children kept journals relating to the topics they were covering in class and if the students allowed their parents to read them, it could be a source of parental feedback to the school. As well as encouraging his students to talk to their parents, Michael also suggested that his students should seek out any help they might need from community support agencies.

Outside providers were used in Pat's programmes and Pat spoke highly of their contributions. The Christian based community group used by her school was expensive (approximately ten thousand dollars per year), but Pat felt that their teaching reinforced the messages being given by the school and were well received by parents and pupils.

A number of teachers talked about working with the public health nurse. Andrea talked about the way she had forged alliances with members of the school community. In addition to the Parent Teacher Association, Andrea worked closely with the school's public health nurse. The nurse was available to talk to students about any health concerns they had and also liaised with Andrea about —~~how~~ things were going and what was coming up" [Andrea 131]. Andrea had other links with community personnel such as the police education officer, who she invited to talk to her senior (non-NCEA) classes. She was keen to foster the idea of a campus cop' (the police education officer) who had a similar role to the public health nurse in the school, that is, someone who was known to the students and who they could talk to.

Teachers were sometimes challenged by health professionals. Public health nurses, for example, though usually supportive of education's role in the health of young people, could be critical of programmes. Michael recalled a conversation about his department's junior sexuality education programme when the school's nurse appeared to be questioning the effectiveness of this programme:

She was saying —~~Do~~ "Do you guys talk about sexuality education at all?" and I was saying —"Yes we do in Year 9" and she goes —"Well I've got a whole lot of girls in Year 9 coming to me now that want to know everything there is to know about contraception". [Michael, 119]

In this last part of the section about groups who contributed to Health Education knowledge, the input of teaching staff who taught mainly in other curriculum areas is discussed.

Teachers for whom Health Education was not their primary teaching role

The possibility of a diverse range of views on Health Education is increased by the involvement of teachers for whom Health Education is a minor part of their workload. Teachers of varying subject allegiances are involved in teaching Health Education and this adds a layer of discursive complexity, one that is shared by other weakly classified and framed subjects such as Social Studies.

The teachers indicated that Health Education staffing was improvised (there were references to part time teachers and full-time teachers with gaps in their timetable) and reflected the low status of Health Education. The views and opinions of these teachers were not likely to have been mediated by shared discipline backgrounds, pre-service teacher education, or professional development.

Paul emphasised that although there was a solid foundation for Health Education at his school because of the commitment of the Health Education specialist teachers, this was not always the case in other schools. According to Paul, the practice was all too often to —chuck it to that teacher because they've nothing else to do" [Paul, 15].

Lack of training was a concern for some teachers who were critical of some of the approaches of their non-health trained colleagues and expressed anxiety that students would suffer. Jane felt that without training, teachers might try to impose their views on students and that resources would not be implemented effectively. Alana indicated that using untrained teachers in Health Education was a widespread practice and anticipated the problems arising if an untrained and unmotivated teacher was to teach Health Education in her school:

We're still doing it and I know a lot of other schools are. You know there aren't the trained health teachers to employ and so health might only be two or three lessons a week and someone who has a little bit of time in their timetable moves in to teach it and when that happens health isn't their main priority and they don't have any knowledge base to draw from

at all so like our Year 9 module, it's down that one of the Maths teachers might be taking a module. [Alana, 31-32]

Guidance counsellors were involved in a support role when sensitive health topics such as sexual abuse were taught. Some counsellors were also identified as Health Education teachers; in Judy's school for example, a guidance counsellor had developed and taught junior Health Education prior to Judy's involvement. In Alana's school, counsellors had also once taught Health Education, but were now reluctant to do so because it was perceived as a conflict of interest.

The issues based approach to Health Education allowed other people, apart from those who specialised in Health Education, to be involved in constructing Health Education knowledge. The involvement of other people contributed to the weak classification and framing of Health education.

In the following section the possibilities and challenges of working with the weakly framed and classified 1999 curriculum are illustrated.

6.4 The non-prescriptive nature of the 1999 curriculum

The weak framing and classification of the 1999 curriculum was reflected in the teachers' accounts of Health Education knowledge and curriculum. In this section the following are discussed: the breadth of the 1999 curriculum, the openness of hauora to interpretation, the wide range of resources used to support the 1999 curriculum, and the effects of professional development.

The breadth of the 1999 curriculum

A recurring theme in the teachers' accounts was the breadth and imprecision of Health Education. The non-prescriptive nature of the 1999 curriculum elicited considerable comment and posed initial concerns for some of the teachers.

Teachers observed that there was a knowledge base for Health Education, just like other subjects, but that in health there was a broader scope. Paul noted that issues that were part of the 1999 curriculum, such as social justice, could not be contained just within this curriculum. He contrasted the broad focus of Health Education with other humanities subjects and used the example of a lesson on alcohol to illustrate the wide ramifications of any health topic: “We’re talking about alcohol, drink driving goes on to responsibility, the role of the person in their family and all those sorts of things. It’s all encompassing” [Paul, 59].

The scope of Health Education was daunting for some, particularly less experienced teachers. Jane explained how uncertainties as to what constituted Health Education in her one year teacher education course in the early 2000s persisted as she grappled with the breadth and depth of the curriculum: “Even by the end of my year I was still a little unsure of what it was and I guess I still don’t really know for sure. There’s no one definition” [Jane, 23].

The elusive and complex characteristics of Health Education were also alluded to by Nicole, one of the most experienced Health Education teachers in the study, as she elaborated on her opinion that there were no authoritative answers (in Bernstein’s terms, weak framing):

I would say that this is one of the biggest challenges we have in Health Education that there’s not one right answer and therefore you can’t say “Well this is what you’ve got to do, here are the five points for your life, you do these, you’ll be fine”. [Nicole, 22]

The curriculum’s weak classification and framing were also expressed in other teachers’ accounts. Michael spoke about his interpretation of spirituality and then the curriculum’s mental and emotional health dimensions:

And it doesn’t mean God. It doesn’t mean that you go to church every Sunday. It doesn’t mean this. It’s actually more open than that and so are mental and emotional. They’re all huge, they’re all interlinked. That’s what I like about it. [Michael, 216]

For Toni, the most problematic area of Health Education was mental health. She expressed confusion over what knowledge was involved and admitted to feeling unsettled when she taught this area of the curriculum: “It’s not as factual, you can feel like your mind is twisted up by the end of the mental health lesson” [Toni, 133].

Some teachers had hoped that the 1999 curriculum document would provide some guidance for teaching Health Education. Nicole, however, recalled that instead she felt perplexed: “What’s the really important stuff? And when it [the curriculum] came out, oh gosh you can do anything!” [Nicole, 210]. The uncertainty Nicole felt about her own understanding was acknowledged by a leader in Health Education curriculum development as a valid position:

I’ve got no idea what I really think about half the things that I used to think I knew about. And I did say that to [Name], something about “I thought I knew a lot more but now I’m really not sure about the answers to most things” and she said “That’s real progress that means you’ve learnt a lot you know and it’s because there aren’t any answers out there”. [Nicole, 158-159]

The weak classification and framing of Health Education appears to have detracted from its status in the opinion of other staff members. Paul, for example, felt ‘senior management’ was not happy having Health Education as part of the curriculum in his school and suggested this was because of their conception of the curriculum area as “a waffly subject” [Paul,64].

Health Education’s weak framing and classification was illustrated in the different ways hauora influenced teaching. Two examples are discussed below.

The openness of hauora to interpretation

Hauora, one of the underlying concepts⁵⁵ and part of the curriculum’s conceptual framework, was talked about by Michael and Jane. For Michael,

⁵⁵ The underlying concepts of the 1999 curriculum were discussed in Section 4.2.

the multi-faceted nature of being human expressed in the curriculum as the four inter-linked dimensions of hauora (mental, physical, social and spiritual) legitimated his values: —The whole spirituality side I love because [of] what's the meaning of life and what's the meaning of death and all that kind of stuff" [Michael, 209].

Jane, working in a low decile school, talked about how she and a colleague used the concept of hauora for the benefit of their students:

It's something that [Name] and myself really pushed in terms of getting the kids to understand it because I think with our kids, maybe they have a lack of connection with something or someone, and we try and use that as a base to connect them with something. [Jane, 190]

These two examples show that the concept of hauora was open to interpretation by teachers and the instances above were linked to Michael's personal values and, in Jane's case, as a way of helping students. In the next part of this section, the range of resources used for junior Health Education is discussed. The eclectic mix of resources is a reflection of the weak classification and framing of Health Education.

A wide range of resources for junior Health Education

In this subsection, the broad range of resources talked about for junior and non-NCEA assessed health is discussed.

The general consensus amongst the teachers was that there was a plethora of junior resources from which to select. The number and range of resources available in Michael's school was daunting, so the idea of using resources recommended by others appealed to him. Jane and Judy used a diverse mix to resource themselves and their students: —Dig a bit of a squirrel and picked up lots of different things. And just put together a course from that" [Judy, 69].

Andrea was enthusiastic about the Family Planning resources but implied that some teachers were uncomfortable with them:

If there's money left over in the budget I always get an extra teaching resource of theirs like I've just bought the new STI kit from them and there's really some hard hitting stuff there that I've sort of pulled out and shown teachers and they say "Oh, I wouldn't do that" and I said —But the students know about it you know and there's a need for those sorts of things". [Andrea, 137-138]

Several teachers talked about using film and television as sources of material. Pat had found Steven Covey's *Seven Habits of Highly Effective People* (1989), a popular self improvement book, to be a useful resource when she taught Year 10 health. Covey's book appealed to Pat's notions of what Health Education encompassed. In addition to using material from the book, she had also recommended that her students read the book themselves.

Easy access to an abundance of resources for use at junior level had not always been the case. This was reflected in Mary's early work in Health Education during the 1980s when she had to develop her own resources: —~~Yes~~, from the grass roots, nothing in place" [Mary, 143].

The wide range of resources available at junior level contributed to junior Health Education's weak framing and classification. In the last part of this section on the non-prescriptive nature of the 1999 curriculum, the types and effects of junior health professional development are discussed.

The effects of professional development

There was no consistent pattern in the individual teacher's participation in professional development — some took part in most of the varieties mentioned, while others had not participated in any. Judy had been to lots of courses in recent years but previously had missed out when she had left teaching temporarily because of family commitments. When she returned to teaching

after time at home with her children, she found she had missed the professional development associated with the introduction of the 1999 draft curriculum, but joined in the second stage of the professional development around the curriculum.

A wide range of professional development opportunities was mentioned. Most courses were offered by the education sector, but others were run by the health sector. In addition to attending practical ‘What shall I do on Monday?’ workshops and policy implementation workshops on curriculum, they also went to ‘social issues’ workshops and local initiatives offered by health professionals such as public health nurses and health promoters. Some also attended conferences or courses run by the New Zealand Health Teachers’ Association (NZHTA). Teachers who had been involved in Health Education for some time had been proactive in organising informal ‘in house’ professional development with colleagues. Mary considered these school based meetings to be valuable. —“That’s probably some of the best PD you can get, particularly when you’re trying to establish something” [Mary, 123].

The main reported benefits of professional development were: the social and emotional benefits gained through interaction with other teachers, and learning new skills and content. Examples of each of these follow. Effects on personal and career development were also mentioned⁵⁶ .

Several teachers described the positive experiences of being together with other like-minded people. Michael talked about going to courses and —“being on the same wave length because we’re doing the same job and generally coming across the same type of people and it’s good to share ideas” [Michael, 94] .

Some teachers talked about learning new skills that had wide application. Looking back on her career, for example, Judy claimed that —“the PD I did then was absolutely invaluable because it improved all my teaching skills” [Judy, 13].

⁵⁶ The contribution of professional development to personal and career growth is described in more detail in Chapters Seven and Nine.

Professional development was particularly important for young teachers such as Jane, who had specialised in Physical Education in her first few years of teaching and then picked up responsibilities in Health Education:

I've got myself pretty sussed for the Phys Ed side of things and that's ticking over nicely so I need to dedicate myself to health so last year I tried to attend as many courses as I was allowed to. [Jane, 54]

Courses were not always perceived as being useful for teachers; this was particularly the case for Mary, who had done a lot of work on her own professional development and was critical of what was available. Here she talks about a course run by a Health Education adviser: —'nbeing brutal here, I thought she'd have more to offer but there was very little in it for us" [Mary, 102].

In this final part of the section on the non-prescriptive nature of the 1999 curriculum, the range of junior Health Education professional development available has been described and its effects recorded. The range of courses and of providers (including those outside education) and variable uptake by teachers suggested that the professional development did not markedly affect classification and framing strength for the 1999 curriculum. In the following section, Health Education's relationship with other knowledge codes is discussed.

6.5 Permeable curriculum boundaries with other curriculum areas

The soft boundaries between Health Education and other curriculum areas was another indication of the subject's fragile construction (weak framing and classification). In this section the following are discussed: the teaching of personal skills in subjects other than health, tensions when a cannabis topic (part of Mental Health in the 1999 curriculum) was taught in Social Studies,

problems of how to accommodate the 1999 curriculum within an already crowded programme, and slotting content from the 1999 curriculum into other subjects such as Science and Social Studies to increase opportunities for health to be taught.

The cross-curricular nature of personal skill development (sometimes called ‘life skills’) located in the 1999 curriculum led this aspect to be incorporated into a range of subjects, not just Health Education. Pat was hoping that a proposed integrated model would be more successful than a “We’re doing a unit on abuse now approach” [Pat, 38]. Pat also suggested it would be beneficial if topics outlined in the 1999 curriculum such as self esteem and relationships could be incorporated into subjects such as English.

Judy was also enthusiastic about possibilities for cross-curricular co-operation in a school she had taught in:

There’s the opportunity for some good cross curricular stuff to happen around some of the issues in Health Ed and in my old school, we were just starting to do some work with Science in terms of reproduction and sexuality when I left. [Judy, 60]

Despite Jane’s espoused view that links should be made with humanities subjects such as English and Drama, her reaction when she discovered a Social Studies teacher had conducted a class debate on legalising cannabis was negative. Jane sought the teacher out and was annoyed to discover that the topic was not part of the content for the Social Studies curriculum.

Jane suggested that she and the Social Studies teacher had taught the topic differently because of their different curriculum backgrounds and personal viewpoints. Jane claimed hers was a more holistic approach which emphasised well-being while the Social Studies teacher appeared to down play the health effects of cannabis use. Jane was reluctant to challenge the Social Studies teacher and modified her approach:

I didn't actually want to ask too many questions. I don't want to play off teachers against each other either. I just went —Okay'. So I changed a little bit and did an article review instead. [Jane, 20]

In her role as Health Education advisor Pat, had heard discussions of where Health Education might fit into the curriculum in integrated Catholic schools. Teachers could see the links between Health Education and Religious Education (RE), but were concerned that one subject might be disadvantaged if the two subjects were brought together:

They could see where it could sit beside RE and be included in RE but they were always worried if health is plonked in with RE how we are going to meet the health curriculum and the RE syllabus and they also had the dilemma, it's hard enough trying to teach RE and do you have to take less time to do your RE in order to do the health even though health was really important. [Pat, 54]

Other subjects were sometimes used as a vehicle to increase opportunities for health to be taught. Andrea had brought Health Education topics into her Year 12 Science class. —I would bring in health issues as well as you know the scientific sort of basis to things" [Andrea, 154]. Attempts to get an autonomous Health Education programme in Year 10 at Alana's school had been unsuccessful but some health topics were taught in Social Studies and Science as a way of at least getting some health taught at this level:

And it was just I guess trying to do as much health as we could like we have health integrated in Year 10 so that Social Studies does the ALAC³¹ programme and science does a bit of stuff on sexuality and smoking. [Alana, 5]

In this section, the weak classification and framing of the 1999 curriculum with other knowledge codes (subjects) has been shown. Aspects of the 1999

³¹ Alcohol and Liquor Advisory Council

curriculum were incorporated into other knowledge codes as a way of covering as much as possible from this curriculum. In one case, there was tension reported when a health topic' was taught in Social Studies.

In the following section pedagogical tensions are explored drawing on Bernstein's concept of an integrated code curriculum. For an explanation of this concept, see Section 5.2.

6.6 An internally contested curriculum

In the final section of this chapter, the effects of including three previously separated collection codes into one learning area are explored. This major change originated in the New Zealand Curriculum Framework policy document of 1993 and meant that Health Education and Physical Education (and aspects of Home Economics) were placed together in the same essential learning area, Health and Physical Well-Being⁵⁷ .

Pat's comments are again very evident in this section. Her reflections are important because they indicate the views of the teachers she worked with during her brief secondment into a regional secondary advisory role for Health Education during the late 1990s. This was a time when teachers were beginning to realise the implications of the 1999 curriculum.

In this section the following are discussed: reactions to bringing Health Education and Physical Education together, curriculum structure influences staffing, reservations about some Physical Education staff teaching health, and competition for resources.

⁵⁷ The change of title for the 1999 curriculum is discussed in Section 4.2.

Reactions to bringing Health Education and Physical Education together

There was some concern expressed about bringing Health Education and Physical Education together into the same learning area. Pat expressed enthusiasm for the health aspects of the curriculum but expressed reservations about bringing Health Education and Physical Education together. She was annoyed when the Ministry of Education had decided to insert Health Education into Physical Education rather than continue with Health Education as a stand-alone subject. She thought that Health Education and Physical Education had only been linked together for reasons of expediency and resources: —I ~~as~~ excited for the health side. I have to say I was disappointed for the PE side, I've always had reservations about the two of them being put together" [Pat, 23].

Some Physical Education teachers became anxious about the inclusion of Health Education in the learning area. Toni reported that one of her male colleagues had reservations about what he saw as the intrusion of Health Education into the Physical Education curriculum: —I mean I've heard [Name] comment... I'd like to know who's behind all the health stuff coming into the PE curriculum' ...that was the end of the conversation" [Toni, 44].

Pat was aware many experienced Physical Education teachers were comfortable with what they did and very anxious when they became aware of the 1999 curriculum's content. She suggested this unease was because they felt ill prepared and also because they were more comfortable with facts rather than the more conceptual aspects of the curriculum document:

There were a lot of physeders who were pretty desperate because they knew they were going to be expected to implement the health curriculum and they were worried that they didn't have the tools or the expertise to do that. It's not just the factual stuff, they could see that that wasn't enough to fulfil the spirit of the document. [Pat, 50-51]

Curriculum structure influences staffing

In this subsection, the implications for staffing that resulted from the creation of an integrated code curriculum are discussed. A dominant assumption about staffing was that Physical Education teachers should be teaching both Health and Physical Education.

The effect of putting Health Education and Physical Education in the same learning area was evident as soon as Physical Education teachers became aware that they would be called upon to teach Health Education. In her advisory role, Pat spent some of her time supporting a few Social Studies and English teachers who were keen to teach health, but the majority of her time was spent with Physical Education teachers who were coming to terms with school interpretations of this structural change: —Most of my time was spent with physeders who knew that their school was going to plonk it with PE and they were going to have to pick it up and they needed some assistance” [Pat, 57].

In this study, it is clear that Health Education is not always taught by those who also teach Physical Education. The staffing arrangements and organisation for Health Education evident in this study is indicative of the fluidity of staffing arrangements. The least complicated staffing for Health Education were in Michael’s and Judy’s schools where Health Education was taught by teachers who were trained in Physical Education and who had also done some professional development in Health Education, although as Michael acknowledged, this training was minimal —basically all physed trained, none of them specifically health trained” [Michael, 86] . Michael considered he had good Physical Education and Health Education staff. This situation was relatively new, however, as prior to this arrangement, Health Education had been taught by a part time primary trained teacher who had an interest in Physical Education but whose main focus was Health Education.

In the school where Mary, Liz and Nicole taught, all those teaching Health Education had also qualified in Physical Education. In comparison with Michael’s school, however, a much more complex picture emerged from the teachers’ accounts, with gender discourses being used to explain why no males

taught Health Education⁵⁸. In other schools that were part of this study, teachers with no background in Physical Education taught Health Education. Nicole's primary subject affiliation was Home Economics and Paul taught mainly Social Studies and History.

There were different perceptions about the reasons for assigning Health Education classes to Physical Education teachers. Timetable constraints at junior level were given as one reason and another was competition for students. Anna, the most senior Health Education specialist in her school, was very unhappy at the prospect of Physical Education specialists taking over Year 9 Health Education in her school. Anna indicated that giving health to the junior Physical Education teachers was driven by expediency because Physical Education was over-staffed.

Although Health Education's 'home' was often within Physical Education, there were instances of separation. In Andrea's school, Health Education (with Andrea in charge) had been split off from Physical Education but was about to be returned with a consequent loss of Health Education teaching for staff. Andrea (who had a Science background) recalled that a previous Head of Department (HOD) of Physical Education had at one time believed that only Physical Education teachers should teach Health Education. This view had been modified after Andrea and the HOD had together participated in a Health Education professional development course.

With Andrea's imminent departure, the HOD of Physical Education would now be in charge of health. This change meant that Health Education would be taken away from some teachers and given to others (Physical Education teachers):

Of course now that I'm leaving it's going back to PE and [Name] has already signalled that, because I've had three staff this year that have not been PE that have been teaching health, but [Name] has already

⁵⁸ Gender discourses are discussed in Chapter Eight.

signalled that there's no way that's happening next year and it's going back to PE teachers. [Andrea, 23]

The above example shows how the 1999 curriculum could be used to justify who should be teaching Health Education.

Reservations about some Physical Education staff teaching Health

Doubts were expressed about the aptitude of some Physical Education staff to be effective Health Education teachers. There was general agreement that: —Just because you're a PE teacher it doesn't make you a health teacher and just because you're a health teacher doesn't make you a PE teacher" [Judy, 142].

It was suggested that it was unusual for teachers to be passionate about both Health Education and Physical Education. Jane indicated that at least in her school, enthusiasm for both Health and Physical Education was a rarity. Reflecting that in only her second year of teaching she had accepted the role of HOD for Health, she commented that she was perhaps the only Physical Education teacher who was really keen about Health Education. Jane's view that Physical Education teachers were not necessarily the best qualified to teach Health Education was shared by Pat and Nicole. Nicole suggested that it would be hard to find teachers who were passionate about both Physical Education and Health: —It's not their passion; they're PE teachers who teach health" [Nicole, 25].

Some teachers thought that some of those training to be Physical and Health Education teachers were more interested in sport at the expense of the wider scope of Health Education. —If you're feeding in from the PE side of things, you're always going to get those guys and girls I guess who are really the sport orientated stereotype" [Jane, 152].

Pat had premonitions of poor Health Education teaching by those Physical Education teachers who she considered lacked emotional warmth and empathy

when the Health Education and Physical Education were grouped into the same learning area:

You could see the writing on the wall. This is one curriculum area so health gets tagged into PE and whereas some PE teachers are very on to all those other issues in health, by in large a lot of them are not interested. I don't see that anything to do with the emotions and feelings, your general physeder is often not that type of person and not understanding of how others operate. [Pat, 24-25]

Michael also suggested that there were differences between health and Physical Education teachers, with health teachers being empathetic while Physical Education teachers were inclined to be heartarty':

It's more sort of ho, ho, ho with the physeders and it's not like that with the health and you know the health teachers around they seem to be a lot more caring and worrying about the person as a whole. [Michael, 92]

Mary expressed some scepticism about some Physical Education teachers' interest in coming to grips with the conceptual framework of the curriculum, and doubted whether they were up to date with the resources designed to help teachers understand the curriculum's conceptual framework.

Some teachers thought that giving Health Education to Physical Education teachers might give the impression that Health Education could be taught by anyone. Anna was critical of the decision to give Physical Education teachers responsibility for her school's Year 9 sexuality education programme. The struggle over who should teach Year 9 sexuality education was all the more bitter because health specialists had only just managed to wrest sexuality education from another group of teachers:

I said to our DP, I said, look, we fought to get sexuality back from integrated to specialist teachers and now it's going out to PE, just going a

different way but —“they can do it, it’s like anybody can teach health”. Well not everybody can” [Anna, 63].

Although most of the concern from the teachers in this study was to with the effects of Physical Education teachers teaching health poorly, Toni, predominately trained as a Physical Education teacher but now also an enthusiastic Health Education teacher, was concerned about the unsatisfactory role models provided by over weight health teachers:

We’re looking at it [obesity] next year in our PE curriculum; we’re upping the levels of aerobic fitness and really hammering lifestyle stuff. A lot of PE teachers are in good shape, you wonder how healthy health teachers are, I think it’s a bit of a concern. [Toni, 158]

Resource competition

Internal competition for resources between Health Education and Physical Education, particularly teaching time, was a feature of the teachers’ accounts. Mary, for example, expressed regret that Health Education had to compete for time with Physical Education in the junior school. Judy commented that there were dangers in cutting into too much Physical Education time to accommodate Health Education and this danger was heightened if the teacher preferred one subject over the other.

Even when there was apparent equity between Physical Education and Health Education in the junior programme at Nicole’s school, the outcome was not quite what it looked like in the plan:

There was a time last year when we played around with having two periods of health a week but it meant them losing a period of PE and of course then they ended up trying to get through the health as quickly as possible so they could go back to PE and then they got three periods of PE so actually they did more PE and less health in the end. [Nicole, 9]

Teachers felt disgruntled by haphazard rooming arrangements for Health Education in comparison with the stable arrangements and dedicated spaces for Physical Education. It was uncommon for Health Education to be sited in specialised rooms. Toni had experienced this fortunate situation in a previous school where there was a dedicated room for health and this was complemented by an equitable share in the junior timetable between Health Education and Physical Education.

A more common scenario for Health Education teachers was to be “chucked into rooms all over the place” [Liz, 107], with teachers having to move rapidly between classes and carry resources from one area to another. This is not an uncommon situation in schools, but for some of teachers who taught both health and Physical Education there were additional demands because they also taught in a fixed space – the gymnasium. —It’s so impractical to have this poor person who’s teaching health, go from the gym which is across the other side of the school and they’re always going to be late” [Nicole, 120].

Gaining purpose designed Health Education spaces was no guarantee that Health Education teachers would remain in these spaces. Liz complained about Health Education being moved out of a space while renovations were being carried out in her school:

Next year we’re getting the admin block done so who are they ‘turfing’ out? Everyone in the health room because it’s got the plug points for the computers and it just seems to happen too often really. [Liz, 107]

Tensions resulting from the formation of an integrated knowledge code have been presented in this section. These tensions were to do with perceptions about the effects of bringing Health Education and Physical Education together, curriculum structure influencing staffing, reservations about some Physical Education teachers teaching Health Education, and competition for resources.

6.6 Chapter summary

In this chapter, evidence for the weak classification and framing of Health Education was examined in relation to the work of the teachers who were interviewed. The main factors contributing to Health Education's weak classification and framing were: the issues based nature of the curriculum and pedagogy, the groups which contributed to Health Education knowledge, the non-prescriptive nature of the 1999 curriculum, permeable boundaries with other curriculum areas, and internal contestation.

In the next chapter, classification and framing for Health Education is shown to have been strengthened by the introduction of a new discourse – the National Certificate of Educational Achievement.

Chapter Seven

Assessment and Pedagogy

Chapter Seven discusses the effects of a relatively new discourse evident in this study, the national secondary qualification of the National Certificate of Educational Achievement (NCEA). The dominant relationship in this chapter is between assessment and pedagogy, as evidenced in the accounts of their work by the teachers in the study. The chapter consists of the following: **7.1 Introduction; 7.2 Implementation issues; 7.3 The effects of the NCEA on learning and teaching** and **7.4 Chapter summary**.

7.1 Introduction

The interviews on which this study was based took place in late 2003 and early 2004, just after the first level of the NCEA was implemented in 2002. It was not surprising, therefore, that there was considerable variation in the teachers' experiences at this time of assessment and pedagogical upheaval. Some teachers (e.g., Andrea and Toni) did not teach senior Health Education, so their talk about assessment policy and practice is limited to other subjects, or silent, as they used the predominantly needs based language of junior Health Education. Others, like Mary and Judy, used both discourses because they taught junior and senior Health Education. Nicole taught both junior and senior health (NCEA and non-NCEA senior classes). Jane was attempting to get Level One of NCEA Health Education in place for the following year. Michael taught senior (NCEA) Health Education, and Paul was teaching Health Education for the first time and this was at the senior level – a Year 11 NCEA class.

This chapter records how the teachers were affected by the emergence of this new discourse for Health Education. In Bernstein's terms, there was evidence of a change in classification and framing strength at senior level if Health Education was part of the NCEA system. The first section discusses the teachers' experiences of learning about the NCEA and what happened when they tried to implement the NCEA in their schools. In the second section, the effects of an NCEA discourse are examined, particularly the effects of the NCEA on teaching and learning.

7.2 Implementation issues

The first major section of this chapter records the teachers' experiences of learning about the NCEA and what happened when they tried to implement NCEA in their schools. In the first two subsections (Structural issues and Professional development tensions) their experiences of the professional development for the NCEA are examined. In the subsequent subsections teachers' experiences of implementing NCEA programmes for Health Education are considered through the following: Assessment dilemmas, Uncertainty about processes and content, Managing workload and competence issues, Anxiety about planning for senior Health Education programmes, Academic demands, and Opportunities provided by the NCEA.

Structural issues

In this first part of the section, the teachers' experiences of learning about the NCEA through professional development are covered. Two important tensions reported were structural issues and the inadequacies of the professional development reported by some teachers. These tensions have relevance for the classification and framing strength of senior Health Education.

There was a logistic problem in the NCEA professional development cycle and the impact of this problem was referred to by several teachers in the study. The

NCEA professional development courses for teachers of Physical Education, Health Education and Home Economics, provided by the New Zealand Qualifications Authority (NZQA), were run concurrently and this meant that teachers had to choose which training they would attend.

Jane, for example, had attended the first Level One Physical Education training days because she was responsible for her school's Level One Physical Education course. Subsequently, when she had wanted to implement Level One Health Education, the NCEA professional development cycle had moved on: —“I had to go to the Level One training for PE, I was in it and then last year I tried to do some health stuff but by then they were introducing Level Three” [Jane, 161].

The Health Education training sessions for the NCEA were generally poorly attended in comparison with Physical Education. Here Mary reports a conversation she had with a senior Physical Education colleague after he had attended a Level Two Physical Education training course. Unfortunately for Mary, there had not been the same opportunity for such an exchange at her Level One Health Education course because there were too few teachers who were using the NCEA:

I said “What did you do and how was it?” and he said “We just kicked things around finding out what works and what doesn't and changing things” and I said “Well that's what it's all about isn't [it], with Level Two you're learning a lot of stuff, it's always good to sit down and kick over what you've been doing and finding out what works and what doesn't work”. See we hadn't done that with Level One health, probably because there aren't enough of us doing it. So I'm flying by the seat of my pants really. [Mary, 86-87]

The separation of Physical Education from Health Education through the provision of separate standards and professional development for the NCEA has important implications for Health and Physical Education as an integrated knowledge code.

Professional development tensions

Several teachers experienced frustration and irritation with their early experiences of the NCEA professional development. While explaining how she had become an unofficial resource person for senior Health Education in her geographical area, Mary explained that because of the perceived inadequacies of the official NCEA facilitator, she had taken a leadership role: “In the NCEA days, guess what happened, I ended up facilitating that. I’m quite angry about that because it was just a complete waste of time for me” [Mary, 100].

Liz recalled being admonished by a facilitator during the NCEA Level One training:

At some of the courses [Name] got really cross with our particular group of teachers saying we were negative this and weren’t supporting that. But at the end [Name] actually thanked us because I think [Name] went away somewhere else to take the same course and they were more likely to rip it to shreds and think it was awful than we were. [Liz, 119]

In an enlightening account of her experience of becoming a Health Education regional facilitator for the NCEA, Nicole revealed the impact of the training by Health Education experts on her and other Health Education teachers.

Nicole reported bewilderment coupled with a feeling of inadequacy when she heard the ‘experts’ talk about assessment and senior Health Education and reflected on the realisation that her initial confusion at a Level One training day (for regional facilitators) had been shared by other teachers:

I got really confused about some of it when I first listened to people like [Names]. Do I know anything? And we had this really funny thing the first NCEA Level One training day thing I went to and it’s a bit like being at school actually. And after Day One I was thinking what am I doing here? I don’t understand anything, everyone else must understand stuff etcetera. It wasn’t until I think a year and half later or something when we’re doing the Level Two training when a lot of the same people got

together and we started talking and the others were in the same place as I was. They were like –Oh this is much better than when we did our first training ~~cos~~ I didn't understand a thing on Day One". Yeah, no one said anything, we were all doing the whole –Right, yeah, hmmm, okay yeah". No one said anything and none of us really understood. And we were the people who were meant to be training other people so you can imagine. [Nicole 224-227]

It would appear that the national experts' strong framing strategy of Health Education at first caused confusion and alienation amongst these experienced teachers. In the next part of this section on teacher learning and the implementation of the NCEA, some assessment dilemmas are described.

Assessment dilemmas

The teachers described a mixture of formal assessment tools for Health Education. Their assessment discourses revealed a number of assessment dilemmas: uncertainty over what type of assessment to offer, different perceptions of internally and externally assessed achievement standards, differences in status between achievement standards and unit standards, a perception that there was a bigger than expected gap between requirements at Level One and Level Two, and anxiety over using the externally assessed achievement standards.

Jane was undecided about the types of assessments she would offer in her first foray into Level One Health Education. She indicated she might do some unit standards such as the one on smoking, which seemed relevant as she knew a number of her students smoked, and she was also trying to cater for a range of ability in her class:

I know there's a huge range, I've already been told that... No ability up to you know...I think with some of the lower ones, I may try to work away through unit standards you know two credits, and the kids are smoking. [Jane, 169]

There is a social issues discourse coming through here as well as an indication that Jane thought unit standards would suit her lower ones'.

Michael's school offered a mix of achievement and unit standards and he seemed to favour unit standards over achievement standards. Paul hinted at some differences of opinion within the Health Education group at his school over the type of standards offered. At his school, the Year 11 formal assessment consisted of three achievement standards and two unit standards and internally assessed achievement standards were preferred:

But I often think that you know, there's no external examination for health, well our kids could do the external, but they don't. I know that would certainly separate those that have applied themselves and those that haven't but that's obviously a decision for the school and department to make. [Paul, 24-25]

The impression gained from several teachers was that internally assessed achievement standards and unit standards were less robust than achievement standards which were externally assessed. There was also a suggestion in Nicole's account that Level One was much easier than the subsequent levels. As time had passed, Nicole had developed a growing sense of security with what was required at Level One and with her students' ability to do well at this first stage of the NCEA. She hoped that with time, she would also feel more confident about the higher levels of the NCEA. This extract also suggests that every day knowledge' has currency at Level One:

I'm not worried about Level One so maybe as time goes though I'll feel more comfortable about where Level Three gets to sort of thing, but at the moment Level Two, don't think my kids will do very well, but Level One, sweet, conceptually Level One is so much easier I think half my kids could walk in off the street and have enough smarts to get it.
[Nicole, 118]

A conflict between what seemed to be appropriate at school level with an expectation of the Beacon Project⁵⁹ emerged in Anna's account of the differences between achievement and unit standards. Anna's school had been identified as a Beacon school in the first round of this initiative. As a Beacon school, the expectation was that its Level Two programme would offer only achievement standards. Anna felt that it was in her students' interests to offer a mixture of assessment types, but also felt the pressure of being a Beacon school. She was reassured when a colleague supported her view that she should be guided by what was best for her students, —because I really felt like a traitor to the whole Beacon Project that we weren't going that way" [Anna, 59].

Achievement standards suit academic students more often than the unit standards I thought. And someone said to me —"Do what's best for the kids". I thought wow, someone understands because that had been on my heart, what is best for the kids? [Anna, 58]

The clear-cut nature of unit standards (unlike achievement standards, there are no grades assigned), their lack of external assessment, and their appropriateness for her students was attractive for Anna (and to Jane [169], above). This was not the case for Nicole. Nicole included unit standards in her assessment programme, but felt that they were boring in comparison to achievement standards.

The externally assessed achievement standards were a source anxiety for Jane:

That's definitely a confusion for me, that is the content. How do I know what they're going to assess or how do I know if I've taught them right, included everything I need to include? Have I talked too much? You know, all those worrying questions. [Jane, 178]

⁵⁹ The Ministry of Education funded 'Beacon Project' was aimed at providing specific and on-going support and resources for senior Health Education programmes. It was discussed in Section 4.3.

She felt she had more control over internal assessment and feared that student failure could be blamed on her teaching:

You've got the assessment there, you know what you need to do to get there so that's something that's a bit concerning, especially with the course that isn't firmly on the ground. If I have some kids that sit some externals and bomb or I haven't taught them what they should have been taught or they don't show up or whatever, how is that going to look?
[Jane, 181-182]

One reason for Jane's apprehension about the externally assessed standards stemmed from the fact that her only experiences in the senior curriculum had been in Physical Education, which at the time of the interviews, was fully internally assessed⁶⁰.

A second factor in Jane's apprehension about the implementation of NCEA was fear that poor performance of her students in the externals would not only reflect badly on her but also on the school when compared with others:

You know the schools are getting compared nowadays with externals and the number of credits and what they got in Level One and if I'm allowing kids to sit externals and I think they're prepared for it and I haven't prepared them properly, I'm going to be questioned and that's a concern and I want to do it right. I don't want to send kids in unprepared.
[Jane, 183-184]

Aside from managing examples of assessment dilemmas such as those discussed above, teachers expressed more general concerns about the use of formal assessment in senior Health Education.

⁶⁰ Physical Education was included in the first group of subjects for which students could sit a scholarship examination at Level Three. For discussion of this see Section 4.3.

Uncertainty about processes and content

A number of teachers were confused, anxious and in some cases critical about the way the NCEA system worked.

Nicole's initial reaction to the NCEA Health Education achievement standards was that they did not build on what had already been learnt about assessment. A flow on effect from this observation was that she doubted her competence for some time, until she decided that it was writers of the new assessment tasks who had it wrong, not her:

And what did confuse me and a lot of other health teachers when the achievement standards first came out was they seem to have thrown away what we had learned for years and gone back to —“here are the twenty things I want in this paragraph” and that made me wonder whether I had any knowledge and then I realised no, actually it's the people who've been writing this material who've made this mistake, but it took two years to realise that. [Nicole, 221]

Despite supporting her school's decision to teach senior Health Education and feeling comfortable about her school's ability to provide a strong senior programme, Liz was critical of a number of aspects of NCEA. Liz did not teach senior Health Education, but was familiar with some of the assessment requirements through attending the NCEA professional development for Health Education and because she was part of a close-knit health team which shared information. As an experienced teacher who was aware of at least one previous assessment reform, achievement based assessment (ABA)⁶¹, she argued that there was a strong element of “re-inventing the wheel” [Liz, 123].

Liz also had some specific criticisms of the NCEA. She could not see where some of the assessment material had come from and considered that the assessment criteria were too vague:

⁶¹ Achievement Based Assessment (ABA) was briefly implemented in the late 1980s after the 1984 Committee of Enquiry recommended that assessment in Form 6 (Year 12) be school based and linked to levels of achievement. ABA involved a procedure in which student performance was assessed in relation to a set of specified criteria.

And even myself as a teacher with a background in assessment, I was looking at this thinking what the hell do they want here, what are they trying to get from me? I can't even see what direction it's going in. It just didn't seem to be logical and I couldn't really see sometimes where to start, even let alone where we're supposed to be arriving at. [Liz, 121]

In contrast to the confidence Liz conveyed when she talked about junior Health Education, she seemed alienated from the NCEA discourse of senior Health Education: —I suppose again it was some of their philosophy or how they approached the thing was just wacko basically and very confusing and waffly” [Liz, 125].

Paul also voiced confusion about applying achievement standards. Paul's concerns about the marking process are in marked contrast to his confidence in his ability to teach within an assessment framework:

The achievement standards where you are after three things. They write one, they still achieve. So it's that distinction and doing justice to it. I must say that the assessments have been confusing for me full stop, trying to mark them, especially the achievement standards. [Paul, 118]

He also expressed reservations about internal consistency and argued the case for consistent approach to assessment, marking and moderation to combat the problems he had encountered.

As much as I love the people in this department, there is a bit of a difference in terms of the approach, not in terms of presenting the information but because a lot of our assessments are open book, it's been really difficult to try and give them the information but not be specific to the question. Do you know what I mean? But there were some, well one staff member, who sort of plays the video all the time and then when it's time to do the assessment gives them all the right answers that are specific, right, so when it comes to marking the assessments, I often feel my kids have been dealt a raw deal. So it's all about the

consistency and approach to assessment and also marking, and I mean I look at the quality of the pamphlets that my kids produce in assessment and the quality of another one from another class when we do the moderation, and you can see a distinct difference but the grade will be the same. So I think, you know there's not a lot you can do about that because it's up to the individual teachers to how they approach things. [Paul, 121-123]

Teachers' uncertainties and concerns about the NCEA system were compounded by workload issues and doubts about their ability and knowledge in relation to this new form of assessment.

Managing workload and competence issues

There were few complaints about the workload associated with the implementation of NCEA. The lack of overtly negative comments may have been because any concerns were counteracted by the desire to get Health Education as a NCEA subject in the senior school. There was, however, indirect recognition of the workload and stress involved with coming to grips with the NCEA requirements.

When the NCEA was implemented in 2002, teachers like Mary who were working by themselves in senior health, worked very hard to prepare their Level One programme. The time and effort that Mary had invested was evident when she talked about how she developed a Level One programme before Health Education was adequately resourced or supported at this level:

I've used up all my holidays and I mean I'm lucky, I'm on my own and the kids have grown up, I've just got myself to worry about which means I can do things on my own terms as well. I mean if I had two boys at home, no way. [Mary, 152]

Concerns about competence as well as the time involved in preparing assessment materials for the NCEA was mentioned by several teachers. Anna,

for example, was concerned about the time associated with preparing her own material, specifically the difficulties of writing valid assessment tasks for unit standards. She was also worried about the repercussions if teachers were not able to do the task properly:

Well where's the teacher going to get the time from, and if you do, then they want teachers to mark their own, well that's pretty narrow because if you've got a teacher that has got it wrong they're going to have got it wrong in all areas. At least if there's a sample on the web you can see. I'd be worried about a teacher doing everything themselves. [Anna, 130]

The wisdom of the suggestion made at an early NCEA Health Education course, that teachers should write their own assessment tasks (in this case for achievement standards), was only appreciated by Nicole in hindsight:

At the very start of NCEA when they said "Write your own", nearly all of us said —"You're joking, we don't want to write our own, we don't feel confident to write our own". Whereas now I can see why they said that because you can adapt and you can actually write your own stuff and make it much more valid. But yes, it's been really a hard concept actually. They were just a wee bit ahead of me. [Nicole, 223]

One of way of addressing workload issues and uncertainties was to buy commercially produced assessment tasks. Alana explained that many teachers were buying unit standard assessment tasks and associated teaching material for Home Economics and Health Education. She attributed this trend to lack of time and lack of expertise, because there had been no recent professional development in the writing and use of unit standards. She cautioned that the tasks were un-moderated, so teachers using them ran the risk that the commercial material might fail the national moderation process.

Faced with the daunting prospect of writing a Year 12 programme for senior Health Education, Alana was encouraged by commercial availability to take this short cut:

So we were looking at writing the Year 12 health programme, like it was going to be a big undertaking and so I said to [Name], “Gosh we don’t want to write them all from scratch, let’s buy some”. There’s an 0800 number and they send you heaps of them that you can buy, the whole package comes, mainly unit standards. They cost, so you can’t buy too many of them. [Alana, 75-77]

Nicole and Anna also mentioned the availability of commercial resources. Both lamented the lack of support and hoped for greater certainty: —I would love someone to come out and with —This is what you are meant to be assessing, this is the ten minute assessment, because there’s stuff you can buy” [Nicole, 218].

Anna’s criticism was specific to a lack of support for the implementation of unit standards:

And then you want to do a unit standard that’s not even on the web, where do you get your information from then, do you have to go back to scratch and write it? And I rang up the Apostolic training people you know because they put them out already done and they’re not even writing it until next year, but honestly, you’d think the Ministry would have a sample of every assessment on the web, I think that is their responsibility and anything short of that is just not on. [Anna, 129]

The accounts in this subsection show how in the early period of NCEA Health Education, teachers’ workloads were increased, particularly if they were working in isolation. There were also concerns about their ability to write suitable assessment material, and in some cases, teachers were using commercially produced material.

Further issues in these early years of the implementation of the NCEA were concerned with the struggle to get health programmes into the NCEA

curriculum' in their schools, and worries about what their programmes should include.

Anxiety about planning for senior programmes

There was anxiety expressed by those teachers involved in planning for the future of senior Health Education in their schools. Some teachers were not sure if senior Health Education would run at all, and some were also concerned about the content and continuity of their programmes.

A number of accounts reflected the struggles and disappointments associated with the teachers' efforts to get NCEA Health Education into their schools. At the end of 2003, Mary was pleased with the way Level One was going and had been making preparations to teach Level Two the following year. Recent developments were not favourable however, and it seemed Level Two Health Education would be excluded from the options available in 2004. Mary was angry because she felt that Level One was providing a solid basis for Level Two and that there was an unfair element to the exclusion of Health Education:

So we've had Level One for two years and it's going well and those girls are angry that Level Two probably won't be offered, they've actually gone into it anticipating taking Level Two and it's not fair, it's not fair. [Mary, 67]

Jane had fought hard to get Health Education as a senior NCEA subject in her school, and at the time of the interview late in 2003, she was preparing for a Level One Health Education class in the anticipation that there would be one in 2004. In addition to not being sure that the class would run, Jane was also nervous about what it would be like to teach at this level:

I just don't know where I'm at with that. I don't know who I'm going to have and because the course has never been run before I'm not as familiar as I'd like to be with it, the timing and how long things will take and things like that. [Jane, 170]

Michael indicated some certainty was provided by the assessment task exemplars provided on the internet for senior Health Education – “there is black and white when it comes to assessment” [Michael, 89]. At a later stage of the interview, however, Michael revealed a level of anxiety about what his whole programme should look like:

What do I include in a Year 11 health programme and what's appropriate? What level do I you know aim at? And the other thing is what, where do I go through for next year with that, what's the follow up instead of having them all stand alone. [Michael, 150]

These comments show that even when teachers managed to get senior programmes running, they then had to deal with another set of issues to do with implementing these programmes. A further anxiety was the perceptions of the academic level of senior Health Education in comparison with junior Health Education.

Academic demands

Some teachers expressed concern about the academic demands of senior Health Education (particularly achievement standards) and how students would cope. Pat thought that the assessments standards were overly sophisticated. —“Some of them seem so complicated maybe it's PhD level they should be looking at!” [Pat, 148].

Alana claimed that the Health Education teachers she had come into contact with were concerned about how non-academic students would be catered for. Michael also thought that the demands of senior Health Education would make it hard for low achievers:

In terms of what I think at the moment, the health curriculum requirements, especially at senior levels, are really really hard so I could not probably see my current class taking Level Two next year which I

hope to move on to. But definitely it would be very hard to do Level Three at the moment. [Michael, 66-67]

Alana claimed that a number of teachers she knew were concerned about the planned expansion of senior Health Education through to Level Three, as they were already struggling to keep up with developments at Level One and Two. It appeared to be more than a workload issue for Alana; she implied that there were challenges for teachers and suggested that Health Education teachers needed university qualifications to be able to teach the NCEA at Levels Two and Three. She suggested that university studies would give teachers the content knowledge that was beyond the knowledge of themselves and their students: —Because they need some base knowledge that's more than the students and more than their own personal experiences" [Alana, 10].

Alana noted a number of differences between junior and senior Health Education and the effects these were having on students. She also acknowledged that she was having difficulty in understanding some of the concepts introduced at senior level:

What is hard is when it's a little bit more of an academic focus and students aren't quite there or don't want to be there, that's when it gets hard or when it's got a bit of an academic focus and I'm struggling with the concepts a bit myself, so you don't kind of teach them as well as you might otherwise teach them. [Alana, 23]

Junior health was characterised by Alana as experiential and personal. In comparison, she indicated that senior health was more conceptual, abstract and challenged students to think critically and not rely on their own experiences:

When they've got to think harder about things, when it's not just from their own personal perspective, that's when it gets hard because they're very keen and they like talking about themselves and what they've done, but when we move away from that, when we look at maybe the societal implications of things, that's when it gets more challenging for them. Also

I guess when there's no black and white answers either, a bit difficult I guess. [Alana, 25-26]

The lack of clear-cut answers at this analytical level, the examination of wider societal influences on health and the role of government policy in health all contributed to a level of complexity which challenged Alana as well as her students:

When you're talking about the social determinants of health and the impact of the different determinants on the health and well-being of society. If you're looking at the implications and all that sort of stuff, what they should be doing and what will they do and who's going to benefit and that type of stuff, that's when it gets quite difficult. And they don't know much about it, which is hard and I don't know much about it either which makes it difficult for me to teach it. [Alana, 27-29]

Although some of those who taught senior health stressed its academic demands, this perception appeared not to be shared by other staff, as it was mentioned that senior Health Education classes became the repository for students who are having difficulties in other subjects:

Because it's seen as a dumping ground and "Oh they only do cooperative learning and colouring in and happy feely sort of stuff like that", and I often think that other staff members think that it's a dumping ground and you know it's interesting to see the roll for the health classes at the beginning of the year will gradually increase as students are weeded out or rejected from other subjects. [Paul, 16-17]

This perception of senior Health Education is significant and affects both teachers and students.

In the teachers' concerns above, there is evidence of a change of classification strength between junior and senior (NCEA) Health Education. Junior Health Education was characterised as more reliant on student knowledge (Bernstein's

commonsense knowledge') than senior Health Education. There were also indications that some teachers thought that Levels Two and Three would be beyond some of their students.

The previous five subsections of this section on implementation issues have presented a rather negative view of what happened in the first few years of NCEA assessment. The teachers also talked about some good effects. These are discussed in the last subsection.

Opportunities provided by the NCEA

The teachers' accounts included positive comments on the impact of the NCEA. For Andrea, the NCEA provided teachers with the opportunity to critically reflect on the senior secondary curriculum. For others, there was a sense of satisfaction and growing confidence in their use of the NCEA materials.

Andrea acknowledged the impact of the NCEA on the senior curriculum and welcomed the beginning of debate around what is a core curriculum. She was, however, concerned about the lack of time to discuss the implications of the NCEA for the curriculum:

Personally I still believe [the debate in her school] has got a long way to go but hopefully there will be a lot more open mindedness about where the NCEA climate is taking the curriculum, because there's discussion now about —~~Ok~~ well why are we still talking about core subjects, you know what's core" and some real, real good philosophical discussion but it's just with all that's happening with NCEA is actually finding the time to do that and deal with how we're going to change it. [Andrea, 90-91]

Andrea was the only teacher to talk about the possibility of wider philosophical debate.

Mary and Judy were secure in the assessment preparation which had gone on in their classes and expressed confidence in the assessment tools. Mary felt

that assessment was working well, and this included the externally assessed standards which few teachers tackled in the first years of the NCEA. Here she reflected on an externally assessed Level One standard that her students had just sat and felt that she had prepared her students well:

My kids have just done 1.6, drugs, and there is a lot of work in that for fifty minutes. I thought it was a good paper and I'm pleased with it and my kids should do well as long as they finish it. I mean I did a mock thing and I used last year's paper and they didn't finish it in fifty minutes and last year's paper was an easy one I thought and this one's a little more, it was bit more demanding I thought. [Mary, 147]

Judy enjoyed the challenge to provide a variety of learning experiences for her first Level One class and liked the transparency of the assessment process:

When the Level One stuff came out that was great because the first class that I had as a Level One class was really good. We tried all sorts of different things and some things worked out and some things didn't but they were all in a way quite successful in attaining achievement standards. I liked the fact that you can test kids, you can assess them and they know what they are being assessed on so they can be well prepared for that. [Judy, 96]

Nicole's account of her experiences of Health Education assessment for the NCEA was perhaps the most interesting, for she was one of the most experienced (in senior and junior Health Education) of the thirteen teachers interviewed. There was a sense of confidence in her ability to understand what was required at each level and acknowledgement of her developing assessment skills: —So I still feel that I've got deficits but you know I don't feel freaked about marking for instance now" [Nicole, 52].

Here Nicole reflected that in contrast to the first year of NCEA implementation, she was now more relaxed about her senior Health Education courses, particularly Level One: —I think the first year I started playing with things

[referring to Level One] I really came to the end of the year and thought —“Oh my God, what the hell did I do?” But yes, I do feel comfortable with that now” [Nicole, 58].

It was clear that despite some residual anxiety about some aspects of the assessment process and her ability to develop programmes through to Level Three, Nicole was clear about the long term conceptual developments in NCEA. She also acknowledged the effects of engagement with NCEA on her sense of mastery and competence: —“It’s been hugely empowering if I want to use the word but also it’s just made me feel that there are skills that I do have” [Nicole, 51].

Anticipation of a useful debate about the senior curriculum, confidence, a sense of direction, and satisfaction were shown in the comments in this subsection. Andrea’s hope that the implementation of the NCEA would open up debate stood out, because she was alone in looking beyond the immediate issues of implementing the NCEA. A limiting factor was always time, however, and she indicated that lack of time might curtail what she saw as the beginning of a valuable discussion in her school.

This major section on implementation issues discussed the teachers’ experiences of learning about the NCEA and what happened when they tried to implement NCEA in their schools. Their experiences of the professional development for the NCEA were examined first, and the second part of the section documented their experiences of implementing NCEA programmes. The assessment issues discussed in this section broadly informed pedagogy. The next section has a narrower focus and considers implications for teaching and learning.

7.3 The effects of the NCEA on learning and teaching

In this section, the emergence of the new health discourse is shown through the teachers' use of 'NCEA language' and the way an NCEA discourse appeared to be influencing junior Health Education pedagogy. This section also shows that the NCEA discourse was itself being influenced by an enduring Health Education discourse, that of personal and social issues. The major part of the section is concerned with implications for teaching and learning in classes where senior classes were formally assessed through the NCEA.

A new language for Health Education

Teachers used a distinctive language to talk about NCEA Health Education.

This is important because it signals a change in classification and framing strength. The sample of the NCEA language used below shows the impact of the system on the way teachers talked about Health Education at senior secondary level. Michael talked in terms of "We're doing 2.3⁶² all of Term Two" [75] "it would be very hard for most of that class to do Level Three" [68], and "I'm not going to get many if any excellences or merits" [59]; Mary about "doing four health Achievement Standards" [69], "we've got on board with Level Two" [88], and "helping [Name] to start the Mental Health Achievement Standard 1.1"⁶³ [97]; Nicole about "my Level two kids" [65]; and Judy about her "first Level One class being quite successful in attaining achievement standards" [96]. It is clear from these examples that the meaning of this language was only accessible to those who had been initiated into the intricacies of this form of assessment.

The new terminology was daunting for both teachers and students. Nicole reported that some of her students did not understand what was being asked of them in an external assessment (exam): "That's ugly [referring to the

⁶² New Zealand health achievement standard 2.3, AS90328

⁶³ New Zealand health achievement standard 1.1, AS90061.

terminology] and that's like my Level Two kids said, that we didn't know, we weren't quite sure of the terminology, it's not the actual content" [Nicole, 214].

The new assessment language used to talk about Health Education at the senior level contrasted with the language used to talk about junior Health Education. The language of junior Health Education was focused on perception of student needs. In contrast, language used for NCEA Health Education was by dominated by assessment terminology. There was also evidence that the NCEA was beginning to affect the teaching of junior Health Education. This is discussed in the next subsection.

The effects of the NCEA discourse on junior Health Education

The issues based nature of junior Health Education remained a dominant pedagogical and assessment discourse for the teachers in this study, but the NCEA was beginning to influence the way some of the teachers were talking about junior Health Education.

Despite some reservations about her ability to cope with senior assessment demands, Nicole was becoming more comfortable with her ability to manage these demands. This growing confidence, however, was not transferring to her approach to junior Health Education; in fact her experiences with senior assessment led her to a more critical view of the school's junior Health Education programme.

She expressed a lack of confidence in her ability to construct valid assessments for junior Health Education given the contextual (classroom, personal) and therefore unbounded (in Bernstein's terms, weakly classified) nature of the subject. She was also ambivalent about having any assessment at Health Education level:

But the bigger thing for me I think is the confusion in assessment in the junior school and how to do it when you've only got one period a week. You don't want to do an exam type setting, you want to something that is

valid. Different classes go in different places and it's a job I know I don't do right. I haven't got assessment in the junior school where I should have. Having said that, I don't know that I'm really supportive of assessment in the junior school either, so I'm not even quite sure where I stand. I'm not sure, different people might even learn different things in class and it's all valid.[Nicole, 215].

A comment from Liz also indicated that junior Health Education was changing because of the NCEA: "With the NCEA they're bringing things into the junior level to get them used to what's coming up in Year 11" [Liz, 47].

Despite a change in classification and framing strength through the introduction of NCEA language, Health Education's long standing social issues discourse remained evident. This is considered in the next part of this subsection.

The endurance of a social issues discourse

Although muted, there was nonetheless a social issues discourse (a dominant discourse in junior Health Education) evident in the teachers' talk about senior Health Education. Paul talked about making sure his students were both well prepared for the assessment task and also given opportunities to discuss relevant issues.

Paul was confident enough to isolate the assessment demands: "right you'll need to know this for the assessment" [Paul, 60], teach to make sure his students were in a position to gain the standard, and then get back into the issues based curriculum:

Basically we have a folder of resources for every single topic and in it we have the assessment, and how I go about that is to teach to the assessment to make sure that I've got everything covered. So long as I do the fundamentals of using the resources that we have and familiarise them with the vocabulary and terminology. Sexuality was good because we'd use the photographs and kits and all those sorts of things. So I

make sure firstly that I cover what needs to be covered in order for them to do the assessment all right and once I've done that, we explore other things.

Health's Education's social issues discourse was evident in the Level Two Health Promotion achievement standard⁶⁴ which was taught by Michael and Nicole. This standard assesses the health promotion work students do on a particular issue. For Michael, who taught in a low decile school, it is perhaps an obvious choice, given his espousal of needs based Health Education. The pedagogy associated with the standard also appealed to Nicole who taught in a school where socio-economic conditions were more favourable.

Michael was keen for his students to tackle this achievement standard because he believed it would result in change that would be evident while the participating students were still attending school. The task was set to stimulate student initiative to change something in their school. It required the students to set up a committee, engage with the school community and come up with a plan which they would implement and evaluate. Michael's comments indicated anticipation of student needs and a strong sense of teacher direction:

At the moment in our college we've got programmes for bullying, we've got the Yellow Ribbon campaign [a suicide prevention peer support programme] going as well and I want to look at something like healthy eating in the canteen and I was looking at something to do with rubbish, and maybe smoking. We've got a corner, most of my girls are smokers, so I'm thinking do they want to do something about smoking at school? Something like that, so something relevant for them. [Michael, 138]

Here a social issues discourse is linked with an assessment discourse as Michael tried to address what he considered to be a student health issue through an achievement standard. This attempt was part of Michael's desire to maintain the issues based nature of his senior Health Education programme.

⁶⁴ New Zealand health achievement standard 2.3, AS90328.

Michael looked beyond the achievement of credits to the long term benefits of Health Education courses for his students:

You know we've got some really good results with the students, even though I'm not going to get many if any excellences or merits. To me it's actually been inputting into the students, seeing changes, and they'll reap the rewards and they'll pass, most of them should get an achieve, but you know the important thing is for input into their lives at an early and vulnerable stage. [Michael, 59]

The issues based nature of Health Education was also a priority for Nicole. Although it was easier to respond to her students in the non-assessed senior life skills classes, she indicated that there was still a lot of sharing of personal issues in her classes that were undertaking the NCEA: —In my NCEA classes, huge sharing to the point sometimes where you just think too much, yes overload, I do not want to hear any more thank you" [Nicole, 142].

In this part of the section, a new discourse for Health Education was shown through language use and the way an NCEA discourse appeared to be influencing junior Health Education. There was also evidence, however, that the NCEA discourse was influenced by an enduring Health Education discourse, that of social issues.

The following subsections illustrate the way the NCEA system affected Health Education teaching and learning in senior Health Education classes.

More emphasis on recording knowledge

There was pressure to ensure students had the information they needed for assessment purposes. Interactive and co-operative learning strategies, such as brainstorming and discussions, were still favoured by teachers. There was, however, some concern about the end point of these strategies. Nicole felt there had been too much formative assessment in one of her classes and was worried that her students may not have got the written information they needed:

One of the biggest things actually with my Level Two kids this year would have been I didn't give them enough formal notes or stuff to back it up, because you get into the way of teaching, well there's the interactive approach to teaching. I need to get much better at —here's my objective, here's the reason why I'm doing something" even if it's interactive and then having some back up to that, whether it's five minutes at the end where they write things down, whether it's a learning journal... This year I got to the end of Term One and we hadn't done any formal assessment, anything bar formative. There was certainly no summative assessment. It was a wee bit like —Ogosh, two months gone and what have we done?" [Nicole 65-67]

Nicole's concerns show how there was increasing emphasis on tangible and homogenised outcomes.

Less creativity

Teachers talked about the centrality of assessment and the way they responded to this change in Health Education pedagogy. Some reported that they were less creative than in their junior classes. Here Mary expressed dissatisfaction that time pressures had forced her to use prepared material rather than producing her own assessment tasks:

You realise that —"this is what I will gear my curriculum to, my assessments because there is no time for anything else". So you start thinking of getting stuff off the internet [the examples of assessment tasks for internal assessment] and what I did I, was I ran everything that was available and I look back and question that but I had no time to try to dream up my own, so I had to use them and hope like hell that the kids weren't able to access them on the net but I'm sure some of them have. [Mary, 144-145]

The ability to be creative was part of Mary's perception of herself as a teacher and also part of Nicole's thinking. Like Mary, Nicole felt that the assessment

requirements mitigated against creativity at senior level and suggested that it was hard to be creative in an assessment environment: —don't think I've been creative enough because you've got to get to that end point" [Nicole, 57]. These comments indicate that some teachers were changing their style of teaching in NCEA classes.

One of the hallmarks of junior Health Education (and non NCEA Health Education) discussed in the previous chapter was the use of a wide range of resources. Teachers reported selecting from these according to the needs of their students. In contrast, those who taught senior NCEA Health Education talked about using a small range of resources.

A narrow range of resources

In contrast to the wide range of resources which were used for junior Health Education, only a few resources were talked about for senior Health Education. Another difference was the professional development attached to the senior resources; none was associated with the junior resources.

The key resources talked about by those who were teaching (or who were anticipating teaching) senior Health Education in Years 12 and 13, were *Social Issues: Alcohol* (Tasker & Hipkins, 2002) *Social and Ethical Issues in Sexuality Education* (Tasker, 2004b) and the Beacon Schools resource material. Although all were aimed at the upper levels of the senior school, the Beacon resource was specifically written to fit the achievement standard assessment requirements of the NCEA ⁶⁵.

The importance of the new resources and the Beacon school professional development were mentioned by several teachers. Alana, for example, indicated that not to have access to such resources and professional development would be a significant disadvantage. She recalled going to a course on *Social Issues: Alcohol* and commented that teachers who were not

⁶⁵ The Level Two Beacon resource material was developed in 2003 and the Level Three material was developed in 2004.

able to attend the course and thereby receive the resource would be significantly disadvantaged if they were teaching Levels Two or Three of the NCEA.

Mary, already a champion of senior Health Education, was enthused by a Level Two Beacon course which she had attended. Mary was excited by the senior Health Education content explored at the course and enjoyed engaging with the intellectual challenge it required: —Just the excellence of the programme, the content, you know a huge step up and so it challenged me as it challenged everybody and just new, new work. It's sociology basically" [Mary, 76-77].

The content and approach of *Social Issues: Alcohol* was challenged by Nicole. Although expressing gratitude that at least there was a resource to begin with, Nicole mentioned a tendency for teachers to use the resource as it was, that is, in an uncritical way. Nicole voiced her reservations about the resource. Her criticism centred on the resource's underpinning philosophy and some of the suggested learning strategies. Nicole reported that her criticism was reinforced by a student teacher who had used the resource with one of her senior classes. Nicole had got on well with this student because he was mature, reflective and had a different background (in public health) from most other student teachers. Nicole had agreed with his slightly sceptical take on Health Education and was enthusiastic about the alternative, open ended activities the student had designed for the alcohol topic he was covering:

Some of the activities he did were I guess more not about finding the right answer. You know some of the things in *Social Issues Alcohol* do come to, well, this is the point of view that we would like you to have. His were more about how we could actually challenge that and look at everyone's views and how different people might see things. [Nicole, 98]

The strong classification and framing of senior Health Education through exposure to a few resources and professional development associated with these resources is suggested by this comment.

Teachers presented junior Health Education and non NCEA Health Education as being responsive to student needs. Those who taught senior NCEA Health Education suggested that there were constraining factors in NCEA assessed classes.

Less time to be responsive to student needs

Responsiveness to student needs was considered an important characteristic of Health Education pedagogy. While attempts were still made to address student needs in NCEA classes (for example, Paul in Section 6.2), opportunities for this aspect of teaching were constrained by the time pressures inherent in the NCEA system. Here a senior non-NCEA assessed life skills course is talked about:

Sometimes the kids will come in and they'll have had something that's happened or they'll be like so someone else blah blah. So that's where the lesson goes, what you're going to talk about goes out the window, so can we boot backwards here please and explain about it, and I'm quite happy with that. [Nicole, 208-209]

There was some regret expressed by Anna that Health Education had become preoccupied with assessment and did not meet the real needs of her senior students:

It's so assessment based that it's you know get your notes down quickly, they've got to regurgitate it and you know for an open book, whereas if it was needs based maybe you could really get in and do some stuff. That's a sad thing in health. [Anna, 148].

The pedagogical implications of assessment for senior Health Education were also lamented by Anna: "I'm sad health is achievement based at senior level. It's so important that everybody get it without fear or time wasted on assessment, do you know what I mean there... because it's so assessed"

[Anna, 149]. Again, assessment seemed to be altering how Health Education was taught in the senior school.

The pressure to get through assessments changed learning

The pressure to get through an assessment dominated curriculum meant that there was more passive learning and fewer opportunities to challenge students: —I'm finding that because the work is chunked up and you've got so much to do that you tend to spoon feed the kids instead of challenging them" [Mary, 91].

Michael felt that his students' responses were sometimes not genuine and more framed in the context of achieving the standard:

For me it's more of what's actually happening in their lives. They could write down the right answers and say I believe this and blah, blah, because that's what I've written, but what do they actually believe? And I ask them —~~I~~ "What do you actually believe?" —~~Yah~~ "Yah I do". —Well good but that sounds a bit like what I've told you. You know you need an education to get a good job. Do you actually believe that? What do you believe?" [Michael, 219-220]

For Anna there was a disjuncture between her views on the purpose of Health Education and that of her students:

My purpose in Health Education was to encourage the students but the students' purpose in Health Education a lot of the time was just to gain credits. That was I found quite sad, they're doing it for easy credits. [Anna, 6]

Some teachers' perceptions about the negative effects of NCEA Health Education on students' learning were indicated in this subsection. One teacher, Paul, appeared satisfied with the learning that was taking place in class but disappointed that the quality of this learning was not evident in the assessment tasks. Paul's pragmatic approach to assessment demands meant that, to a

large extent, he had been able to maintain his exploratory and interactive learning strategies. He was pleased with his students' responses in this discussion based environment but expressed disappointment that his students' results for the assessment tasks did not reflect the understanding they displayed in discussion. He conveyed his frustration with the way in which the assessment tasks failed to adequately reflect the nuances and complexities of what was going on in the classroom:

Because we do a lot of discussion they often don't, they know much more, how do I say it, it's much more relaxed so they don't actually do well in the assessment, whereas if you were to sit them down and perhaps ask the questions of them and have a discussion with them, their understanding of it's fine but they just can't translate that into written stuff. It's often they say —I can't sort of explain, in words, on paper how I feel but this is blah, blah". It's that sort of thing so orally speaking they're really good and tease out those ideas and answers but being able to translate that into an answer I guess which is acceptable is quite difficult. I struggled with that a bit but I guess that's the nature of the beast really.
[Paul, 119-120]

In this section the emergence of an NCEA discourse for Health Education was illustrated. The effects of this discourse were shown through language use and in the beginnings of an assessment discourse for junior Health Education. This section also showed that the NCEA discourse was itself influenced by a social issues discourse. The major part of the section was concerned with implications for teaching and learning in classes that were assessed through the NCEA. There was a change in pedagogy when Health Education became assessed by the NCEA. In comparison with the weakly classified and framed junior Health Education, teaching and learning was more strongly classified and framed.

7.4 Chapter summary

The NCEA created a new discourse for Health Education. This chapter has indicated how, in the years immediately following the 2002 implementation of the NCEA, pedagogy was affected by this new discourse. Evidence of this change in pedagogy was provided by the teachers' accounts of their work.

The major part of this chapter discussed the teachers' experiences of learning about the NCEA and what happened when they tried to implement the NCEA in their schools. Significant points relating to professional development were the separation of Physical Education from Health Education, frustration and confusion about the professional development process, and the effects of strong framing on teachers who were being trained to work as regional facilitators.

Implementation issues affected how the teachers conceptualised and taught Health Education. Concerns about the assessment process (such as what type of assessment to offer and perceptions of an increase in academic demands) dominated the discussion. While there were some positive comments about the effects of the NCEA, such as increase in teacher competence, most of the comments showed that the teachers were anxious and uncertain. Despite anxieties about implementing the NCEA, however, teachers were trying very hard to get senior Health Education established in their schools.

Early indications of the effects of the NCEA on teaching and learning in Health Education were also discussed. The language used for NCEA Health Education was dominated by assessment terminology and there was evidence that the NCEA was beginning to affect the teaching of junior Health Education. However, the social issues discourse that is strongly associated with junior Health Education was also present in senior Health Education. The main implication for teaching and learning in classes where senior classes were formally assessed through the NCEA was that an assessment discourse dominated. Teachers therefore had to make compromises between how they

would like to have taught Health Education, with the way they felt they had to teach in order to prepare their students for the NCEA. The overall impression was that teaching and learning in senior NCEA Health Education was different from that of junior Health Education. This change was brought about by the effects of the NCEA pedagogical discourse.

In the next chapter, two further pedagogical discourses important in this study are examined: gender and the emotions of teaching.

Chapter Eight

Health education pedagogy: Gender and emotion

This chapter and the previous two chapters analyse layers of interview data. Chapter Six examined the pedagogical discourse of curriculum and Chapter Seven that of assessment. Chapter Eight addresses two further Health Education pedagogical discourses evident in the interviews: those of gender and emotionality. These discourses bring new dimensions to the study of the way teachers construct and practise Health Education. The chapter is divided into two parts: the first is concerned with an essentialist gender discourse and the second an emotional discourse. The chapter consists of: **8.1 An essentialist gender discourse** and **8.2 Emotionality in Health Education teaching**; and **8.3 Chapter summary**

8.1 An essentialist gender discourse

Introduction

I was into sport twenty four seven and I was drinking and many relationships you know I was a real, probably typical kiwi guy which I didn't like and then I changed so a lot of my students, when they tell me about them I say I was like that, I was actually like you guys but then I changed. [Michael, 99-100]

In this section, the effects of gender discourses on pedagogy is shown as teachers draw on and report deeply embedded ideas of what it means to be

‘female’ and ‘male’. As the choices of subheadings in this section demonstrate, the teachers were operating in a biologically essentialist male/female frame. To illustrate various dimensions of this, data have been presented to show their view of the world. The section is organised using the following headings: Men are generally uncomfortable with Health Education’s aims, The negative impact of men not teaching Health Education, A distinctive male approach to teaching Health Education, Some men teach Health Education better than others, Women are better at expressing their feelings and are more inclusive, Male and female students have different preferences and needs, Gendered organisation and finally, Gender no longer an issue. Unless stated to the contrary, the data are from interviews with the women who participated in the study.

Men are generally uncomfortable with Health Education’s aims

Men were, by and large, thought to lack understanding of Health Education and be unsupportive of its aims. Toni mentioned a number of men who were unsympathetic towards Health Education at the departmental level in her current school and also commented on the lack of support for Health Education amongst the senior management team, particularly the principal. She contrasted this with what she implied was an unusual situation at a previous school, where the male leadership “was very supportive with the health so I thought that was good, the first time I’d seen that which was great” [Toni, 112].

It was suggested men did not understand the aims of Health Education and that the dominance of men in senior management was perhaps the reason why Health Education had a low status in many schools. There was also speculation that what some men in senior management thought was happening in the sexuality aspects of Health Education resulted in discomfort. Mary, for example, mentioned two principals who were uncomfortable about Health Education because of their assumptions about sexuality education:

While [Name] was fantastic to me when I was seeking support, channelled me into health, both he and [Name] I think get a bit nervous about the sexuality component. It’s part of life. Well it’s guys I think, I

mean it's got something to do with, they think we talk about homophobia all the time. [Mary, 111]

Some reservations about Health Education being taught by male Physical Education teachers were expressed, with some male physical educators portrayed as being antagonistic to the aims of Health Education:

There are male PE teachers on the staff that are anti-health. I heard one of them saying the other day –Well you needn't think I'll be teaching this hauora when I'm teaching it" and you know —I dn't know why we have to do that". So they haven't sort of really got that health background on board and they're not that comfortable with it. [Andrea, 24]

The assumption that men did not support Health Education had significant implications for pedagogy. A further assumption evident was that there were disadvantages if males did not teach Health Education.

The negative impact of men not teaching Health Education

Women teachers suggested that the relative rarity of men teaching Health Education had implications for the subject. They were concerned that a male perspective was likely to be missing along with positive male role modelling of the full range of what it means to be healthy (all the dimensions of hauora).

Some women teachers expressed disappointment if no men taught Health Education in their schools as this would result in unrealised potential for the subject and a lack of male role modelling:

Those guys could have been really neat health teachers but they're so busy doing other things that they just haven't got time to get into health and they could have been perfect role models too for the students at this school to be able to see this with teachers. [Judy, 32]

In one school, women teachers had taken up the issue of the men in the Health and Physical Education department not teaching Health Education with their principal. According to Toni, their principal had implied that it was acceptable to have only women teaching Health Education: —At the principal here says either you guys teach health well or get the men to teach it and don't get it taught well but that's upping the workload" [Toni, 27]. The principal's views reinforced the construction of a female Health Education discourse and overrode the effects this might have on pedagogy (and in this case, the additional workload for the women in the department).

If a man did teach Health Education, there was evidence of reaction to this disturbance of the binary discourse. In his initial year of teaching, Paul was given a senior Health Education class. He noted that that there was staff and student interest in his situation as a beginning teacher who taught sexuality education in a predominantly female Year 11 health class:

They thought —"here's a new teacher, not only is he new but he's a male in what is a largely female class", you know I've only got about four or five male students in my class of thirty. [Paul, 40]

The male/female binary operating here was the perception that a male teaching sexuality education to a predominantly female class was unusual.

A distinctive male approach to teaching Health Education

Men were depicted as not being well suited to teaching Health Education because of their interests, dispositions and teaching styles. Some men were reported as having tried to teach Health Education but had given up after a short time as male aspirations did not align with Health Education: —The really is a boys' thing here at school where they're here for their sport and their own development rather than actually looking at the students as such you know, what makes them" [Andrea, 26].

The lack of personal interest in the broader needs of students suggested in this quote was reiterated by other women teachers who felt men teachers tended not to focus on strategies that would enable students to cope: —~~It~~ spending time on helping students develop strategies or how to think about what's this going to do to my life not just this weekend but next weekend and six months time and in a year's time" [Pat, 28].

It was implied that men had a directive style of teaching and were inclined to intervene too early in student discussions and impose their own views on students. Male Physical Education teachers were characterised as being judgemental, imposing their own views and finding it difficult to deal with students making statements they disagreed with.

An example of a prescriptive approach to Health Education by men teachers is given below, where it was reported that a male colleague had found teaching a drug education topic an uncomfortable experience because he wanted to prescribe correct behaviour and was upset by what the students told him:

I know [Name] found that the hardest thing was that you let kids give their viewpoint or discuss things but he'd been horrified with some of the sorts of decisions they'd made and absolutely mortified about some of the things they were doing which he felt was reflecting on him. I suppose he felt dreadful in some of the discussions because he actually couldn't handle it, because he didn't know how to steer them around or ask the right questions then delve into decisions they would make and what actually were the consequences and what other options could they have followed. He found that very difficult and that was just for an alcohol unit but he's probably a little bit black and white. [Liz, 28]

One teacher suggested that there was an element of laziness in men's reluctance to teach Health Education, because it meant personal interaction and also that this connection with students made her male colleagues uneasy because of what the students revealed: —I definitely think they're too lazy sometimes too because you do have to interact with your class and you do find

out some things about kids that maybe you wished they'd never told you, oh my goodness!" [Toni, 37].

A number of women suggested that male teachers were interested in the more concrete or factual aspects of the subject and when teaching topics like drug education, focused on the tangible aspects of the topic such as the chemical composition of various drugs. Jane perceived that her principal, despite having taught Health Education himself, understood Health Education as just about the physical side of health and predominantly a matter of giving students information:

I know he used to teach it but I think he thinks it's a very physical subject. I think that he thinks that it's very much —"Give them the facts" and that's it. This how you should eat, this is how you should wash, this is what a condom is, this is what a relationship is. My impression is that he doesn't really understand about the discussion that can go on and the decisions and the whole hauora, you know the four aspects. I don't think he actually, oh he may, but my impression is that he doesn't really think about it like that. [Jane, 134-136]

There was a feeling amongst the women that men were less comfortable than women with mental health and sexuality education. It was noted that women seemed to be more comfortable teaching sexuality education in coeducational classes and students reacted more favourably to women than men:

I have not seen a male comfortable in teaching sexuality education in a mixed class whereas I think a female manages better. I don't know why, but they just seem to handle it a lot better and the kids seem to accept it better. The boys in the class are often prepared to engage with you because they might embarrass you as a woman but you can get over that and once you've got over that you can actually start doing some stuff that's worthwhile, but when it's a male teacher I don't think the girls can, I think it's probably the girls that can't handle it so well as the boys can

handle a female, the maybe it's the mother figure, I don't know. [Pat, 30-31]

The 'natural affinity' women (particularly mature women) had for Health Education as linked to their maternal experiences by other teachers: —"I find health people, I find there are more late twenties to later age women around who've been mothers, have that motherly instinct and that motherly touch and that's probably why they have an interest in it" [Toni, 93].

Maturity and life experience were talked about as factors which increased the likelihood of a man teaching health well.

Some men teach Health Education better than others

It was suggested that some men were better at teaching Health Education than others because they had a range of life experiences. Men who, for example, had attended single sex schools were perceived as being more protected and less suited to teaching Health Education than men who had attended co-educational schools.

Age and parenting were also suggested as reasons why some men would be better at teaching Health Education than others: a male Physical Education colleague —"would be perfectly capable of doing it" (teaching Health Education) because he had taught Health Education at an earlier stage of his career and because he was —"older" [Mary, 50].

The personal circumstances of the staff who taught Health Education were thought to have affected attitudes towards teaching Health Education:

I think you know if I look at them, the fact that that guy has three children under five, this probably means that his view will be slightly different from the twenty seven year old female who is in another place. [Nicole, 28]

These examples above illustrate assumptions about the effects of life experiences, age and parenting on the ability of men to teach Health Education. In the next subsection, women are portrayed as having a greater capacity for affective communication than men.

Women are better at expressing their feelings and are more inclusive

Women were portrayed as being more open and comfortable with sharing their feelings than men:

Us women will talk about issues and how we feel about things, about certain decisions that are made say in the school and go off and we have chats about that, but [Name] and that didn't actually do that. You just deal with it and gone, that sort of thing. I think that's probably why they wouldn't be as good at teaching health. [Toni, 114]

It was thought that women were better at discussing sensitive health issues and that is why fewer men taught Health Education. This male characteristic' was also evident in classes, and teachers such as Liz were determined to work on ~~erally~~ properly involving the boys in discussion I see as one of my major challenges in every class" [Liz, 32].

It was signalled that Health Education is a more female orientated subject which involves an inclusive leadership style:

In PE you often get more male dominated courses, they tend to control it a little bit more as males tend to do. Of course you find a lot of PE ladies are still quite strong but if you're a young PE teacher you watch the dynamics in the department NCEA days, the males still lead but in health everyone leads, very different because it's all females. I actually think that's because health is more female orientated. [Toni, 94-96]

The binary framing is very clear in this extract with the additional implication that women Physical Education teachers had more attributes associated with being male than women who taught Health Education.

Male and female students have different preferences and needs

The attraction of Health Education for girls was mentioned by some teachers. It was suggested that offering senior Health Education in one school meant that the Health and Physical Education department retained more students in the department. This was because the trend had been for girls to drop Physical Education at senior level and these girls were now opting into Health Education.

It was proposed that the reason why a disproportionate number of girls opted for Health Education in the senior school was related to that the nature of activities which suit girls' who liked such creative activities. Such activities were, however, a disincentive for boys – make a pamphlet, make a pamphlet well you know guys aren't really into pamphlets" [Anna, 8].

In contrast, boys were portrayed as being reluctant to take Health Education although this was something that could be altered: when they take a subject that's not something they'd choose first up but once they are there they enjoy what happens with them in class so it's matter of trying to change that perception" [Judy, 117].

Physical characteristics of boys and girls were mentioned. One teacher speculated that girls were more engaged with Health Education because of the characteristics of the female body:

A lot more goes on with the female body, a perception thing, do you know what I mean, menstruation and breasts and nurturing and breast feeding and all that sort of thing so maybe females have better grip on health than males. [Anna, 11]

Comments about the poor body image of students in a predominantly female Health Education class provided a different perspective on links between female bodies and Health Education:

I'm just trying to get in touch with these mainly girls just to get them to express themselves because a lot of the girls in the class you know like are still wearing jerseys and jackets when it's hot because they're worried about their body image. In the high performance phys ed class basically they all sort of look good, feel good. [Michael, 62]

In this extract there is a suggestion that not all girls are able to express their feelings, particularly when it comes to beliefs and feelings about their bodies. The quotation also reveals a belief in the potential of Physical Education to produce an attractive body and therefore positive self regard.

The idea that boys were happier doing physical activity whereas girls favoured a combination of physical activity and social interaction was evident in a some accounts:

I mean that's who they are, you give them a ball and take them on the basketball court and they're different again, but you see a girl wouldn't be happy to be on the basketball court all day, she would want to sit down and have talk, you know the sort of thing. [Anna, 15]

Some teachers talked about differences in what suited male and female students. Here, an apparent gender difference in the needs of a co-educational classroom is reported:

So the girls mainly ask for contraception information and you know keeping themselves safe information and looking at relationships and what to do when and things like that. The girls want a lot more talky talky, touchy touchy emotional things whereas the boys want the cold hard facts of things. But certainly we need a lot more input with them as to the discussion. [Judy, 151-152]

There was also the notion that unit standards were straight forward in comparison with achievement standards and were particularly suitable for boys: —“you mixed in that unit standard on smoking, it’s cut and dried, it’s factual, we can do this, we can do that. We’re not asking them to explain in detail how they feel” [Anna, 59].

It was reported that engaging boys in junior Health Education classes was demanding. One teacher admitted to avoiding some topics with some classes because —“it ~~was~~ going to be too much of a battle” [Liz, 35], and referred to an occasion when she talked to a teacher trainee about the work being planned. In the course of the discussion she had explained that boys did reasonably well in decision making activities but found it hard to express their feelings. She and the trainee had worked out some visual strategies with the boys’ reluctance in mind. The strategies involved colours and pictures and required the class to respond to these triggers rather than their own experiences. She reported that this technique had worked well with the boys in the class. Liz felt she and the female teacher trainee had a considerable amount in common on this point because the teacher trainee had told her that the men in her Health Education classes at her tertiary institution were also reluctant to talk about their feelings.

Liz mentioned her other attempts to get more affective participation from the boys in her classes. She talked about a game designed to show the transmission of sexually transmitted infections and the emotional and relationship repercussions of having a sexually transmitted infection. She was pleased with this activity because —“I guess it has ripped a few feelings out of some guys” [Liz, 140].

Gendered organisation

The essentialist binary reported above points to the development of male and female pedagogies. At one school, assumptions about gender were the reasons behind a decision to organise junior Health and Physical Education classes on the basis of the biological sex attributed to students.

It has been the most successful thing we've ever done. We've seen a huge improvement in especially the girls, their practical movement, skill wise and also with the boys in health classes they're opening up an awful lot more. [Michael, 51]

The gendered implications here are that boys dominate in physical aspects of the curriculum while girls restrict boys' engagement in Health Education classes.

The male/female binary was reinforced by the NCEA professional development. Although not organised on gendered lines, it was more likely that the men in the Health and Physical Education department would go to the Physical Education professional development and the women to the Health Education professional development. This was the case at Mary's school, where men teachers favoured the Physical Education professional development over Health Education. Their attendance at the Physical Education NCEA courses reinforced the binary of men doing Physical Education and women doing Health Education: "With a lot the new curriculum stuff they were always doing PE when I was doing health and the NCEA days exactly the same" [Mary, 33].

Gender no longer an issue

Given the strength of the essentialist discourse apparent in the data, it was not surprising that one teacher did not consider gender to be an issue. Anna spent some time explaining her confusion about the content requirements and reasons for not liking a gender achievement standard.⁶⁶ She was at a loss to explain the rationale behind the achievement standard because she argued that gender was no longer the issue it had been in the past. She described how the achievement standard is taught from a historical perspective, which for her did not reflect the modern reality of gender roles:

But the gender thing, it was all like it was socially constructed gender so you go along and teach it and this is how it happened and this is the way

⁶⁶ New Zealand Achievement Standard, 2.5 AS90330

back in the war you know and then you put the women back in the kitchen and all that sort of thing and then you're trying to divide a line, male and female behaviour so why are we teaching it and trying to get that point across that it's the naughty males who are going to work and leave the women having babies and cooking meals when she is not. I feel there was a feminist, and that could have pertained to this particular school, but there was an overhang of feminism that really is not that real today as it was say in the seventies and eighties. [Anna, 83-86]

This example of a teacher's thinking shows a lack of understanding about the critique of gender discourses that this achievement standard task was meant to be assessing.

In this first section of the chapter, the significance of gender as a discursive thread in this study has been illustrated. Teachers were simultaneously positioned by gender discourses, while at the same time they positioned others. A dominant discourse was that of essentialism. This theory of gender difference is based on biological arguments which attribute particular physical, mental and emotional qualities to males and females. The fixed nature of this theory is in contrast to theories which suggest that gender is a concept which is fluid because it is influenced by a variety of social processes over time. These examples show how the binary of male in opposition to female works to restrict the development of a range of different ways of being for teachers and students.

In the second section of this chapter, another dimension of Health Education pedagogy is explored – an emotional discourse of teaching.

8.2 Emotionality in Health Education teaching

Introduction

The section is divided into two parts. In the major first part, interview data and commentaries elaborate each of the emotional geographies developed by Hargreaves (2001). The rationale for this approach and its key features were explained in Chapter Five. Focusing on the Hargreaves typology provided a useful framework to acknowledge and explore the emotional side of Health Education teaching.

The purpose of the second part of this section is to highlight the issues which had emotional consequences for the teachers. In this part of the chapter, two examples are used to illustrate the emotional investment and costs of working in Health Education. These were concerned with struggles to establish senior Health Education programmes and the emotional effects of internal school politics.

Emotional geographies

Hargreaves (2001) identified five geographies: sociocultural, professional, political, physical and moral. This typology was particularly illuminative of emotionality data for three dimensions – professional, moral and political – and less so for sociocultural and physical. There is therefore an imbalance in the sections below, with more attention given to professional, moral and political dimensions.

Sociocultural

The use of the term sociocultural in this study is derived from Hargreaves's concept of being close or distant according to ethnicity, social class, culture and physical location. In this study, sociocultural geography was used in its general sense to explore emotionality through the relationships between Health Education teachers and their schools' communities. In this subsection,

emotionality associated with sociocultural geography is discussed through personal connections, shared concern for student welfare, and espoused community values supporting teaching.

Close links with school communities were illustrated in some accounts. One link occurred through either growing up in the same community in which they subsequently taught or one which was very similar.

Empathy with students was implied when teachers and students shared similar experiences.

At a school like this I sort of come back. I come from a similar background as well so I sort of know how they're feeling, what their hurts are, why they're making these decisions, because my life you know I haven't had it all together and I tell them that and so I'm hoping to relate a bit more one on one with them. [Michael, 26-27]

In this extract, the teacher identified with the emotional experiences of his students and talked about the rapport he hoped to be able to establish with them because he shared a similar background.

Communities and schools were brought together through a shared interest in student welfare. Teachers felt supported and encouraged when this happened. Boards of Trustees were in some cases made aware of Health Education's role in addressing community health issues:

[Name] made a presentation to the Board and he did it in such a way that he got them to brainstorm all the issues that face adolescents and then they wrote them all up and they didn't know what he was there to talk about and then he said "Where do we address these in any of our subjects in this school; alcohol, and drugs all that stuff, peer pressure, where, which is the subject which will address these issues for the students, teach them how to handle these situations?" And they said "health" and he said "Why aren't we teaching health?" and that was such

a neat way of saying health is so important it was so simple but I thought so effective. [Toni, 100-102]

In this example, an improvement in community health was linked to the inclusion of Health Education in the school's curriculum and this was affirming for staff. In the following example, teachers reported a sense of security in their teaching because there was explicit articulation of community values underpinning their teaching.

In one school, Health Education was taught in the context of explicit Christian values espoused by the school's community. The sexuality programme at this school therefore took place under the umbrella of Christian Family Life Education (CFLE), which meant that teachers taking the programme all had to be CFLE trained. Teachers reported feeling comfortable with providing information on sexuality because having clearly articulated values made it easier to teach the topic.

Because particularly in this school we take it from a values base. I found [it] much easier to do and I mean you know I'm quite confident about you know talking about all the bits and bobs and all the rest of it because if the purpose behind it is to help students develop the ability to look at their values and other people's values and the effect that is going to have on them, then it's much easier. [Pat, 66]

Teaching sexuality education within a community values framework provided confidence and a sense of common purpose.

In this subsection, sociocultural geography was used to explore emotionality through the relationships between Health Education teachers and their schools' communities. In the next subsection, professional geography is discussed.

Professional

Hargreaves (2001) suggested that there may be tension between the demands of being ‘professional’ and therefore remaining aloof and uninvolved with a ‘caring ethic’ which entails being close to students. In this section, the emotional effects of varying degrees of distance between students and teachers is explored through considering: differences in the ways teachers managed distance, multiple roles, tensions in the ‘safe classroom’ strategy and managing worries about students.

By and large, it was felt important to maintain some sort of distance between teachers and their students when personal issues were raised. An example of a distancing approach is reported below if students reveal something which is an unhealthy choice, such as risky behaviours involving alcohol.

But you can't really let that reflect on you and affect you because it's all about how you steer them to perhaps view it a bit differently next time and that maybe they were just damn lucky this time. [Liz, 38]

Some teachers reported difficulty in maintaining an emotional distance, however, Nicole reflected that she had become better at accepting that students were mature enough to make their own decisions and saw her role reflecting her students' issues but not getting involved: “I think I've come to a point where I'm able to know that they have choices and like I listen, I always listen but I don't take on board their problems” [Nicole, 146].

If personal information was shared, a clear and considered response to students was seen as desirable:

I do think that health teachers, because of the nature of the content, they are quite often given information about the students and things that they need to know how to deal with. I mean I'm not necessarily talking about abuse because I don't think that's an issue [for my students], but other stuff, you know the whole sexual activity and the issues around drugs

and alcohol. I think teachers need to know in their own mind, know how they will deal with it each time. [Mary, 127]

Some teachers used their own life experiences such as decisions they'd made as a young person and the merits of these decisions:

I mean I never had any problems with, I mean I'm quite open. The kids can know just about anything about me, not my family, but about me. I'm quite open about that stuff and if they ask questions most times I'd answer them as well as I could. [Judy, 139]

In this instance, the teacher was quite comfortable with students asking her personal questions.

The teachers' role in making students aware who of they might go to for support, and also to identify students who might benefit from help by people such as public health nurses and guidance counsellors, was mentioned.

If somebody is after help in whatever way they have expressed it within my class and I'm good as an identifier and I'm good as a helper but I think that should go up the chain to a professional after that and I'd say that's for just about everything, it should go up the chain for a professional to deal with. [Liz, 83-84]

In these examples, the balancing act of on the one hand being close to students and on the other managing student issues in a professional way has been indicated.

There was evidence of overlapping roles with several of the teachers and this created some tensions around distance. This was particularly the case for Anna who was both a Health Education teacher and filling in as a part time counsellor in the school. Here she expresses her frustration at the inability of services to deal promptly with a student with a STI problem:

I mean you know I have a boy come to me with an STI you know I want book him into the clinic it's Wednesday, I can't get him in till the next Tuesday, I know he's going out drinking and sexually active on Friday, he's running around with an STI, you know there's a gap in the services. [Anna, 28]

As a counsellor, Anna was working very closely with a student but in a classroom situation, Anna would be working at comparative distance, despite having knowledge of a student's personal circumstances.

There was a role overlap too for teachers who were themselves parents of adolescents. Some teachers felt able to position themselves as both parent and teacher when students approached them with personal problems:

There were times when there were issues and I would say, well, as a parent I would not encourage any of my kids to be involved in sexual activity at your age. You're just too young. I'd say things like that to them and they would also see where I'm coming from as a health teacher. I'd say —“You need to have this information so that you can keep yourself safe”, but as a parent I'd say —“Don't even think about it!” [Judy, 130]

The two discourses drawn on here are conveying different messages: as a teacher she's saying ‘Here's the information’ and implying students are free to come to their own decisions but as a parent she's saying, ‘Don't do it!’

The ideal of ‘safe’ class rooms, in which everyone including the teacher are afforded the opportunity to be honest and to participate freely is off set by teaching norms of ‘boundaries’ and the teacher in charge of regulating these boundaries.

Just where teachers and their traditional authority and professional distance fitted into this was a moot point as it was suggested that teachers should conform to the negotiated guidelines. Nicole talked about how teaching Health

Education had made her aware of such idiosyncrasies and how they sometimes did not match with the ideal of how to teach Health Education.

Maybe the biggest thing too has been trying to role model more and picking myself up on things that I think, I talk the talk, but I don't walk the talk, because once you start getting into Health Education in big way, you can't really let yourself get away with some of the stuff you know in terms of behaviour. I guess apologising or allowing kids to pick me up on things sometimes like when, because I have this flippant sense of humour, allowing kids to say to me... "That was a put down" and you know not having to say "Well, actually cos I'm a teacher dadada". [Nicole, 187-188]

Privileging students' viewpoints could lead to some discomfort, but for Nicole at least, this was seen as being part of a Health Education teacher's role.

You've got to be prepared to let kids challenge you, you've got to be prepared to go places that you might not have been you know a hundred percent comfortable with at times but if you don't you know you're not doing your job. [Nicole, 184]

There was an emotional cost to applying a caring approach and teachers talked about ways to manage distressing student issues. Sharing concerns with colleagues such as guidance counsellors was mentioned as one strategy, and not taking worrying issues home was also talked about.

One teacher seemed to suggest that, in addition to the on-going worry she would expose herself to if she brought issues home, partners like her own who was not a teacher could not be expected to empathise or understand, so it was best not to involve them and leave work issues at work:

Also my partner [Name], he's not a teacher and he doesn't, and he doesn't necessarily understand how schools work and how teachers think a lot of the time and so I quite, I didn't very often talk to him about

stuff because he just didn't understand or get angry you know so there was no point in discussing some, a lot of the stuff with him because he wasn't in the right space to deal with it. I mean he's always a parent he'd never teach it so that's quite different. Yes, you become quite adept at just leaving stuff where it's supposed to be I think, you'd go mad otherwise wouldn't you? [Judy, 135]

In this last extract, the emotional effects of teaching Health Education were shown, along with the way one teacher 'compartmentalised' in order to cope with the emotional demands and the need to protect her home life.

Different degrees of proximity and distance can be traced through the teachers' discourses of caring and professionalism. The dominant discourse was one of caring and being emotionally engaged with students, but there were also strands of a professional discourse which prompted distance and disengagement.

Political

Hargreaves used political geography to expose the emotional effects of power. The overt exercise of power by senior management in schools had a significant emotional impact on teachers. The two main sources of frustration and disappointment were the lack of recognition of the importance of Health Education and the control senior staff had over senior programmes. In this section, one episode is used as an example of the emotional effects of political disempowerment. This presentation is a departure from the rest of the data chapters, where data were summarised and illustrated with a range of quotations. The decision to use data from one interview was because i) it shows how a Health Education teacher's role can be interpreted as involving school and community health and the political implications of this, and ii) because it is a compelling example of the effects of power on a teacher's emotions.

There was one episode that Andrea reported as having had an immense effect upon her both personally and professionally. Andrea spent a good deal of the interview talking about an incident when senior students had been involved in a

serious bullying incident outside of school hours. Andrea had taken a proactive role in the aftermath of the incident because she had been the students' dean and because it was a health related incident which involved bullying and alcohol misuse.

Andrea was very disappointed that her skills and long term association with the students had not prevented the incident from occurring. She was also extremely disappointed with the way the school handled the issue, particularly with the principal and senior staff who viewed the incident as not relevant to the school as it had not happened during school hours.

And the whole thing was terribly dealt with really, really poorly dealt with and most of that was driven by the administration. The statement was, this hasn't been done at school so it's not an issue. [Andrea, 43-44]

Andrea incurred the hostility from senior staff when she sought to get the school and community to look at the health issues revealed in the incident and also when she tried to work with the students involved.

It got to the stage where the principal actually asked me to sign a piece of paper to say that when I went to see the families and the students I wasn't to go on school business, I was just an individual and when I refused to sign that, well... [Andrea, 57]

Her attempts to get the staff to reflect on the implications of the incident were not well received. Andrea had sought professional help and a report was prepared which was intended as, not an attempt to apportion blame, but to look at the way the school functioned in general terms and suggest improvements, a 'where to from now and let's move on' exercise. The 'help' was regarded as hostile as it was considered to be a criticism of the school and the report and professional helpers were rejected by the senior staff.

Andrea was very disappointed at this result as she could see the positive aspects of the critique. —That was very difficult for me to cope with because I

could see that there were some really positive things that could have come of it” [Andrea, 63-64].

In this subsection, the emotional consequences of being overruled have been illustrated. At the time of the interview, Andrea remained bitter because of the way senior staff had distanced the school from the incident and effectively blocked her attempts to use the episode as a platform for analysing and improving community health issues.

In the next section, physical geography is used to show the emotional effects of what were perceived as physical barriers to effective Health Education programmes.

Physical

Hargreaves used physical geography to indicate levels and qualities of physical contact between people. In this study, a lack of time was the physical limitation which affected teachers’ perceptions of their ability to teach Health Education and develop on-going and positive relationships with students. Physical geography was therefore useful in describing the time constraints and the negative emotions this aroused.

Getting enough time to do justice to Health Education was a recurrent theme. In one school, the struggle to implement any sort of Health Education programme in junior classes had been difficult. Toni reflected on the significance of a new staff member who had arrived at the school and began teaching a small amount of Health Education and then — gradually got a bit more health but she had a battle” [Toni, 103].

The struggle to maintain or develop time for Health Education was sometimes associated with political manoeuvrings. Anna reported that there had been increasing pressure from a senior staff member to take Health Education out of the senior timetable:

That had been on-going for years even when [Name] was here going back two years the option teachers were moaning, but I think the climate of the school and personnel involved might have precipitated that because last year he tried to can it and I went to [Name] over it and [Name] reinstated it so it's been a fine line. [Anna, 54]

Various unsatisfactory compromises were described which inevitably involved tensions with other teachers over time allocation. Teachers in schools were pessimistic about establishing the rapport they considered necessary to run effective programmes. In one school, the proposed solution for Health Education was to allocate three weeks (fifteen periods) for Health Education at Year 10 by taking time out of from Mathematics during the year: —So next year they're trying one week out of Maths in the beginning of the middle and one at the end, how it's going to work I've no idea" [Paul, 38-39].

A senior staff member at one school made the suggestion that Year 9 health could be run as a block course and be taught by outsiders. This suggestion was strongly resisted by the Health Education teachers:

As the DP put it to me, we could have a two day time slot and bring people in and I thought yeah, that's just not educating, that's not building relationships, that's not health. [Alana, 40]

Teachers also framed their anxiety over too little time for Health Education within a general concern on the pressure schools were under in order to cope with the continued expansion of the curriculum:

It worries me that in schools there is more and more to teach and there isn't any more time and there's no one saying in order to teach the Arts or Health or what ever we will teach a little less English or Maths or Science so I don't know how schools are going to manage that whole crowded curriculum stuff to use the jargon. I think that's a worry that has to be addressed by someone up there. [Judy, 102]

Jane was aware of competition for resources with other minor subject' teachers at senior level who also saw their subjects as equally as important as hers:

We offer so many, we offer dance, drama, media and all those things as well as and then sort of I've come in with my health and I see it as a very important subject and other staff see it as a minor subject and I think well actually maybe its on a par with yours, a minor subject. [Jane, 146]

Comments were made about the difficulties which had occurred since Health and Physical Education had to work within a shared time allocation in Years 9 and 10. In one instance, the Health Education teachers had won the argument with their HOD about how Health Education time should be organised in the junior school and were pleased with how this system was working, but observed that it was unfair that Physical Education and Health Education had the same time allocation as other core subjects:

So we battled with [Name] about being modular and it's certainly been good but we get less time than other core curriculum subjects. So [Name] has not got the physed time this year that he had last year because he's had to give it to me, for health. You know that's not fair and we don't get as much as Social Studies, so that's an on-going battle for us. [Mary, 126]

In addition to insufficient time, there was uneasiness about the timing of Health Education in relation to student need.

Teachers were concerned about the timing of Health Education because timetable constraints sometimes meant that a programme had to be offered at times which did not match perceived student need.

In one school, Health Education was compulsory at Years 9 and 10 but thereafter the subject was taught in an intermittent way with no Health Education in Year 11 and for Year 12 it was offered in Term Four. Senior students had been surveyed and had indicated they would have preferred the

beginning of the year –when they could talk about issues and rights and responsibilities” [Andrea, 50]. It was felt that the way health was timetabled in Year 12 was unsatisfactory and resulted in superficial coverage:

So by the time you get them [Year 12] in Term Four they’re well set in their ways and it takes a couple of weeks to actually get them on board again and once you’ve got them on board you can start doing some things with them but nothing in depth. [Andrea, 149]

The issue of mistiming was also mentioned in relation to particular times in students’ lives when major health issues emerged:

You see that’s why I think they should be getting more in Year 10, fourteen, fifteen is where they really start the socialising circuit, they’re into the ‘I want to try a drink’ and they’re into their boyfriends and that’s when we’re not delivering and that’s the sad thing. [Anna, 52]

This previous section has focused on the time constraints that distanced teachers from their goals of doing justice to Health Education and building relationships with students. In the next subsection, moral geography is discussed.

Moral

In this study moral geography refers to an alignment of purposes or moral harmony, and the degree to which teachers felt supported in their endeavours. When there is moral agreement, teachers feel supported and are likely to be motivated and enthusiastic. Where they are not, teachers may become dispirited and frustrated. The following examples are used in this subsection: A gap in perceptions about Health Education with colleagues, the effects of feeling supported and valued, student attitudes towards Health Education, and validation and the development of shared purpose through professional development.

While a few teachers in the study spoke appreciatively of the support they had received from senior staff, generally the attitudes of senior management towards Health Education were reported as being lukewarm or, on occasion, hostile.

It was suggested that while those who taught Health Education thought it was an essential part of the school curriculum, senior staff were more concerned with management issues:

We all think it's a great thing that needs to be in the curriculum, that it needs to be happening in the school. Senior management look at it more from a numbers game, say well, numbers are not that high, we don't need it, rather than what are you actually doing? [Paul, 66]

The power wielded by senior management, and particularly the principal, influenced what happened in Health Education. One teacher talked about “the fights” she and another colleague had experienced over Health Education with her current principal and how “they determine what you do with your health” [Toni, 32].

Tensions between classroom practitioners and senior management over the value of Health Education were referred to: “kind of like a them and us” [Paul, 64], and suggested that senior management's views on the subject had developed in a vacuum, remote from the realities of classrooms:

None of them know what goes on in our classrooms because they don't dare go down that end, nor do they come up here. It's all about their perceptions of it, not about what actually happens. [Paul, 65]

Teachers reported frustration with senior management and identified a lack of knowledge as a reason for this problem: “There's a degree of ignorance at the top, they don't really know the purpose of health ed and they don't really want to know” [Nicole, 36]. Nicole also cited the view of a senior staff member at her school who thought that Health Education should be taught by parents: “I know

one of the DPs at school, her view is definitely that that sort of stuff should be taught by parents” [Nicole, 13].

There was a strong feeling that in addition to not understanding the content and breadth of Health Education, senior management also did not understand the implications of Health Education for the school community. Some teachers were clear that their role as health educators extended beyond the classroom. Nicole, for example, was explicit about a wider role available to Health Education teachers because of the nature of the subject, but suggested this holistic sense of the subject was not understood by senior management. She suggested that this concept of Health Education is very complex and engaging with it might be too challenging and unsettling for “people at the top” [Nicole, 5].

I would say in terms of the purpose of Health Education is that Health Education is bigger than the period; Health Education is about your environment and I don't think they [senior management] understand that. I don't think they understand that you have to look at role modelling, really you have to look at the whole environment and all those things related and interrelated and it's quite complex. I don't think they want to look there because it then challenges again. [Nicole, 44-45]

Health issues which were addressed through teaching and the wider school community environment required support for health staff. In the example above, the wider ramifications of health pedagogy were not recognised and or if they were, it was claimed they would be ignored because they were too unsettling.

Distance characterised the moral geography of the teachers in this study but there were also examples of proximity. The majority of these examples involved colleagues who taught Health Education and shared a belief in its importance but there also instances of support from other colleagues.

Individuals who had demonstrated support for Health Education teachers featured in a number of accounts. Of particular significance were senior staff members who had an influential role in the school. Sometimes these supporters

were within the senior staff: —was really really gutted when she left because I thought she was up there with the administration pushing these things” [Andrea, 157].

Senior staff sympathetic to the aims of Health Education were appreciated by teachers. For Jane, respect for others was a foundation principle for Health Education and she was appreciative of what she interpreted as the priority a senior staff member had given to sensitivity towards others when he had spoken to her class about a harassment issue:

And the senior management person, I went in with him and I listened to what he said to the whole class. He said the most important thing you will learn at secondary school is what we call emotional intelligence and it’s how you treat others and how you think about others and how you go about your life and the decisions you make etcetera, and I walked out and I couldn’t believe he’d said that you know. This is a Science, a Physics teacher saying this, and I thought yes, this is excellent. [Jane, 127-128]

Jane was delighted that the same senior staff member shared this view with their principal who had expressed surprise that one of his senior team had supported Jane by speaking to the —whole top Year 10 class” [Jane,132] in this way.

Teachers reported positive emotions when working with colleagues who shared an enthusiasm for Health Education. Even differences of opinion were not necessarily a cause of distress in themselves, as long as there were opportunities to talk about these differences in a supportive environment

Mutual respect for each other’s practice were emphasised in one account, despite differences in approaches to Health Education:

The great thing about our particular department here is that we all support each other and I might be the only one expressing a particular view but the nature of it is that though everyone may not agree with my view, they take it on board and I feel you know comfortable having expressed it and we can move on. I haven't encountered any sort of negativity within the department, only from other staff members really. [Paul, 92]

Although teachers varied in their approaches to Health Education, teachers appeared secure expressing their views.

There was some evidence of a gap between the teachers' perceptions of the value of Health Education and student attitudes towards the subject. While some teachers reported enthusiastic responses to Health Education from students, negative attitudes were also noted. Alana was philosophical about student attitudes towards taking non-academic subjects like Health Education.

So they're not subjects they'd carry on with at university or wherever but then for others they try harder because they really like it. So it's a bit like you've just got to accept that and try not to listen to any of that sort of stuff. [Alana, 20]

Some teachers were irritated by the way some students did not appear to value Health Education:

In a certain health period this kid had a music lesson or sometimes a remedial something session, and I don't mind supporting that but it has irritated me that it's sometimes they've chosen health to miss out on where perhaps it's not viewed as a real subject or it's easy for me or just do it in health because we don't have the same academic homework or something like that. [Liz, 89]

The implication here was that that Health Education did not really count and that missing a class or two was of no consequence.

Student expectations and attitudes to Health Education classes was a problem for some teachers. Paul suggested that the nature of students in his Year 11 Health Education class were a constraint on pedagogy and Nicole noted that the class culture of health was very different from the other subjects, with some students registering surprise that they were expected to work.

The pervasive nature of the idea that Health Education is of less value than other subjects, has been illustrated in these examples of student responses to Health Education.

Professional development was conducive to the development of a shared purpose for a number of teachers. For Jane, there were social and emotional benefits from her attendance at the New Zealand Health Teachers Association's conference in 2003. It was a chance to catch up with other young teachers and she also expressed a sense of excitement and enthusiasm engendered by the event which was absent from her experiences at her school: —“gosh I think it was a general feeling of being around people who were excited, as excited about it as I was” [Jane, 73].

Experienced teachers recalled the inspiration of participating in professional development at different times in their careers. For a number of them, professional development was the beginning of an interest in Health Education. They were stimulated by content which was new and different, learnt from their colleagues, and in some cases there was the impact of the course facilitators.

This impact was evident at an HIV/Aids residential course in the early 1990s, a course identified as —“the real big beginning” of a —passion for Health Education”, [Andrea, 12]. One of the facilitators was described as —“a wonderful, charismatic personality that yes, you sort of feel very affirmed and privileged to know her” [Andrea, 16].

The networking that took place as result of attending Health Education courses was another perceived benefit of professional development. The relationships which were facilitated by professional development functioned to provide

contacts for other things and a sense of collegiality. Several teachers felt that the contacts with other Health Education teachers through the Beacon Schools initiative were as valuable as the content of the sessions.

There was particular significance in the improvement in collegial relationships which took place at one course:

It certainly gave me a better bond with the main person that was working in health at the time because there wasn't a lot between the two of us then and I felt a lot more comfortable around her, because I got to know her basically and was sort of more aware of some of the trials and tribulations that she was experiencing; you get this view that this person is like this and they're sort of 'no go' whereas as it was, our relationship when we got back to school was quite different and I think she was more at ease with me and more prepared to accept me because I was that Science teacher and it was always her view that you didn't teach health unless you were a PE teacher because at the time she was HOD PE.
[Andrea, 19]

Emotionality was explored through moral geography in this subsection. Moral geography refers to an alignment of purposes or moral harmony. Instances of closeness and distance were explored through consideration of the effects on teachers of different perceptions of Health Education, being supported and valued, student attitudes towards Health Education and professional development. The emotional consequences of alignment of priorities and a sense of shared purpose were shown to be conducive to positive emotions; in contrast, negative emotions were evident when there was distance.

The previous section used Hargreaves's (2001) typology to illustrate the emotional effects of proximity and distance over the five geographies. In the final subsection on emotionality, two examples are used to illustrate the emotional investment and costs of working in Health Education. These are the emotional consequences of struggles to establish senior Health Education programmes and the emotional effects of internal school politics. These

examples are not specific to the Hargreaves typology and are therefore considered separately.

The emotional investment of working in Health Education

Struggles to develop senior Health Education programmes

Some teachers in the study saw the NCEA as a way of moving Health Education into the senior school. Getting Level One NCEA Health Education established was an achievement given perceptions about the subject and resource issues. Even if this was achieved, there was no certainty that Level Two or Three would follow. In the following examples, the emotional dimension of these struggles is illustrated through Mary, a very experienced teacher in her sixties, and Jane, a teacher in her early twenties.

The work and emotional energy involved in getting a Level One course into the senior curriculum was significant. Confronting senior management over senior Health Education came at considerable personal cost for Jane, but she had also benefited from the encouragement from other staff members:

There's been times when I've thought, —“this is such hard work”, but in saying that because I have had so much support from other teachers whom I respect as teachers, they've given me their support with the subject so I think —“who cares about the rest of them”. [Jane, 139-140]

Jane felt that her ability to suppress negative emotions had worked to her advantage as other teachers were sympathetic to the hard working and cheerful exterior she projected:

I think they see me as this crazy girl who's coming in trying to make changes and I think there's some support for me personally as well I think because I don't let anyone know that I'm angry about something. I'll just keep smiling and deal with it later and sort of working hard to get what I want with the subject. I don't think they see the frustration at times. I think they see that and admire that. [Jane, 143-144]

Despite support from colleagues, uncertainties about the status of the course remained and Jane felt discouraged as the process was extended. The support of a senior staff member was pivotal in getting approval:

I was a bit disheartened that I had to go to a second curriculum meeting and really push my case and then it wasn't at all clear, I didn't know where the members of the group were and it wasn't until a senior management person said —~~L~~ok, we can't let someone with this much enthusiasm not at least be given the opportunity to offer the course".

[Jane, 94-95]

Gaining approval to run a Level One course did not mean that courses at Level Two and Level Three would be automatic. Even though Level One had finally been approved for the following year, Jane was already anxious about Levels Two and Three. Jane felt that the characteristics of the students attending the school should have made it obvious that a full senior course in Health Education was warranted. She expressed anger that her principal appeared to be making a concession to Health Education and that there would be barriers to getting approval to run courses at Years 12 and 13:

Because I was having to fight for it and I didn't believe I should have to considering who we had at the school, the type of kids and the work I'd put in. I thought —~~h~~w dare you not let me have it" you know, and even just before school finished this year after the course had been approved I had enough students and it's all up and go, the principal said —~~y~~u should be thanking us you know because there are other subjects that are missing out" and I thought Well yes there are but you should be thanking me, look at what the kids need" and I was angry, I was really angry. And then following on from that I was told —~~O~~h you won't be getting Level Two or Three" so right then and there I know that I'm battling every, every time. [Jane, 97-101]

At another school, Mary, a late career teacher, was experiencing similar emotional consequences as she sought to extend Health Education in the

senior school. Already running a Level One course, Mary described her anger and frustration at not being able to offer Level Two Health Education. She had invested time, effort and emotional energy in preparing for a Level Two Health Education course in the anticipation she would be offering the course the following year. Mary was very disappointed when late in the year she was told that Level Two would not run.

She suggested that the reasons her school's curriculum committee had turned down her proposal for the Level Two course were pragmatic and were to do with the anticipated roll growth in the junior school. Mary indicated that the students were very unhappy that Level Two would not be offered; disgruntled students in Mary's Level One class had organised a petition and Mary was keeping this in reserve: —I've got these thirty signatures so that's just sitting at home waiting" [Mary, 81].

For both these teachers, the emotional demands of advocating for Health Education were considerable. Their struggles to achieve a place for Health Education in the senior school were only partially successful and demonstrate the difficulties of the task. Neither teacher was equipped to deal with the complexities of internal school politics. In the final part of this section on the emotionality of teaching, other emotional consequences of political struggles are examined.

The emotional effects of internal school politics

In this subsection the following are considered: the way teachers were affected by other staff members' perceptions about Health Education; the emotional effects of isolation and criticism, and the emotional impact of being involved in what turned out to be controversial Health Education policy development.

The reported perceptions of other staff were not necessarily negative, but the overall impression was generally of understandings about Health Education that were different from those who taught Health Education, and an unsupportive climate for the subject.

A number of teachers reported that Health Education was perceived as an interloper making inroads into academic subject time, and several felt that Health Education was classified as worthless along with non-academic subjects such as employment skills, transition education and work experience: —I think sometimes you almost get a snigger or you know, that's just health, mind you employment skills is seen the same way" [Anna, 75]. Alana felt some staff ranked Health Education alongside other low status subjects like Home Economics and that for these teachers —there's definitely a hierarchy of subjects and health and Home Economics aren't up there" [Alana, 15].

The lack of recognition attached to subjects like Health Education and employment skills was evident to Anna, who stressed the value of learning job skills and the significance to students, but noted that this was not valued by many teachers: —You know employment skills, the greatest success is when one can get a job after going out on a Wednesday but then you'll get the teachers moaning about kids missing their classes" [Anna, 77].

Teachers who worked in isolation were more vulnerable than those who were part of group. The accounts of teachers like Nicole who were not part of such a group in their schools reflected a sense of isolation. Nicole talked about health educators being in the minority in schools and also made the fatalistic assessment that Health Education would always be on the margins: —You know there's always someone in the hierarchy or someone around who's going to be marginalising you. I mean that's the thing with Health Education, often we are marginalised" [Nicole, 14].

Although expressing the intention to put negative feelings associated with feeling left out of decision making processes behind her, Nicole expressed anger and frustration because of some covert criticism from other teachers which led her principal to question her junior Health Education course:

Something that did annoy me was the boss starting to question my junior Health Education programme when someone else had obviously said something to him and that was really frustrating and I think the biggest

frustration is that you know that it has come from somewhere else, but you're never allowed to know from where. [Nicole, 122]

Nicole implied that because Health Education teachers were isolated they can keep on improving their teaching but no one is aware of their effort. Nicole likened the French teacher to herself in that they both lacked collegial support and were conscious that they could always do a better job. Being left to one's own devices could also have a negative impact by encouraging self doubt. Nicole felt that most Health Education teachers she had met were doing well but, like her, were lacking confidence; a confident Health Education teacher was an exception:

Most people you meet that you think do a really good job still question, they say I'm not sure what I'm doing. The times you meet a health ed person actually who is really confident it almost blows you away, like [Name], it's almost intimidating. [Nicole, 233]

Although Anna was less isolated than Nicole (there was one other teacher who shared her enthusiasm for Health Education and who supported her efforts), Anna nevertheless reported feeling isolated and stigmatised. She recalled an occasion when she criticised the way junior Health Education in her school was organised:

I had spoken out in staff briefing and talked about it and of course they just then immediately think you are a feminist on a band wagon; that's how they lump health teachers together, usually a lesbian feminist on a band wagon is how they term it. [Anna, 73]

Newly appointed teachers like Paul and Jane reported experiences where their association with Health Education had caused some negative reactions from other staff. Jane's enthusiasm for Health Education sometimes caused tensions with other teachers. She recalled how she had unintentionally upset colleagues. —It's hard one not realising how they felt about it until I've sort of said something or asked them something and they've snapped back" [Jane, 145].

The impression that teaching Health Education was something to be endured, but hopefully for only a short time, was communicated to Paul. —“For me at the beginning of the year you know other staff members have said health, na na ne na, what do you want to do that for? Or you’ll get out of that in a year’s time and I thought, yeah, okay” [Paul, 10]. He was also the object of staffroom banter about the sexuality education content of the curriculum: —“Paul, what are you teaching in health as a sort of a joke. Oh spending the whole term on sexuality oh, ohhh, you know, that sort of negative feedback” [Paul, 54].

Health issues will inevitably expose different values and beliefs. This can affect those who teach Health Education and are associated with health policies. In addition to the emotional consequences of teaching a low status and marginalised subject, some teachers became involved in very testing situations. Early in her career, Andrea’s association with Health Education had led her to take a key role in reviewing a Board of Trustees policy which concerned the processes involved in dealing with blood at school. Andrea viewed this as a safety policy and was surprised how some staff had reacted:

There was this incredible time, really opened my eyes to some people on the staff when we were looking at the bloods policy, and the Board have got all these policies that they regularly have to review and of course the staff looked at it first and —“Yes that was fine”. It was almost —“For goodness sake this is really important, yes yes yes”. And then it got down to me having to go to the Board with it and getting it approved and the assistant principal arrived and I thought, —“Oh that’s great, he’s really come to support me on this” because at this time I was a relatively young teacher, I didn’t perceive myself as being a senior teacher, and through the whole meeting he pulled apart nearly every single statement on that policy and basically he was, I saw him as a closet homophobic, that he couldn’t come to terms with some of the statements in the policy and it really wasn’t supposed to, it was a safety policy, it wasn’t really a policy of disclosure you know HIV and things, like that but it ended up being that sort of discussion and at the end of the Board meeting I was sent

away to totally rewrite and take some of the insensitive words out of the policy. That was a real shock. [Andrea, 107-110]

The devastating emotional impact on a young teacher of this incident would have had an on-going effect on her confidence and relationships with other staff. It is another example of the potentially high cost of being a Health Education teacher.

8.3 Chapter summary

Health Education teaching is clearly not just shaped by curriculum and assessment discourses; to get closer to the experience of the teachers in this study, other discourses needed to be explored. The discourses of gender and emotionality discussed in this chapter were selected because they emerged from the data as major themes.

Gender discourses revealed social practices that can be attributed to ideas and beliefs about males and females. In these practices, women were portrayed as having a natural affinity for Health Education, particularly its emotional dimensions. Men, on the other hand, were characterised as being less comfortable with the personal aspects of the subject and more attuned to its physical dimensions. In their analysis of gender and its effects on Health Education teaching, the teachers used a biological essentialist analysis. The limitations of this binary approach are examined in the discursive analysis of gender which takes place in Chapter Ten.

The emotional investment and consequences of working in Health Education for some teachers was illustrated in the final part of this chapter. The final data presentation chapter shows how individual teachers' pedagogies negotiated curriculum, sexuality, gender and emotionality.

Chapter Nine

Personal agency of Health Education teachers

The previous three data chapters presented a layered analysis of the interviews. Chapters Six and Seven considered the discourses of curriculum and assessment and Chapter Eight the discourses of gender and emotionality. Chapter Nine shows how individual teachers' pedagogies negotiated curriculum, assessment, sexuality, gender and the emotionality of teaching Health Education. The chapter consists of an introduction and three vignettes that are organised into two subsections: the first subsection explains personal dimensions – the teachers' personal histories, dispositions, values and the second how they exercised pedagogical agency.

9.1 Introduction

The purpose of this chapter is to illustrate individual pedagogical agency of teacher types. Each type exemplifies different life and career histories, values and dispositions. In each of the three types presented, variations in pedagogical agency are considered. These three types are based on the idea of constructed biographies (Connell, 1985). The justification for using this form of data presentation was set out in Section 2.3.

The first vignette illustrates: the opportunities for agency when official Health Education curricula had less influence, how an early career emphasis on Physical Education is modified to include Health Education, the effects of a physical health discourse; the effects of professional development, the effects of personal experiences on pedagogy; the way pedagogical agency was exercised

by health teachers, and the interplay of their agency with that of others – a student, a parent and other teachers.

The second vignette illustrates how personal experiences influenced decisions about teaching Health Education. This vignette also discusses pedagogical agency through a student needs discourse and an alignment of personal values with the curriculum. In the final part of this vignette, an example of collective agency is discussed.

In the third vignette, teachers' personal experiences are again shown to be important influences on pedagogical choices. The teachers' agency in Health Education pedagogy is represented by different positioning in relation to colleagues, foregrounding student views, encouraging student participation, teaching as facilitation, and taking risks in sexuality education.

9.2 Olive Sutherland and Rosie Albert

Personal dimensions

This subsection introduces the teachers and then explains the common themes that linked their life and career experiences. The commonalities were: An early emphasis on Physical Education, the influence of a physical health discourse, personal experiences which influenced decisions about teaching Health Education, personal development through teaching Health Education, and career development through professional development.

Olive and Rosie taught Health and Physical Education in a state (public) coeducational school in an affluent area of a provincial city. Olive taught a mixture of senior and junior Health Education and Physical Educational junior level. Rosie taught Physical Education to Year 13 and junior Health Education.

Olive was in her early sixties and Rosie was in her late twenties. Olive's career spanned two Health Education curriculum documents, the 1985 syllabus and the 1999 curriculum. She also remembered implementing assessment regimes prior to the National Certificate of Educational Achievement (NCEA) and, like Rosie, had participated as a student in other assessment systems.

Working within the broad non prescriptive climate of the 1980s, Olive and a colleague had developed a Health Education programme based on what they perceived to be the needs of their students. Olive was aware of the 1985 syllabus but did not give the impression that she had consciously implemented its provisions. She was aware there was some sort of official curriculum in existence, but —~~certa~~ly no curriculum that was ever put in your face to deal with”.

Olive was a little irritated when the effects of the 1999 curriculum became apparent in her school. It was at this stage that Health Education became a —~~curriculum~~ issue”, something that was driven from the top and had to be dealt with. Olive's unofficial curriculum —~~the~~ booklet that was all there was, the bible you taught from”, was sidelined as the implications of the new learning area emerged.

Early emphasis on Physical Education

Neither Olive nor Rosie had set out to become Health Education teachers. Olive had a Science and Physical Education background and had trained as a Physical Education teacher. Rosie had enrolled in a Physical Education teacher training course in the in the late 1990s, and during the course became conscious of the expectation she would teach Health Education as well as Physical Education.

Their secondary schooling had also emphasised Physical Education. Olive had enjoyed Physical Education as a student but could not recall being taught anything she could identify as Health Education. Rosie had also enjoyed Physical Education as a high school student and recalled some junior Health Education classes when she had been —~~the~~en out of Physical Education to do

Health". She noted a lack of continuity in these classes: —~~w~~ always had to go to the drama room, it was always kind of one offs".

The influence of a physical health discourse

Olive and Rosie were both influenced by a dominant discourse in Health Education, that of physical health. The emphasis on physical health was obvious to Olive when she began teaching Physical Education and Health Education in the 1970s. Health Education for Olive at this time was concerned with looking after yourself by eating well, keeping clean, understanding the way your body worked and preventing illness: —~~e~~ry much hygiene, absence of disease type stuff".

Olive suggested that at the time of the introduction of the 1999 curriculum many people still thought of Health Education as focused on physical health: —~~th~~ prevention of scabies and nits and all that sort of stuff" and not as she saw it, —~~th~~evelopment of the whole person". Olive likened Health Education to extra curricular activities in that it gave her an appreciation of a different side of students and suggested that the subject presented an opportunity akin to the holistic approach afforded primary school teachers.

Personal experiences which influence decisions about teaching Health Education

Personal experiences influenced decisions about teaching Health Education particularly in Rosie's case when an episode in her tertiary education made her question her suitability to teach Health Education for a number of years.

Rosie recollected the sexuality education class which had a profound effect upon her. At the time of the class, Rosie was going through a personal trauma and felt vulnerable. The lecturer noted Rosie's reaction and challenged her to confront this trauma. An on-going effect of this episode was that Rosie felt she had to work through her personal issues before she could teach sexuality education:

She bailed me up and told me I wouldn't be able to teach health until I

dealt with my issues and I blew it, it put me off health. I wasn't interested in health in those first few years because I thought yes, I've got issues, that was really raw and she said you can't be a health teacher pretty much to me, you know you've got to deal with your issues first, your issues to do with sexuality.

Rosie began teaching Health Education in addition to Physical Education some years into her career when she began to get "a bit bored with teaching Physical Education" and a sporting injury had limited her physical activity for a period of time. A further factor in Rosie's developing interest in Health Education was the prevalence of student health problems in the school she was working in at this time. Although she did not say so, the implication was also that she had come to terms with her past.

Age had strengthened Olive's realisation that teaching Health Education was the right career choice. Olive had suffered two debilitating illnesses during her teaching career, one in her early in her career and the second more recently. She considered herself very fortunate to have got over both illnesses and felt she had developed personal coping strategies because of them. The first illness had also attracted the attention of her principal at that time. This principal had suggested that Olive consider moving into Health Education. His rationale was that the classroom based nature of Health Education would be more conducive to rebuilding her health than the physical demands of Physical Education.

Personal development through teaching Health Education

Health Education was perceived by Rosie and Olive as having benefits for those who teach it that were beyond the satisfaction of feeling that student needs are being met. Rosie talked about the skills that Health Education teachers could apply to their own lives:

Many health teachers use it as a way of counselling themselves in some ways to remind them of how to live and strategies to use, because I find what's really good about it if something happens in my life I've got the coping strategies that I'm teaching every day right in front of me.

Both teachers spoke of the impact of Health Education professional development on teachers as they made links between the subject, self knowledge and a developing philosophy. Olive expressed the view that personal development was inevitable for anyone working in Health Education:

All the time you're developing a philosophy, a continuous growing philosophy the whole time, you learn about yourself when you go to a new health course, you apply it to yourself first don't you and then you go in and think how does this apply to the students?

Professional development was also reported to have had beneficial effects for their professional growth.

Career development through professional development

Olive and Rosie had both become more confident about their understandings of Health Education through professional development. For Rosie, a Ministry of Education contract in mental health was —a huge learning curve” and one which further developed her career as a Health Education teacher.

The mere fact of being asked to take on a leadership role has the potential to increase teachers' confidence. Olive had become well known amongst other Health Education teachers in her area as a knowledgeable teacher and her advice and experience were in demand. This acknowledgement of her expertise gave her a feeling of competence and growing sense of self worth. It made her realise that she —had a contribution to make and that maybe it wasn't just everyone else that had all the answers”.

Olive also noted that the skills she had learnt in Health Education professional development courses during the 1980s and 1990s were —absolutely invaluable” because they improved her teaching skills, particularly in group work and cooperative learning strategies, and were also very useful when she began to take on pastoral care roles.

In this subsection Olive and Rosie were introduced and the following relevant personal dimensions considered: they had begun their careers as Physical Education teachers but had subsequently developed an unanticipated enthusiasm for teaching Health Education; personal circumstances had influenced their decisions to teach Health Education and both had benefited personally and professionally from participation in professional development.

In the next part of this section, pedagogical agency is discussed.

Exercising agency in Health Education

This subsection shows how Rosie and Olive exercised pedagogical agency through guiding student decision making, teaching sexuality education, and basing teaching decisions on personal experiences. It also illustrates how their agency interacted with the agency of others – a student, a parent and other staff. This interaction was exemplified by: student agency and sexuality education, parent agency and sexuality education, and limiting agency through a heterosexual discourse.

Guiding students' decision making

Olive and Rosie expressed the view that students had the right to make their own decisions but they also exercised guidance, particularly Olive.

Rosie emphasised the importance of her students' perception of her non judgemental role in providing students with information to enhance their resistance to peer pressure. Implicit in her account, however, is the hope that students will make choices consistent with a rational decision making process rather than one based on social pressure:

I'm always telling students that I'm not here to do that [judge them] that I'm here to give them as much information as I can so that they can be responsible for their own health choices and that they know they can make informed choices rather than just going on the back foot or the knee jerk reaction – I'll do this because everyone else is.

Olive was less ambivalent about letting students know where she stood than Rosie. Olive felt secure about how she went about this because of her experience and relationship with the students. In this extract she hints that her approach is not official Health Education discourse:

I have been teaching for a wee while now and I'm quite comfortable with where I am in terms of health teaching. I have no problem telling kids I think this is wrong and this is right and this is what you should do or you shouldn't do, which is not what we are necessarily led to believe we should do but I have no problem doing that. I had no problem doing that because of the relationship I had with the kids at the school.

Teaching sexuality education

Olive and Rosie reported that they enjoyed teaching sexuality education and gave examples of their teaching strategies. Olive was vigorous in her description of how positive she felt about imparting valuable information in sexuality education:

I enjoy it. I feel good about it, oh it's so damn rewarding. I mean you talk about some of the stuff in the sexuality module and you're telling people how it is with unprotected sex and STIs and contraception and their eyes hang out of their heads.

Rosie talked about the affirming student reactions she got when she taught sexuality education: —get some incredible respect from the students once we start teaching relationships and sexuality education and things change in the class as a whole”.

Teaching styles described varied according to their personalities and perceived needs of their students. Admitting that at the start of her teaching career she would not have thought she would ever be enthusiastic about teaching sexuality education, Olive now professed enjoyment with her more recent experiences:

Sex, I always used to joke with people that you know, sexuality education is the only unit you know that you're going to get full and total attention and it's a lot of fun, and you get a lot of fun out of it as well as them.

Olive tried to make social issues authentic for her students by providing activities which linked the outside world to the personal realm. Here she describes how she locates sexual health statistics from the school's provincial setting in interactive strategies such as role plays, to show how teenage pregnancy might affect someone at an individual level:

I've said okay, how do you feel about being a father? And you get some amazing answers because it's not actually them but it's being able to talk about what their role has been and saying —Okay you're pregnant, you're going to have a baby. How is it going to change your life? What are you going to do?"

Olive's perceptions of an inadequate sexuality education programme at the high school's contributing intermediate school meant that her programme went right back to the basics, —doing tampons and pads and that sort of thing". Her down to earth approach was represented in her recount of a recent sexuality education module: —I got kids in Year 10 who don't know anything so last time I started doing sexuality and I remember sitting on the desk and I said Okay kids, what do you want to know?"

The teaching approaches described above reflected the teachers' sense that they could be responsive to student needs and wider social issues.

Basing teaching decisions on personal experiences

Olive and Rosie believed that life experiences and maturity were significant predictors of becoming effective Health Education teachers and their approaches to sexuality education drew on personal discourses.

Olive's experience of difficulties with carrying babies to full term had a direct influence on the way she taught Health Education. She explained how this personal heartbreak had made her stress the importance of supportive relationships in her classes:

Something that made me really think about the importance of health is really to do with my family. I had an enormous number of miscarriages before I managed to have a child, in fact it happened about ten times and I've only got two children to show for it and it really reinforced for me that our families, belonging, support, all that network, how important it was. So I always with students spend a lot of time talking about friendships support and the family. So I hope the little darlings can go home with a slightly different view of their parents. I think that has been effective and that's probably something that really has brought home to me just how important that is so I don't apologise for thrashing that slightly in some of my classes just to really get them thinking about it if nothing else.

Here pedagogical agency is exemplified by Rosie's inclusion of her knowledge of the importance of supportive relationships in her Health Education teaching.

Student agency and sexuality education

Students also exhibited agency in sexuality education, as in the activity described by below. Olive had been explaining an activity in which students used a visual prompt (a body shape) to explore different aspects of what it meant to be healthy. She explained what happened:

You know I can still remember from that activity one boy who was, I can't remember where he put the arrows now, but he had written down —No. Tell your father off". I've never forgotten that. Just from doing that activity. It was amazing but yes, it brings back quite a few memories. Quite emotional.

In this example, a student had felt able to communicate a worrying personal situation. This episode also illustrates the emotionality of Health Education pedagogy.

Parent agency and sexuality education

Olive and Rosie both felt that, by and large, parents were happy with the sexuality education their children were receiving. Parental criticism did, however, have the potential to constrain sexuality education pedagogy. Sometimes this criticism was unexpected. Rosie, for example, was surprised that a parent had objected to a game called Body Bingo which she had used in class as an aid to memorising the reproductive parts of the body and as a “—b!b! a filler” at the end of a lesson:

I got a letter from a parent saying how she was really disappointed that I'd trivialised such an important aspect of the teaching content and I was quite gob smacked because there wasn't any attempt to trivialise it, it was just a fun way to get those kids to remember the correct anatomical names.

Olive was very positive about a recent community consultation meeting despite nervousness about the topic (sexuality education) and the size of the meeting – some eighty parents. There was, however, one upsetting incident which Rosie recounted. The episode involved a parent, described by Rosie as a “religious zealot”, who had aired her concerns.

The parent's concerns related to Rosie's use of an HIV/AIDS video in a Year 9 class. The use of this video evoked an irate parental response. Rosie explained that in a break with her usual practise she had not viewed a video in its entirety and she also had not realised that the daughter of the “problematic” parent was in the class. The video had featured a transvestite and in response to a question, Rosie had explained what a transvestite was.

The daughter of the parent Rosie had identified as problematic had gone home and reported the transvestite discussion to her mother with predictable consequences:

Mum just went through the roof on how I was promoting the fact that (well it's actually a fact that there are transvestites in our society) and that's really all I answered, I hadn't been promoting it as an option or something for people and she wasn't even willing to accept that there were people like that, oh not at all.

The conflict which had begun at the consultation meeting was eventually handed over to the principal, who wrote a letter to the parent:

She kept going at it from there, wrote a letter to the paper, sex is a dirty word, one of those. You're never, never going to win so in the end I said to [Name] —“Ok, she's all yours and you can have her, she's not listening to me” and he wrote her a letter and said that everything that she was arguing against is in the curriculum, end of story.

Rosie argued that Health Education was different to other school subjects because people other than teachers thought they knew best. The parent who spoke at the consultation meeting, for example, had not offered to teach the Mathematics or Physical Education curriculum, but “feels the need to have an input in the health curriculum and it's always to do with the sex education of course”.

In the episode recounted above, a parent attempted to exercise agency through challenging an aspect of Rosie's sexuality education programme. This agency was situated in a community consultation discourse which legitimates the right of parents to dispute the curriculum and also withdraw their child from sexuality programmes.

Limiting agency through a heterosexual discourse

In this illustration of the role of agency in Health Education pedagogy, the effects of a heterosexual discourse are evident. Early in her career, Rosie had been employed at a girls' school where Health Education was taught by health specialists who were not part of the Physical Education department. She described how a proposal to enable more Health Education to be taught through the Physical Education department, had not eventuated. It had been proposed that teachers in the Physical Education department should teach a Year 10 sexuality education programme. The proposal was withdrawn because two of the Physical Education teachers were known to be lesbians. Rosie explained that at a meeting to discuss whether the Physical Education department should teach sexuality education, it emerged that it would be unsafe for the teachers:

It wasn't safe to be teaching it and the girls were quite cruel, some of the girls to them, and would put them in a terribly awkward position. That sort of age group, that Year 10 fourth form girl can be very, very unpleasant and inappropriate and it's not even what they say really, it's just the look you might get. Like they wouldn't outwardly say anything but it would have just put these people in a very difficult situation, a very unpleasant situation to be involved in.

The issue was discussed with the principal and it was decided that aspects of sexuality education would instead be put into the Year 10 Science programme. In this example, the agency of the Physical Education teachers was proscribed by the operation of a heterosexual discourse. As a result, sexuality was taught within another subject, presumably by teachers who were not known to be lesbians.

This subsection has illustrated how Rosie and Olive exercised pedagogical agency through: guiding student decision making, teaching sexuality education and basing teaching decisions on personal experiences. It has also been shown how their agency interacted with the agency of others – a student, parents and other staff. This interaction was exemplified by learning sexuality education,

disputing sexuality education, and limiting agency through a heterosexual discourse.

The first vignette illustrated a Physical Education discourse, the way Health Education developed when official health curricula had less influence, the effects of professional development, the effects of personal experiences on pedagogy, the way pedagogical agency was exercised by Health Education teachers, and the interplay of their agency with that of others. In the second vignette, a second teacher type is used to exemplify variation in agency and is discussed in relation to data themes.

9.3 Phil Blackett

Personal dimensions

Phil held a senior position in a state coeducational school. The school was situated in a poor area of a city and a high proportion of its students were socially and economically disadvantaged. Phil was in his mid thirties and had left a career in the armed forces to train as a Physical Education teacher. An anticipation that he would “only be teaching phys ed” was dispelled when he discovered that Health Education was part of his teacher education course. In common with Rosie, he was introduced to Health Education through the 1999 curriculum.

Phil’s Health Education pedagogy was strongly influenced by his life experiences. He was determined to be a positive influence in his students’ lives and found that Health Education provided opportunities for this to happen.

Personal experiences which influenced decisions about teaching Health

Phil had embraced the opportunity to teach Health Education because he could locate the effects of a family crisis in Health Education. Phil had been sensitised to the importance of family after the birth of a “special needs” baby. The first two

years of his child's life were very difficult with managing the baby's needs and frequent travelling to another city for medical treatment. He believed this event made his family stronger and also reinforced his belief in the importance of family.

Phil stressed family values in his classes:

Love your Mum and Dad because they were put on earth to bring you up and even though there's some hard stuff you go through you still need to respect them; doesn't mean you need to do what they say but you do need to listen to them.

Phil's experiences and the values associated with these experiences had led him to believe that Health Education was valuable because it had direct relevance to his students' everyday lives: —I like it because it actually feels as though you're giving them some really good life skills". He was very pleased, for example, that after teaching an alcohol education topic a student reported to him that she had helped her comatose friend:

You know one girl came in on a Monday, —Oh Mr Blackett, you know I really did what you told us to do on Friday" (it was Year 10 health, we'd done alcohol). —You know my friend was comaed' out and I didn't leave her on her own". So that's one thing that was taken on board.

Health Education legitimated a pedagogy which was informed by Phil's values and beliefs about life. The strength of his convictions conveyed a strong sense of agency. In the next part of this section, Phil's pedagogical agency is discussed.

Exercising agency in Health Education

This subsection illustrates pedagogical agency through a consideration of the following: the foregrounding of student needs, and the alignment of personal

values with the curriculum. In the final part of this vignette, an example of collective agency involving Phil's colleagues is discussed.

Foregrounding student needs

Pedagogic agency was based on a student needs discourse. Phil was pleased that students —at risk both in their personal life and as well as where they are going educationally” were taking Health Education. Phil enjoyed the freedom afforded by Health Education to work on what he perceived to be student needs. He felt the subject gave him latitude and independence to develop appropriate classroom programmes without anyone —looking over my shoulder saying “No, you can't do this and that”.

One aspect of the students' lives at school which he had become aware of was poor interpersonal relationships. He spoke of the negativity of students towards each other in one of his classes but could see gradual improvement, a —“friendliness there”, which he hoped would lead to a —“really close” class by the end of the year.

Phil indicated that his student's personal lives were often a starting point for the content of the lesson:

We're only six weeks into it [the first term] and they're starting to share little bits, I mean these are hard kids and like some of their stories are, ...yeah. So I get most things fried up through that.

Phil qualified his account of what was shared in classes where openness was valued by explaining that —“really intimate personal stuff” was not talked about because that would be —“inappropriate”. Phil also implied that while nothing was off limits for him, he had boundaries for his students and distinguished between what he expected of himself from his students.

Community health issues which were of particular concern to Phil and his Health Education colleagues were the high rates of teenage pregnancies and STIs (sexually transmitted infections). Teachers were concerned that their

students had little knowledge about STIs and contraception: —Ad it's such a big thing about the STIs and the contraception and they know so little when they come in here, they don't even know the word contraception though they might talk about the jab”.

Another problem was the range of experiences represented by students and how this should be addressed: —We don't only have thirteen year old girls pregnant, we have thirteen year old girls still asking why boys don't have periods, why can't they have babies”.

Sometimes student needs were not able to be acknowledged and this caused some disquiet for Phil. He recounted one situation where he might have handled things differently if he had known before a lesson on contraception that one of his students was pregnant. He was not sure what he would do another time to anticipate a similar situation, for as he said: —she didn't let me know she was pregnant before the lesson and it's not something that springs to mind that you need a sort of disclaimer at the start of the lesson: Now if any of you girls are pregnant we're going to talk about contraception and decision making”. Agency which is grounded in a needs based pedagogy is illustrated in this example. The episode also serves to emphasise the emotionality of teaching Health Education.

The alignment of personal values with the curriculum

Phil's sense of agency was supported by his understanding of the 1999 curriculum's philosophy. He often referred to hauora, the well-being philosophy underpinning the curriculum document, and discussed to the way this —opened up people”.

It was evident that the curriculum provided an official platform for his views rather than a blueprint to be followed. He believed, for example that the curriculum endorsed his conviction that teaching sexuality education would encourage the postponement of first sexual experience and that the abstinence option was something that could be promoted.

Phil alluded to his Christian convictions and while maintaining that he did not seek to impose his values on to his students, he indicated that the spiritual dimension of the 1999 curriculum permits God to come into the frame of choice for students. Here he talks about his role in helping students in their choices:

My mission in life is just to make people to be what they're meant to be and if that means choosing God that's up to them. We'll leave it to them, it's up to them. I know it's for me and yes I don't push anything, if you push anything, that just gets you into trouble and that's a bit too controversial.

Another element of the curriculum which supported Phil's sense of agency was the underlying concept of —attitudes and values". Phil stressed the importance of getting his students to scrutinise their values and decide whether there was a match between their espoused values and their behaviours, and if there was a mismatch, to identify if inconsistency would cause inner strife. He pointed out that other teachers in his school shared his values based approach, even if they came from a different values perspective. There was one issue which had united Health Education teachers on Phil's staff – posters advertising the Emergency Contraceptive Pill (ECP) which had recently arrived at their school. This issue is an example of the collective agency of the Health Education teachers in Phil's school, and is discussed in the last part of this section.

Collective agency

The ECP posters had not been requested by the teachers. Phil though they had arrived at the school as result of an initiative involving the school's public health nurse, the regional health board and the Family Planning Association. The teachers were opposed to displaying the posters and outlined their reasons for not doing so. Their response to this poster provides an example of teacher agency based on values and beliefs about sexuality education.

Phil reported that he and his colleagues were angry that the information on the posters gave the impression that the ECP was not a form of termination: ~~What~~

really irritates us the most about it is the fact that you could say that it's not a termination but we view it as a chemical termination, it's not surgery okay but it is a termination".

Phil and his colleagues accepted that teaching about contraception was part of their role but they objected to the prescriptive tone of the posters. Phil conceded that students needed to know about the ECP but he was adamant that the publicity was giving the wrong message to their students, one that discouraged responsible decision making, offered an easy way out, and didn't draw attention to the ECP's shortcomings. He explained that while they did not want to conceal information about the ECP in their lessons on contraception, they were also adamant that they did not want to promote it as a contraception option:

I see it as telling kids it's alright to have unprotected sex and then you just take this you'll be fine. That's high level dosage of hormones in those pills and it's unprotected sex that doesn't stop STIs.

Phil contrasted Health Education's holistic approach with the "biological approach" which he identified with the public health nurse who saw it "more from a biological perspective not the whole person perspective of education".

The ECP material also prompted an articulation of the claim that Health Education was about presenting students with accurate information and encouraging students to make informed choices. Phil thought that the material undermined this teaching approach by making assumptions about students' ability to make choices and offering easy solutions that might be perceived as a temptation to be careless and rely on the ECP:

It sticks in my gut, the fact that they're promoting this as the ambulance at the bottom of the hill and I think we're the ambulance at the top of the hill so morally I disagree with it so the poster is going to sit on my desk and I'm not going to put it up on the wall. I just don't like the philosophy behind it. It's giving up on kids, saying "Well you're stupid you're going to have unprotected sex because you can't make decent decisions for

yourself so here you are, we'll make it easy for you, you can hop into the chemist and buy it yourself", so I think it's terrible.

The decision not to use the ECP material is an example of collective agency. The teachers' decision was the consequence of deeply held values and beliefs about sexuality and education.

The second vignette has illustrated how personal experiences influenced decisions about teaching Health Education. This vignette also discussed pedagogical agency through a student needs discourse and an alignment of personal values with the curriculum. In the final part of this vignette, an example of collective agency was discussed.

In the final vignette, a third teacher type is used to exemplify variation in agency and is discussed in relation to data themes.

9.4 Chris White and Isobel Sanders

Personal dimensions

Chris and Isobel had different educational backgrounds but shared a liberal perspective and were both prepared to confront inequalities and injustice in their schools and communities. Chris was the staff representative on her school's Board of Trustees, a position which gave her the opportunity to scrutinise decisions which might disadvantage Health Education; hopefully she —~~could~~ keep them honest". Isobel was active in community issues and an outspoken critic of the lack of a comprehensive approach to bullying in her school.

Chris had completed a Physical Education qualification and then trained to be a Physical Education teacher. Now in her mid forties, she remained keen on sport and coached a number of school teams. She had been in her current position at a high decile coeducational school located in a provincial town for

eleven years. Chris specialised in Health Education from Year 9 through to Year 13 and no longer taught Physical Education. Chris's decision to concentrate on Health Education suited the school's Physical Education teachers who preferred teaching Physical Education and if they taught Health Education, did so at the junior level.

Isobel, a young teacher with a humanities degree which included some psychology and sociology papers, had been advised to take a Health Education minor in her teacher education course. Isobel had not expected to teach any Health Education but was given a senior Health Education class in her first year of teaching at a low decile city school. Teachers in other subject areas indicated to Isobel that this was not something she would have to endure for long: —They said things like, don't worry you'll be out of it by next year".

Isobel had assumed that teaching Health Education would be relatively straightforward as she had thought it was simply a matter of giving her students accurate information, —very black and white", and leaving them to make up their minds about how this information would affect their lives. The sexuality topic she taught was more complex and contentious than she had anticipated, but also proved to be the most enjoyable topic she taught during the year.

Personal experiences were influential in the way Chris and Isobel approached their teaching. Chris talked about the significance of her own experiences in relation to her views on issues like homosexuality:

I think that often depends hugely depends on your own experiences and even I mean things like homosexuality, I've never found it confronting at all for me. I played cricket with women, a large percentage of whom were lesbians and it didn't worry me at all.

Isobel emphasised the effect of different life experiences on teachers' perceptions of Health Education. She acknowledged how in her case, teaching had been influenced by her sexual orientation:

I guess with my own sexuality, it's a huge driving force behind me wanting to make sure that the students in the class are aware of others' feelings and that they don't just look at everybody as being the same as them, and that when they talk to each other and they talk to me or anybody they consider that the person to be someone who is an individual.

In this subsection Chris and Isobel were introduced and their liberal and political inclinations signalled. In the next part of this section, pedagogical agency is discussed.

Exercising agency in Health Education

This subsection shows how Chris and Isobel positioned themselves in relation to Health Education pedagogy. Their agency is discussed through consideration of: different positioning in relation to colleagues, foregrounding student views, encouraging student participation, teaching as facilitation, and taking risks in sexuality education.

Different positioning in relation to colleagues

Chris and Isobel articulated an approach to Health Education which was at variance with their colleagues in their respective schools. Their approaches drew on liberal discourses and personal experiences.

Chris noted that some of her colleagues in her Health and Physical Education department were not as adventurous as she was: —There's a lot of them who wouldn't feel as comfortable as I would and really going into no man's land because they feel a lot safer if they've got — this is what I want to teach and this is the answer”.

Isobel also positioned herself differently from other Health Education teachers at her school. She indicated that not all teachers had the same student centred priorities and she was concerned that in some classes, the teacher's opinion dominated and all viewpoints were not encouraged. Isobel alluded to her own

liberal beliefs, implying that her colleagues were not coming from the same perspective:

I think we are a bit varied in our department about what exactly is the purpose, is it to inform and educate or is it to tell them things, say alcohol is bad, or taking drugs, don't do it sort of thing. There are some people I feel in the department who have a different take on that, whereas they think we should be sending home a negative sort of image that all drugs are bad therefore don't take any of them, my particular take on that is well, I see it as my role to present the information, for example on smoking, but at the end of the day, if the students still want to smoke well that's their choice and I think that's because my sort of liberal approach to things comes through there. That's the defining view point really.

In these extracts, Chris and Isobel talked about teaching approaches that they perceived as being different from those of their colleagues. This perception of difference and confidence in their own approach illustrates their agency. In the next subsections, further examples of their agency are given.

Foregrounding student views

Isobel and Chris talked about the significant role students had in their classes, with Isobel reflecting on the notion of what is meant by resources and the effects of sharing the knowledge students brought with them into classes:

Talking about resources, yes we have resources but you know there're thirty kids around here who are all a resource in themselves. We all come from different backgrounds and have different morals and values and that sort of bouncing off everyone creates a good environment.

Chris acknowledged the contribution students made to her learning when they challenge her to see things from their point of view:

I've learnt a lot from the kids and I guess I've learnt a lot about myself when they challenge me or when they say you know something about

where they're at, and I think gosh, you're right I hadn't even thought about it from that perspective. Actually, I think that's one of the best things about teaching health is that you are constantly learning from the kids in front of you and it's always about them as people.

Isobel spoke of her respect for students who were prepared to share something personal in her sexuality classes:

I really admire those kids who I guess when I'm teaching it [sexuality education] can come forward and say something personal about themselves, whatever it is, at their age that they can do this and I really try and build that into classes as much as possible.

Chris and Isobel consciously created a classroom environment which was conducive to students' active participation. These pedagogies are discussed below.

Encouraging student participation

Chris was conscious of —not doing too much of the talking” and not saying anything which would inhibit student responses and, in particular, not giving offence to individual students. She stressed the importance of encouraging different viewpoints and emphasised the importance for students of feeling that they could make a contribution without fear of censure: —It is important that the kids feel that they can make a contribution without being jumped on from a great height”.

At the beginning of her first year of teaching, Isobel had begun by taking a —no smiling for the first six weeks” approach, but realised that if she was too controlling, students would not talk openly in Health Education classes: —I started off like that but had to actually modify that you know because you're not going to get discussion from kids if you're going to take that hardline approach”.

Isobel could now reflect on the benefits of her liberal pedagogy which permitted opinions of all persuasions:

Because of this liberal approach that I take, it fits quite well with the sexuality topic because that exposes where everyone sits quite well and the great thing was that you would think, well I would have thought, that those that had a conservative approach probably would just sit there, shut up and say nothing but in actual fact, no, they didn't, they did say things which was great. I mean personally I may not have agreed with what they were saying but that's fine, they're entitled to their point of view but to actually feel confident, to be able to air it, that's good.

Teaching as facilitation

The open classroom environments favoured by Isobel and Chris and their espoused non-authoritarian roles were significant factors in their descriptions of themselves as facilitators of student learning. Contributing to this view of teaching Health Education was a belief in a lack of certainty about much of the subject's content.

Chris felt that students were encouraged when teachers admitted that they don't have all the answers and indeed that there are no definitive answers out there to be transmitted anyway. The 'greyness' of Health Education meant a range of views were acceptable. Isobel articulated a similar stance with regard to her role in Health Education. She enjoyed the non prescriptive nature of subjects like Health Education which allow open discussions to take place where a range of viewpoints are acceptable, providing students can justify their positions.

I've always said there's no 'yes' or 'no' answer to this, you can see it how you like as long as you are able to support that particular stance and I think that's it, you know in health you don't come in with a preconceived idea about 'This is how it's going to be guys, better write this down, alcohol is bad, you will die if you drink alcohol', all that sort of stuff but rather 'Well, these are some of the things that could happen, these are some of the things that won't, this is the information now Johnny over there you decide on your particular view'.

Isobel talked about her facilitation role in Health Education classes: –and often you feel like you're not actually in the role of the teacher as such but like I said, a facilitator". She elaborated on her conceptualisation of facilitation by giving a hypothetical example:

Someone who has a strong Christian outlook on sexuality, yes you might think that's great, that's fine and you're entitled to that, can you see any other issues that you might come up with or can you see why someone would do this? Yes they do. What do you think about that? Oh well, that's fair. What about consistency, this happens over here is there a difference here, maybe there's not, maybe there is.

Being a facilitator sometimes exposed tensions, especially when students' views conflict with a teacher's strongly held beliefs. There was a part of both Isobel and Chris which objected to what the students were saying and wanted to change their opinions. Chris was pleased that, at the end of a unit, there was a possibility that students were more aware of the different view points on a sexuality education topic:

Then we started to look at homosexuality, relationships and just the various liberal and conservative views that come up and I think by the end of the term there weren't any drastic changes, you know someone who was a conservative became converted to liberal, but I think there was an awareness of those issues because up until then I don't think a lot of those students are actually aware of the issues.

Isobel indicated sometimes it was difficult to maintain an objective facilitator's role because of the personal nature of the subject, and this had been particularly difficult when she began teaching Health Education. She described her early experiences as a –step learning curve". She wanted to challenge for example, what she perceived as the effects of a mismatch between what was taught at school about homosexuality and negative messages from home.

Her perception of her role in teaching sexuality education was that she was —a bit of a battler for the underdog or disadvantaged” and this influenced her teaching of sexuality topics:

Some things have actually made me want to deal with it or expose it more, do you know what I mean, you know gross ignorance I guess in terms of misinformation and perceptions and all those sorts of things. They kind of niggle away at me and I want to give more emphasis to it and it makes me more convinced and determined to push that particular issue.

Chris was also aware of the tension between respecting students’ rights to arrive at their own conclusions and reigning in her personal urge to get students to see things differently:

And not making people wrong, for even with homophobia where I really want to make them wrong you know, but to be able to challenge that in a way that it’s making them think about what they’re saying but still come out with their own point of view rather than, —Couldn’t you possibly change that?”

Most of the examples used by Chris and Isobel to demonstrate the tensions involved in taking on a facilitative role were taken from sexuality education. In the following subsection, agency is discussed in relation to sexuality education.

Taking risks in sexuality education

Isobel and Chris were determined to address some of the more controversial issues in sexuality education, such as sexual diversity. In this subsection, pedagogic agency is illustrated through risk taking in sexuality education and a situation where another teacher is involved and agency is constrained.

Encouraging a range of opinions based on experience, —you know this person over there might have a lesbian aunty”, introduces unknown variables into the class. Thus encouraging a free exchange of views is always a calculated risk

as this style of teaching may bring up more than is expected. This risk, however, is counteracted by the good which might emerge. Here Chris talks of this dilemma:

I was just thinking of mistakes in terms of bringing up something in class and then thinking, —~~Cap~~, I wished I hadn't gone there". But sometimes I don't worry about that too much because I hope that where we get to is okay.

Much is made of safe classrooms' in Health Education resources and professional development. A common strategy is to involve students in the development of guidelines aimed at ensuring classes are emotionally and physically safe places. Guidelines usually include a confidentiality clause — ~~what's said in the class room stays in the classroom~~", but this does not preclude the possibility that a student may reveal something about their lives which teachers fear makes them vulnerable. Isobel was very aware of this possibility:

You can have your guidelines and you try to ensure safety, well you can't and yes that's a biggie at times. You almost want to say to them —~~Don't~~ share anything if you really don't want it going anywhere else because there's no way I can stop it happening".

Chris gave specific instance of how students can make themselves vulnerable in a Health Education class. It was a senior class which, according to Chris, did not fit the ideal health education model of —~~safe~~ and supportive". This was because of time constraints (just two periods a week for a short life skills module) male domination and lack of the more able students (defined as those who took six subjects) who could usually be relied upon to provide a moderating influence on the more ~~boorish~~", "jock strap" element. The class was considering some different parenting scenarios and one of the statements was about parents being lesbians. Chris had then asked the class what they thought about parents being —~~gay~~ guys" and got a negative reaction from some of the boys in the class. She was alarmed when a girl whom she described as

—time” revealed to the class that her father was gay and that —e’s always been really cool”. Chris admitted to some anxious moments at this point: —ad I’m thinking shit”.

What is interesting about this account is Chris’s description of how she was escued by one of the students whom she praised for sensitivity and bravery in supporting his female classmate. The boy’s contribution allowed Chris to take the lesson on to where she wanted and also offered some protection for the exposed student:

The thing I guess I rely on at times like that is the effect it has on others in the class. Normally they don’t go to that horrible state. And another boy in that particular class actually said then —Well, maybe he had to be a better Dad because people did know he was gay and they were watching him” which was the perfect thing to say you know and it was like, thank goodness for that and allowed me in to then talk around that. I think I sometimes get myself in a wee bit of trouble for challenging the seriously homophobic. Well I didn’t have to be the person who was basically defending her or giving that point of view. It allowed me to then say —Well absolutely. Can you see how that would be for someone to have other people watching them all the time and having all the you know stereotypical, he can’t do this because, or he might do this because?” It just allowed us to go to a place that was then I felt defending her and the support from another student is always worth a great deal more than the support from a teacher.

Boundaries between what is allowable and what is not are potentially open to negotiation at any time in open environments such as those preferred by Isobel and Chris. For Isobel, there was personal risk involved in sexuality education. On the one hand she thought it was important to —e real with our students”, but she also recognised that she had to set some limits to protect herself. Here she describes how she deals with personal comments from students during sexuality education lessons by not getting drawn into student initiated dialogue:

You know the students will sometimes say —“you’re gay” and all this sort of stuff. I mean those sorts of things students make comments like that anyway. It doesn’t faze me. It’s all about professionalism and you know I don’t justify those with any responses.

Chris’s senior role in Health Education meant that there was always the possibility that she might become involved in difficult situations which were not of her own making. One of the expectations of the role was that she would monitor what was going on in classes taught by other Health Education teachers. It was in this role that she was required to respond to a complaint from a parent about a role-play aimed at developing an empathetic understanding of sexual diversity. Chris had not observed the role play but had reservations about the way it might have been taught by a teacher whom she considered lacked training in Health Education:

I don’t know how this activity was done during this person’s class but a couple of days later I had a letter, a note brought by the student to the teacher saying they were totally unimpressed and how dare you tell my daughter to pretend to be gay, she’s not even sexually active, how could you, how could you put these ideas out or make her do something she’s not doing.

In Chris’s reflection on her letter of response to the parent who had made the complaint, there was unease about how the activity might have been taught and a sense of regret that she hadn’t been able to say what she really wanted to:

I thought oh how was it taught, what was happening there what, and that really, oh it just frustrated me I guess. So I had to write a big letter back saying, no look this is not what we’re aiming at, we’re aiming just to consider others’ feelings and I felt like saying a lot more than that, your narrow mindedness etcetera.

In this last extract, Chris’s capacity for pedagogic agency is circumscribed by the need to protect a junior colleague and mollify a parent.

The pedagogical agency negotiated by Isobel and Chris has been discussed in this vignette. Teachers' personal experiences were again shown to be important influences on pedagogical choices. Decision making about Health Education pedagogy was represented by: different positioning in relation to colleagues, foregrounding student views, encouraging student participation, teaching as facilitation, and taking risks in sexuality education.

9.5 Chapter summary

These vignettes have illustrated pedagogical variations across the group of teachers in terms of their individual agencies. Personal career and life histories, dispositions and values were shown to be significant factors in the way the teachers negotiated curriculum. The first vignette illustrated a physical Health Education discourse, the way Health Education developed when official Health Education curricula had less influence, the effects of professional development, the effects of personal experiences on pedagogy, the way pedagogical agency was exercised by Health Education teachers, and the interplay of their agency with that of others. The second vignette illustrated how personal experiences influenced decisions about teaching Health Education. This vignette also discussed pedagogical agency through a student needs discourse and an alignment of personal values with the curriculum. An example of collective agency was also discussed. In the third vignette, teachers' personal experiences were again shown to be important influences on pedagogical choices. Decision making about Health Education pedagogy was represented by: different positioning in relation to colleagues, foregrounding student views, encouraging student participation, teaching as facilitation, and taking risks in sexuality education.

This chapter concludes the data presentation chapters. The findings from the four data chapters are synthesised and analysed in the next chapter.

Chapter Ten

Health Education teaching in context

This chapter provides a synthesis and analysis of the findings about teaching Health Education discussed in Chapters Six to Nine. The findings are analysed with regard to: i) power and knowledge, sexuality, gender and emotionality as discussed in Chapter Five; (ii) agency as discussed in Chapter Two; (iii) the curriculum and assessment policy discourses of Chapter Four; and iv) Health Education's broader socio-political and historical discourses of Chapter Three. The chapter comprises: **10.1 Summary of findings; 10.2 Power and knowledge, power and sexuality, gender and emotionality; 10.3 Agency; 10.4 Policy into practice for Health Education; 10.5 Socio-political and historical discourses; and 10.6 Chapter summary.**

10.1 Summary of findings

The purpose of the empirical part of this study was to document secondary school teachers' reported responses to recent changes in Health Education curriculum and assessment policy. The interview data were reported in Chapters Six to Nine. Chapter Six illustrated the weak classification and framing of contemporary non-NCEA assessed Health Education; Chapter Seven considered the change in classification and framing strength that occurred when Health Education became part of the NCEA; Chapter Eight discussed the effects of gender and emotionality discourses on health pedagogy; and Chapter Nine illustrated how individual teachers' pedagogies negotiated curriculum, sexuality, gender and the emotionality of teaching Health Education.

In the first section of this chapter, findings from the interviews are summarised. The section is organised using the titles of the data chapters as the headings for each subsection. They are as follows: Health Education curriculum and pedagogy, Health Education assessment and pedagogy, Health Education pedagogy: gender and emotionality, and Personal agency of Health Education teachers. The findings about sexuality and sexuality education were interwoven across the four data chapters but mainly occur in Chapter Nine. They are summarised in the final part of Section 10.1.

Health Education curriculum and pedagogy

In Chapter Six, the effects of the 1999 curriculum on Health Education teachers' work were considered. Teachers in this study saw Health Education as a means of addressing issues such as mental health, sexuality and, in some accounts, their concerns about poor food choices and physical inactivity among students. Some teachers believed that their Health Education roles extended beyond the classroom, so they were active in school and community health issues. Although there was similarity in the way teachers prioritised health issues (sexuality and mental health dominated), students' specific needs were seen in a community context and teachers tried to ensure their pedagogies were relevant to these contexts.

The weak classification and framing of junior and non-NCEA assessed Health Education was exemplified through the teachers' accounts in the following ways: the involvement of people other than Health Education specialists; teaching pedagogies based on student needs and which valued student experiences; the use of an eclectic range of resources; individual pedagogies which were crafted in relation to class, school and community contexts; considerable variation in the kinds and frequency of professional development courses attended; moves towards integration with other subjects and variation in the subject specialisms, teaching backgrounds and 'departmental home' of those who taught Health Education.

Pedagogical tensions resulting from the combination of previously separate subjects into one learning area was clearly of significance for some teachers. The period immediately following the release of the draft (and the subsequent final version) of the 1999 curriculum was reported to have been marked by concerns about bringing Physical Education and Health Education together. Among these teachers, there was no speculation about why the integration had taken place. Doubts were expressed about the suitability of some Physical Education teachers to teach Health Education effectively. As a group, Physical Education teachers were portrayed by teachers in this study as focused on sport and the physical dimensions of teaching Health Education. Those who taught Health Education by choice were characterised as being more holistically inclined and interested in the affective dimensions of Health Education. Competition for resources between Health and Physical Education was also a concern for some teachers.

Health Education assessment and pedagogy

Chapter Seven considered NCEA implementation issues and the effects of the new assessment system on learning and teaching. Implementation issues reported by these teachers concerned the organisation of professional development; dissatisfaction with the quality of the training provided; feelings of inadequacy; dilemmas about the kinds of assessment to offer; uncertainty about processes and content; strategies to manage workload; and competence issues which included buying commercial resources, anxieties about planning senior programmes, and reservations about the academic demands of Achievement Standards. The rewards and opportunities presented by the NCEA were also discussed. There was satisfaction that their students were well prepared for assessment tasks and approval of the transparency of the assessment process. Some teachers also appreciated the opportunity to develop assessment skills. One teacher hoped that the NCEA would initiate debate about the intent of the senior curriculum.

Reported changes to Health Education pedagogy in NCEA assessed Health Education classes indicated that the NCEA system was beginning to affect

classification and framing strength. Teachers used a technical language for senior Health Education (in contrast to the non-technical language of junior Health Education) and, although junior Health Education pedagogies were in the main different from senior Health Education, there was some evidence that a NCEA discourse was beginning to affect junior Health Education. A social issues discourse remained but it was muted and teachers reported using a narrower range of resources than in junior Health Education. The importance of recording information so that it could be retrieved for assessment purposes was mentioned and some teachers reported that their pedagogies were less creative. There was talk about the pressure to get through the assessments and less time to be responsive to student needs. One teacher expressed the concern that students' learning was not always reflected in assessment tasks.

Health Education pedagogy: gender and emotionality

In Chapter Eight, discourses of gender and emotionality were discussed in relation to pedagogy. Data was presented to show how the teachers drew on a biologically essentialist gender discourse, and the emotional cost of teaching Health Education was also illustrated. Of the teachers in the study, two were male and ten female.

The strength of an essentialist discourse was exemplified through assumptions evident in the data. Male and female students were represented as having different needs and preferences, and female teachers portrayed male teachers as in the main unsuitable for teaching Health Education. Some concern was also expressed about the lack of suitable males teaching Health Education because this was perceived as depriving students of male role models. Health was spoken of as a curriculum which suited female teachers and students. Females were generally considered to be better at expressing their feelings than males, more comfortable with handling students' personal issues, and less judgemental and more inclusive than males. Maternal experiences were suggested as one of the reasons why females were more attuned to teaching Health Education than males. The professional development for the NCEA

reflected a male/female divide with more males reported as favouring Physical Education courses and females dominating Health Education courses.

Data that illustrated the emotionality of teaching Health Education were also presented. Some teachers expressed close emotional bonds with the school communities in which they were teaching and the emotional dimensions of interactions with students were also illustrated. The effects of power were evident in the accounts of several teachers, particularly the power of senior staff to control the senior curriculum and thereby include or exclude Health Education as a NCEA subject in their schools. Emotional energy was also expended on efforts to secure adequate time for Health Education in what was conceded to be an overcrowded curriculum. Teachers felt affirmed when their aspirations for Health Education were supported; when they were not, there were negative emotional consequences. Professional development created a sense of shared purpose and provided opportunities for the development of relationships with colleagues and emotional support from like-minded enthusiasts. Teachers experienced emotional fallout from the effects of internal school politics with some reporting that they had been upset by other teachers' negative reactions and perceptions of Health Education as a low status subject. Feelings of isolation and self doubt were also expressed. The emotional cost of being associated with health policies that had the potential to become controversial was also shown.

Personal agency of Health Education teachers

Chapter Nine illustrated individual pedagogical agency through three teacher types. Each type exemplified different life and career histories, values and dispositions.

Teachers followed idiosyncratic pathways to become Health Education teachers. Different pathways meant there was differential access to opportunities in which agency could be exercised. There was more scope, for example, to develop a school based Health Education curriculum before an official curriculum had to be taken into account. At a later stage, when

curriculum and assessment policy was more entrenched, there was less opportunity to influence school curriculum direction. It seemed from the interviews that pedagogic agency might also be constrained by individual circumstances. Although the individual trajectories varied, none of the teachers had begun their careers with a strong sense of wanting to become Health Education teachers; it was more a case of particular circumstances, experiences and dispositions that led them into teaching Health Education. Teachers' experiences, values and beliefs played a significant part in agency. Decisions about teaching Health Education were sometimes linked to personal crises and in some cases, personal experiences and values informed the teachers' interpretation of aspects of the curriculum such as sexuality education. For some teachers, there was a perception of alignment of their values and experiences with the content and intent of the curriculum. When this occurred, teachers felt their approach was validated by the curriculum. Professional development was reported by some teachers to have had beneficial effects as they made links between the curriculum and self knowledge. Professional development also promoted confidence, and acknowledgement of expertise led to significant gains in perceptions of self worth. Agency was expressed in the pedagogical decisions reported by teachers. Although teachers espoused the view that students should be encouraged to make their own decisions, the degree to which student agency was supported varied. There were examples of teachers' agencies interacting with those of others: parents, students, and other staff. Agency was also evidenced in the way some teachers positioned themselves in relation to their Health Education colleagues.

Sexuality

Sexuality was part of a social issues discourse and there was an emphasis on female reproductive health and individual responsibility. Female teachers were in general portrayed as being more suitable to teach sexuality education than males. In one instance, one of the two male teachers in the study reported that he had been the object of staff room banter because he taught sexuality education. Perceptions about gender orientation were recorded as being voiced

by students and staff. Most of the discussions about sexuality took place in classrooms, but there were several reported examples of sexuality being discussed in other contexts. These included meetings with parents and meetings and conversations with school staff. Homophobic attitudes were reported amongst other teachers, parents and students and some teachers commented on the discomfort of senior staff with sexuality. Teachers' personal histories, values and experiences influenced sexuality education pedagogy.

In this first section, the findings from each of the chapters in the empirical phase of this study have been summarised. Across the four chapters as a whole, the findings revealed the following major themes: health issues were the primary motivation for teaching Health Education; junior and non-NCEA assessed Health Education were weakly classified and framed in comparison with senior Health Education; there were pedagogical tensions resulting from the combination of previously separate subjects into one learning area; teachers drew on a biologically essentialist gender discourse; there was an emotional cost to teaching Health Education; different life and career histories, values and dispositions affected teacher agency, and sexuality and sexuality education discourses were affected by other social and personal discourses.

In the following sections (10.2 to 10.5), the findings are analysed in relation to the literature and theory discussed in Chapters Three, Four, and Five and aspects of the methodology considered in Chapter Two. The overall section structure is organised from the micro (10.2 Power and knowledge, sexuality, gender, and emotionality, and 10.3 Agency), through to the mezzo (10.4 Policy into practice for Health Education), and finally the macro (10.5 Socio-political and historical discourses). The section is therefore organised around each of the theoretical and literature chapters, beginning with Chapter Five in Section 10.2 below.

10.2 Power and knowledge, power and sexuality, gender and emotionality

In this section, the findings about curriculum and assessment (analysed using Bernstein's theories about power and knowledge), power and sexuality, gender, and emotionality are discussed with regard to the relevant literature, theories and methodologies from this study's toolbox' (Ball, 2005). The relevant parts of the toolbox are reiterated at the beginning of each subsection.

Power and knowledge

In this subsection, Bernstein's theories about how power works in the selection and teaching of knowledge are applied to Health Education. The concepts of classification, framing and knowledge codes (Bernstein, 1971, 1996)⁶⁷ are used to analyse tensions in Health Education curriculum and assessment. The methodological tools of positioning and discourse⁶⁸ are utilised to illustrate how the teachers made meanings about Health Education through positioning themselves in relation to the discourses of non-NCEA Health Education, and Health Education that was assessed by the NCEA. Positioning refers to the way people locate themselves either consciously or unconsciously in relation to different discourses. A discursive approach argues that knowledge is socially produced and that it always includes power relations.

Health Education pedagogy in this study was shaped by the two discourses of junior Health Education (and senior Health Education that was not assessed through the NCEA) and senior Health Education that was part of the NCEA system. These two discourses both positioned teachers but also provided opportunities for them to position themselves. Although there was variation in the ways teachers positioned themselves in relation to these discourses, their positioning was affected by the different ways Health Education knowledge was selected, structured, transmitted and valued (Bernstein, 1971, 1996) in each of these discourses. Junior Health Education was, in Bernstein's terms, weakly framed and classified, whereas there was evidence of much stronger

⁶⁷ See Chapter Five, Section 5.2.

⁶⁸ See Chapter Two, Section 2.2.

classification and framing for NCEA assessed health. The factors contributing to the weak classification and framing of junior and non-NCEA assessed Health Education are discussed below.

Junior (and non-NCEA assessed) Health Education knowledge was selected by the teachers based on their perceptions of student need in relation to perennial social issues such as sexuality and mental health. The topics selected by them were broad and the knowledge was loosely structured as teachers were prepared to follow student interest. The pedagogical relationship between student and teacher tended to be less hierarchical (Bernstein, 1971) and therefore conducive to student agency. Student and community knowledge or commonsense knowledge (Bernstein, 1971) was legitimated as Health Education knowledge because teachers made learning specific to school and community contexts. The selection and use of a wide range of junior Health Education resources was indicative of intentions to craft teaching so that it was relevant to specific groups of students. A broad range of professional development opportunities was also reported. Those teachers who were able to attend professional development adopted the same pragmatic and eclectic approach as they had for selecting resources.

Learning rather than assessment was the primary focus of junior Health Education although there was some evidence of the discursive effects of the NCEA. Health Education was valued because it was thought that it would make a difference to the present and future lives of students. For two of the teachers interviewed, a focus on improving students' long term health meant that formal assessments were inappropriate. This finding was consistent with a New Zealand study by Barlow (1994). Indeed, no teachers suggested that formal assessment should be part of junior Health Education programmes. This view of junior Health Education underscores the persistence of a social issues discourse which, from its inception, promoted the role of education in developing students' personal knowledge and skills rather than meeting assessment and credentialing requirements.

Health Education was weakly classified and framed in relation to other subjects. Some teachers indicated that at junior level, boundaries with other knowledge areas such as junior Science were permeable (weakly classified) and that other subjects and subject teachers could teach aspects of Health Education. This subject integration was promoted as a means of increasing the amount Health Education available to students. Attempts at integration were inevitably going to affect the selection, structure, transmission and valuing of Health Education. Variation in the subject specialisms, teaching background and subject department home of those who taught health at junior level, also contributed to weak classification and framing. How knowledge was structured and transmitted, for example, by a teacher whose primary affiliation was Physical Education or another subject such as English, was likely to be different from teachers who positioned themselves within a Health Education discourse.

The pedagogical tensions of bringing Health and Physical Education together in the 1999 curriculum were most evident at the junior level. In one sense this was an example of school internal politics because Health and Physical Education were now competing for resources. In terms of pedagogy it was about power and control – the nature of relations between two discourses which in the past had been largely insulated from each other (collection knowledge codes). Relations between Physical Education and Health Education were concerned with what was legitimate pedagogical communication or “struggles for symbolic control” (Bernstein, 1996, p. 30) within the new discourse (an integrated knowledge code).

The discursive gap (Bernstein, 1996) created by the integrated code of the 1999 curriculum opened up possibilities for new thinking and ways of doing things. A discursive gap occurs when meanings have not become confined to a specific context: —if ~~the~~ these meanings have an indirect relation to a specific material base, because they are indirect, there must be a gap” (1996, p. 44). There will be tensions and contradictions in attempts to realise the latent possibilities of this gap for power inevitably comes into play and increasingly, as Bernstein (1996) pointed out, it is the state which has a significant role in determining the kind of discourse which is created. There was no evidence that

a new integrated Health and Physical Education discourse was being created in Bernstein's 'discursive gap' (1996). Rather, there was evidence of an increasing separation of knowledge codes. This separation was expressed in concerns about the ability of some physical educators to teach Health Education effectively. There was generally a consensus that only a certain type of Physical Education teacher could adequately address student needs and that these teachers were in the minority.

The opportunity to develop an integrated knowledge code (for Health Education and Physical Education) was only possible at the junior level, because at the senior level, the inclusion of Health Education as a separate subject in the NCEA communicated strong classification and framing. Separate standards and the accompanying implementation process (separate subject professional development) for the NCEA emphasised the differences between Health Education and Physical Education. Strong framing and classification were also conveyed through Physical Education's inclusion (in contrast to Health Education's exclusion) from the first group of subjects for which students could sit a scholarship examination at Level Three. The pedagogical implications of the NCEA for Health Education are discussed next.

The implementation issues and changes to teaching and learning (the selection, structure, transmission and valuing of knowledge) reported by teachers were illustrative of the stronger classification and framing of Health Education that occurred when an assessment discourse dominated pedagogy. While there was some continuity with junior Health Education pedagogy through a social issues discourse, there was also a marked difference between junior and senior (NCEA) pedagogy. This change was a function of the NCEA structure of defined standards against which the students were to be assessed. There was also evidence that an NCEA discourse was beginning to influence junior Health Education, consistent with an Education Review Office report from the same period (Education Review Office, 2007).

In this study, teaching and learning were reportedly more controlled and delimited because of the pressures to get through the material required for

assessment. There was evidence, however, that some teachers were trying to retain flexible pedagogies in order to be responsive to students' personal needs. Overall, however, teachers were constrained by assessment demands. In comparison with non-NCEA assessed Health Education, it was reported that there was more emphasis on recording knowledge, less creativity and less time to be responsive to students' needs. The implications of this shift to stronger classification and framing for Health Education were that: knowledge selection was determined by the NCEA, knowledge was tightly structured around each standard, teaching was more hierarchical and knowledge was extrinsically valued for credentialing purposes.

There was evidence of strong framing and classification through the use by these teachers of a small number of key senior Health Education resources. Accompanying professional development (allocation of the resource was conditional on professional development attendance), further strengthened and framed NCEA Health Education. The use of commercial material as a means of managing workload served as an additional classification and framing factor. The narrow resource base for senior Health Education was in contrast to junior Health Education where teachers reported using an eclectic mix of resources. Thus junior Health Education, with weaker classification and framing, encouraged the use of teacher developed curriculum resources. The emergence of NCEA with a limited number of achievement standards encouraged homogeneity through greater use of published and online resources. Further evidence of the stronger classification of NCEA Health Education was the use of a distinctive NCEA language which was different from the commonsense' language used to talk about junior Health Education. This change in language also communicated classification and framing strength.

There were some examples of internal (to the NCEA system) classification and framing. Unit standards were considered by some teachers to be less conceptually demanding than achievement standards. The implication was that unit standards were weakly classified in relation to home and school (Bernstein, 1996), while there was stronger classification for achievement standards. Some teachers were concerned that achievement standards were too academic' for

most of the students who took NCEA Health Education and that unit standards were more straightforward and therefore more suitable for less able students⁶⁹. The expectation of the Beacon School project (discussed in Section 4.4), was that the Beacon Schools should be offering achievement standards, not unit standards. This expectation suggests stronger framing and classification in relation to school and home/community knowledge.

Strong classification and framing were also conveyed through NCEA professional development. Strong framing from experts sometimes resulted in teachers feeling inadequate and incompetent. This finding was consistent with an earlier New Zealand study by Barlow (1990). Potentially strong framing through professional development was, however, diminished through teachers missing out on training, and confusion about the purpose and process of the NCEA system. An imbalance in power relations and a desire to appear competent in some cases makes it difficult for teachers to challenge assessment knowledge (Glasby, 2004). Some teachers in this present study did nevertheless challenge the process and the content of professional development.

The NCEA introduced a new pedagogical discourse for Health Education. The strong classification and framing brought about by its implementation signalled a major shift in the way Health Education was conceptualised and practised. Non-NCEA Health Education was dominated by individualistic and social issues discourses about improving young people's health and there was evidence of teacher and student pedagogical agency. When Health Education was formally assessed through the NCEA system, agency was more constrained.

Power and sexuality

All the findings discussed in relation to the literature in this section are associated with a Foucauldian perspective on power. From this standpoint, the

⁶⁹ See also the Ministry of Education's summary report (2005) on the Beacon Project where teachers suggested that (i) classes tended to consist of "less academic" students (p. 6) and (ii) whereas principals were prepared to run small classes in academic subjects, they were less likely to sustain ones perceived as less academic" (p. 10).

body is identified as a primary location for the implementation of power (Foucault, 1980). The effects of power are not likely to be uniform for wherever power is present, resistance is also possible (Foucault, 1978).

The disciplining of individual bodies or bio-power' (Foucault, 1978) was evidenced in this study through a reproductive health discourse (e.g., contraception and the prevention of STIs) and was mainly associated with female bodies. Public health discourses (through the public health nurses who worked in schools and the resources funded by the health sector) also contributed to a bodily discourse of control.

Another form of biopower' evidenced in the study was the regulation about who should teach sexuality education. Female teachers, because of their physiology and associations with biological discourses of reproduction, were preferred over males. There were other examples of regulation based on perceptions about teachers' suitability to teach sexuality education. The potential for students to use sexuality discourses to regulate teachers' behaviour (Middleton, 1998) was also illustrated.

The inclusion of sexuality education in Health Education curricula mandated sexuality as a topic for teachers and students in schools. While in theory sexuality discourses could be examined by teachers and students in class and school contexts, the data indicated that sexuality was a classroom discourse rather than a school discourse. Several exceptions where sexuality was talked about in non classroom contexts were significant as they illustrated the power of a heteronormative discourse (e.g., Epstein, 1996; Kehily, 2002).

There was evidence of teacher and student agency (the capacity to exercise power) in sexuality education, and this can be partly explained by the reported discomfort senior staff communicated about sexuality – they did not want to know what went on in classrooms. This could be interpreted as denial that sexuality has anything to do with education (Sikes & Everington, 2003). However, there was some evidence of a principal's support for sexuality education decisions made by a teacher when she was challenged by a parent.

Classroom structure, when viewed from a Foucauldian perspective (e.g., seating and the organisation of resources), conveys messages about power relations (Foucault, 1976) and can facilitate or constrain student agency. The reported Health Education pedagogies in this study indicated flexible physical arrangements when Health Education was taught in dedicated Health Education rooms. Health Education was, however, more likely to be roomed in a variety of subject rooms which conveyed different pedagogical relationships.

Some teachers' pedagogical approaches allowed for student agency in sexuality education. One teacher made it clear that her sexual orientation had strongly influenced her pedagogy and she was encouraged when her students shared their personal views. In another account, a teacher described how a student had supported another who had talked about her gay father in a class discussion about the 'suitability' of gay men as parents. These examples were representative of —alternatives, resistances and creativities” (Middleton, 1988, p. 3).

Although the controversies that had affected the development of sexuality education in schools during the 1970s, 1980s, and to a lesser extent the 1990s, have subsided, sexuality discourses continue to affect pedagogy. As exemplified in this analysis, an important effect was their role in power relations. Pedagogy was also affected by an essentialist gender discourse.

Gender

The toolbox for examining teachers' accounts of their work in Health Education was incomplete without an explicit articulation and theorisation of gender⁷⁰. The most significant finding about gender in this study was the strength of an essentialist discourse which restricted gender possibilities for teachers and students by defining suitable behaviours for males and females (MacNaughton, 1998).

⁷⁰ See Chapter Five, Section 5.3.

Essentialist discourses focus on biological differences and minimise the influence of social processes in the construction of gender. This discourse was exemplified in the suggestion made by one woman teacher that the reasons girls were more interested in Health Education than boys was because of their physiology: —menstruation, and breasts and nurturing and breast feeding”. The same teacher could not see the point of a NCEA achievement standard which was meant to assess learning that challenged essentialist assumptions about gender.

Women teachers portrayed females as more nurturing and emotionally attuned to the needs of their students and their colleagues than males. There was also evidence of what Acker (1999, p. 107) has called a “mothering subtext” where maternal experiences were seen as useful in Health Education pedagogy, particularly in teaching sexuality education. Males were also considered more judgemental than women and less inclined to support students to come to their own decisions.

Dominant discourses about the correct way to be a male were challenged in one case. In this example, one of the male teachers in the study taught sexuality education to a predominantly female senior Health Education class. He reported some derisive comments from other staff members when this became known. His experience was an example of a prevailing ‘gender regime’ (Connell, 1985) in his school that male teachers did not teach sexuality education, particularly to senior classes where there were more female than male students.

There were gendered dimensions to emotional discourses evident in the data. An emotional discourse was less evident in the accounts of the two male teachers. This perception is a reflection of a gender regime where emotionality is linked with a feminine discourse. The idea that there are correct ways to be male and female prevented teachers and students from experimenting across a continuum of feminine and masculine positionings (Davies, 1989).

Some female teachers expressed concern about the lack of suitable males teaching Health Education because this was perceived as depriving students of male role models. This finding was endorsed by a summary report on the effects of the Beacon Project in which some of those interviewed noted that there was often —~~a~~ lack of strong role modelling by male teachers to support Health Education” (Ministry of Education, 2005, p. 6).

Perceptions by female teachers that males were in general better at teaching Physical Education than Health Education and that boys preferred Physical Education⁷¹ and girls Health Education, imposed a binary male/female discourse on the two subjects. The inclusion of Physical Education (but not Health Education) in the first group of NCEA subjects which could be assessed by a scholarship examination sent a strong message about subject status. By implication, higher status was accorded a subject which in an essentialist discourse was associated with males. A hierarchy of subjects, where those associated with masculine knowledge are rated more highly than those linked to the feminine (Kenway & Willis, 1997), implies a gendered hierarchy (Paechter, 2006).

The teachers and students in this study were limited by hegemonic gender discourses. The main basis of teachers’ analysis and positioning was biological difference. The dominance of this essentialist discourse restricted both student and teacher access to the diversity of masculinities’ and femininities’.

Emotionality

Goodson (2003) suggested that attention to personal and emotional responses to change —~~are~~ symptoms of a growing awareness of the absences that sit at the heart of the predominantly technical and managerial paradigms of educational change and reform” (p. 67)⁷². The emotionality of teaching was revealed as responses to policy changes in curriculum and assessment in

⁷¹ See also the summary report on the Beacon Project where participants reported that —Health education is seen as an easy subject with no status and not interesting or relevant to issues for boys” (Ministry of Education, 2005, p. 6).

⁷² See Chapter Five, Section 5.4.

Health Educational the micro level; that is the struggles largely involved individual teachers trying to effect changes in their schools.

Emotionality was evident in political struggles for resources (made particularly difficult at the junior level by having to compete with Physical Education) and to advance the uptake of senior secondary Health Education. The emotional investment required to establish senior NCEA assessed classes was considerable and even more so for young or inexperienced teachers.

Issues which generated emotionality were situated within the hierarchical structures of secondary schooling. As several teachers indicated, senior staff had the final say on what happened to Health Education when it became an optional subject in the senior secondary school. Policies (in this case, curriculum and assessment) –*enter* into rather than simply change power relations” (Ball, 1996, p. 19). Teachers who believed that their Health Education role extended to school and community health issues also felt constrained by senior staff. The discursive effects of these historically located (O’Neill, 2001) hierarchical discourses were consistent with Acker’s (1999) longitudinal study of British primary schools, which showed that some of the situations which caused them to feel stressed –*predated* the additional stresses credited to government policy” (p. 115).

The potential for both positive and negative emotional interactions between community and teachers is arguably greater in Health Education than other subjects. This is because Health Education is intimately connected to community through its aim of contributing to the healthy development of individuals and communities. The formal means of communication about Health Education is biennial community consultation, a legal obligation for schools. Informal emotional ties with communities occurred through teachers’ personal identification with their school communities, through perceptions of helping to address community health needs and alignment with community values.

Emotional discourses occur in other subjects but are especially relevant for Health Education because its pedagogy is concerned with personal

relationships and experiences, particularly in the junior school. Emotional closeness and distance (Hargreaves, 2001) were associated with personal student and teacher discourses. Teachers had to negotiate the contradictory discourses such as professional distance and Health Education's relational pedagogy. They also negotiated different roles such as teacher/parent. Teaching which was influenced by teachers' experiences and values conveyed strong emotionality.

Affirmation that Health Education was important provided emotional support for teachers. Appreciation of Health Education as a subject and acknowledgement of Health Education teachers' work came from within the ranks of Health Education teachers (sometimes associated with professional development) and occasionally from colleagues who did not teach Health Education. Support from senior staff rated highly.

The emotional investment and consequences of teaching Health Education were evidenced in Health Education pedagogy and in school politics. Emotionality was one discursive resource (Bourdieu, 1986) which teachers utilised in the development of their agency.

10.3 Agency

Agency, or the capacity people have to control their lives (Acker, 1999; Connell, 1985; Middleton, 1998; Weiler, 1988), was exercised as the teachers positioned themselves in relation to pedagogical discourses. Their positioning within these discourses was on-going and shifting (Luke, 1995; Moore, 2004) and resulted in variation of pedagogical agency over time. The historical development of agency was shown in the decisions and choices they made to become Health Education teachers. For some this was a gradual process (e.g., a developing interest in health) and for others there were triggers such as an illness. Newer teachers were to some extent positioned by the integrated structure of the 1999

curriculum (the assumption that teachers would teach both Health and Physical Education). Agency still operated here, however, as teachers chose to identify more closely with health discourses. The potential to make decisions and influence Health Education programmes within schools varied according to circumstance. Early health educators, for example, had more scope when curriculum and, more significantly, assessment discourses were less powerful. Teacher agency was therefore influenced by the effects of the current regimes of truth (Foucault, 1980) within their schools.

The weakly framed and classified curriculum (Bernstein, 1996) of junior school and non NCEA Health Education generally encouraged agency. There was variation within this trend, however, with some teachers suggesting that they were more prepared to take risks in their teaching than their colleagues. There was also variation in support for student agency among the teachers.

The weak framing and classification of the 1999 curriculum also allowed teachers to draw on the parts of the curriculum which aligned with their values and perceptions of student needs, at least in the junior school. Perceptions of a personal values alignment with the Health Education curriculum were associated with a strong sense of agency. Collective agency based on shared values about sexuality and education was exemplified by a decision to reject a sexuality education resource.

Agency was shown through the teachers' individual trajectories. Their career histories, experiences and personal values were influential as they shaped their pedagogical responses to the different contexts of their work (Little, 1995). Personal experiences were drawn upon and expressed in their teaching, especially in non-NCEA assessed Health Education. Several teachers revealed the emotional impact of lessons which were associated with their own experiences. Professional development supported agency when teachers felt that their knowledge and expertise was recognised, and in some cases, teachers reported personal therapeutic effects.

In these two sections (10.2 and 10.3), the reported work of the Health Education teachers in this study was analysed using theories about power and knowledge; power and sexuality, gender, emotionality and agency. These theories were used to illuminate pedagogy and provide explanations of what went on in the teachers' *micro* worlds.

Health Education pedagogy was shaped by two discourses: Health Education that was assessed by the NCEA and Health Education that was not part of the NCEA system. These two discourses both positioned teachers but also provided opportunities for them to position themselves. Although there was variation in the ways teachers positioned themselves in relation to these discourses, their positioning was affected by the different ways Health Education knowledge was selected, structured, transmitted and valued (Bernstein, 1971, 1996).

The relationship between sexuality and power was analysed from a Foucauldian perspective. Sexuality discourses were shown to affect pedagogy through a reproductive health discourse and a regulative discourse. There were, however, examples of teachers positioning themselves differently, particularly in relation to the regulative discourse.

The teachers (and by implication, the students) were limited by hegemonic gender discourses. The main basis of teachers' analysis and positioning was biological difference. The dominance of this essentialist discourse restricted both student and teacher access to the diversity of masculinities and femininities.

The emotional investment and consequences of teaching Health Education were examined in relation to pedagogy and school politics. The emotionality of teaching was revealed as responses to policy changes in curriculum and assessment in Health Education at the micro level; that is the struggles largely involved individual teachers trying to effect changes in their schools. Emotionality was evident in political struggles for resources (made particularly difficult at the junior level by having to compete with Physical Education). Issues

that generated emotionality were situated within the hierarchical structures of secondary schooling. The experiential basis for non NCEA assessed Health Education also contributed to the emotionality of teaching Health Education.

Agency was shown to have been exercised as the teachers positioned themselves in relation to pedagogical discourses over time. There was variation in how teachers expressed agency and this was associated with their different career histories, experiences and personal values. The weakly framed and classified curriculum (Bernstein, 1996) of junior school and non-NCEA Health Education generally encouraged agency.

In the following two sections, the study's findings are contextualised within the curriculum and assessment policy (mezzo) discourses of Chapter Four and the historical and socio-political (macro) discourses of Chapter Three⁷³.

10.4 Policy into practice for Health Education

In this section the mezzo analysis of Chapter Four is used to examine the findings about curriculum and assessment as they were reported to have been put into practice in the teachers' schools. The following are considered: the social issues discourse that was reflected in the 1999 curriculum and the teachers' talk about their work, the reported pedagogies that were consistent with the weak framing and classification of non-NCEA assessed Health Education, the tensions that occurred when Health Education and Physical Education were placed in the same learning area, the conditions that favoured pedagogic agency in non-NCEA assessed Health Education, the strength of individualistic health discourses in comparison with health discourses that involved critique of inequalities, the apparent variation in the discursive resources used by students in NCEA assessed health and the social issues

⁷³ For explication of this micro/mezzo/macro typology, see Section 2.2.

discourse that was evident in teachers' efforts to extend opportunities for students to take Health Education at senior levels.

The enduring social issues discourse of Health Education was evident both in the 1999 curriculum (the Key Areas of Learning: Sexuality Education and Mental Health) and in the teachers' accounts of their work in the interviews conducted for this study. Those given most weight by the teachers were sexuality education and mental health, particularly drug education. Their issues based pedagogies were often linked to perceptions of school and community issues.

The teachers' reported Health Education pedagogies reflected the weak classification and framing of the 1999 curriculum in the junior school and in non-NCEA assessed classes. Teachers reported using student centred pedagogies where the teacher's role was often facilitative. The non-prescriptive characteristic of the curriculum was foreshadowed in the literature review commissioned by the Ministry of Education to guide the curriculum's development. The literature review emphasised the importance of post modern' conceptualisations of curriculum in which knowledge was contestable and learning was not focused on pre-determined ends. The teacher's role was envisaged as being "facilitative and reflective, rather than predominantly instructional" (Shaw, 1994, p. 2).

One of the pedagogical and relational tensions exemplified in this study was a consequence of the creation of an integrated curriculum – the bringing together of three previously separate subjects. Tensions signalled by Physical Education commentators (e.g., Culpan, 2004; Stothart, 2004) at the time when Health Education and Physical Education were brought together, were also illustrated in this study. Subject politics were evident as Health Education and Physical Education competed for resources in the junior school. What was of greater significance, however, were doubts about the suitability of some Physical Education teachers to be good' health teachers. Those deemed least suitable to teach health were physical educators who were associated with "individualistic, masculinist, and performance orientations" of sport and human

movement studies (Kirk et al., 1997, pp. 293-294). The majority of the teachers in this study (nine out of the twelve) were, or had been, Physical Education teachers and some spoke enthusiastically about sport and Physical Education. It was also apparent, however, that these teachers felt they had also embraced the spirit of Health Education. By implication, this positioning within a Health Education discourse had not been adopted by other Physical Education teachers. Among the female teachers and one of the male teachers, these beliefs about Physical Education teachers were associated with an essentialist gender discourse.

Although not as prolonged or intense as the political conflicts connected with the 1985 health syllabus, the production of the 1999 curriculum was also marked by controversy and delay (Tasker, 2004). Paradoxically, the long delays encouraged teacher agency. An allied factor illustrated in this study was the absence of strong framing and classification (Bernstein, 1996) of the 1999 curriculum through professional development. Apart from one teacher who had been involved because of an advisory role, none of the experienced teachers talked about attending any consultation meetings when the draft document was released, nor the professional development offered when the 1999 curriculum was published.

A strong subject organisation for Health Education might have strengthened classification and framing of the 1999 curriculum in schools, but this was not the case as the New Zealand Health Teachers' Association (NZHTA) was then only in the early stages of development (Stothart, 2000). A further factor contributing to weak framing and classification was that, in comparison with other subjects such as English (Locke, 2004), subject knowledge was not gained through common tertiary experiences. Health Education pedagogies were therefore constructed in a curriculum vacuum and contingent upon teachers' values, experiences and individual school contexts.

The teachers were, by and large, focused on individual behaviours such as harm minimisation if students used alcohol and the prevention of unwanted pregnancies at the junior level. Efforts to improve individual health outcomes

for their students were embedded in social issues discourses, particularly sexuality. Significantly, the teachers did not refer directly to a major policy change in the way health had been conceptualised, the development of the *Ottawa Charter for Health Promotion* (World Health Organisation, 1986). A health promotion discourse was discernible in the 1999 curriculum (e.g., the underlying concepts of the socio-ecological perspective and health promotion). This signalled a new socially critical/social justice conceptualisation of health. The new discourse contrasted with the more individualistic discourse of the 1985 syllabus which focused on individual behaviour change. The policy associated with the Ottawa Charter and subsequent World Health Organisation initiatives emphasised the social, economic and political determinants of health.

The teachers in this study positioned themselves primarily within an individualistic discourse. This positioning resulted from limited access to the discursive resources (the new health' discourses) which might have resulted in different positionings. An individualistic perspective was apparent in their attempts to effect behaviour change in their students. Although there was variation in support for student agency, by and large teachers wanted their students to make choices that would result in good' health outcomes. This individualistic discourse was consistent with the healthism discourse (Crawford, 1980) and is situated within neo-liberal discourses about health. Individualistic health discourses emphasise the role of the individual in changing health behaviours, rather than critiquing the social and economic inequalities which are argued to be major factors in determining health.

The credentialing effects of NCEA Health Education on pedagogy have been discussed in earlier sections of this chapter. The effects of credentialing on creative pedagogies were noted in other subjects and contexts (e.g., McCulloch et al., 2000). Here, some additional observations pertinent to discursive resources and subject status (below) are made. Some teachers who had begun teaching NCEA Health Education, reported a change in what was required from

students, particularly at Levels Two and Three of the NCEA⁷⁴. A shift from the experiential basis of junior Health Education to a more academic focus (particularly in achievement standards and at Levels Two and Three) was noted. It was at Levels Two and Three that the critique of social and economic inequalities became part of the required discourse for senior NCEA Health Education. The more abstract and conceptual knowledge required at senior level appeared to pose difficulties for some teachers as well as students. There were indications in this study that teachers did not have access to these discursive resources (understanding of the social, economic and political determinants of health for example) and this was reflected in their pedagogies. This practise tension illustrated a major difference between junior Health Education (dominated by a neo liberal discourse of individual accountability) and social justice discourses emphasising collective responsibility and aimed at addressing social and economic inequalities.

There were differences indicated in the match of everyday knowledge of different groups of students with what was required by Level One of the NCEA. One teacher suggested that many of her students from a high decile school would be able to pass the Level One NCEA Health Education examination without having done her course. This claim suggested that her students had access to a greater range of discursive resources than students attending other schools (from less advantaged socio-economic backgrounds), who teachers reported were only just coping with Level One.

One of the anticipated changes of including Health Education in the NCEA system was an improvement in subject status (Aldridge, 2000; Tasker, 2004). The pursuit of academic credibility has been typical of low status subjects (Goodson, 1996). The Beacon Schools project initiative was an attempt to change perceptions of health as a non-academic subject (Ministry of Education, 2003). While some teachers were enthusiastic about creating and sustaining senior NCEA Health Education programmes, their motivation for doing was

⁷⁴ The interview data on which this study is based took place at the end of 2003 (the first year for Level Two NCEA) and the beginning of 2004, when assessment at Level Three of the NCEA was available for the first time.

more to do with increasing opportunities for students to take Health Education than pursuing subject status as an end in itself. This finding is consistent with literature that argued that teachers' responses to structural change (in this case changes to curriculum and assessment) included "active agency" (Helsby, 1999a) "in accommodating, ignoring, or adapting such changes within the particular contexts and cultures of schooling" (p. 13). Teachers interviewed about the effects of the Beacon initiative in one region (Ministry of Education, 2005) also expressed support for senior Health Education because of its relevance to students' lives and a preference for it to be offered to all senior students. This discourse of relevancy to students' lives is located in a broader social issues discourse.

In this section, literature from the mezzo analysis of Chapter Four was used to examine the findings about curriculum and assessment as they were reported to have been put into practice in the teachers' schools. The enduring social issues discourse of Health Education was evident both in the 1999 curriculum and in the teachers' accounts of their work. This social issues discourse was also evident in teachers' attempts to extend student participation in Health Education into the senior school through the NCEA system. The facilitative roles for teachers and the student centred pedagogies that were reported were consistent with literature about the intent of the 1999 curriculum. Tensions resulting from the integration of Health and Physical Education discussed in the literature were also illustrated in the findings. Health education pedagogies were constructed in a curriculum vacuum due to factors such as the delay in producing the 1999 curriculum and the lack of a strong subject organisation. An analysis of the teachers' accounts indicated that they positioned themselves primarily within individualistic and experiential discourses. There was also some evidence that those who taught NCEA Health Education were not familiar with the more conceptual and socially critical discourses that were required at Levels Two and Three.

10.5 Socio-political and historical discourses

In this section the macro analysis of Chapter Three is used to contextualise contemporary Health Education pedagogy. The following are discussed in this section: the early establishment of the link between the health of students and the work of schools, the development of an academic tradition in secondary schools, the long standing efforts to address social issues through schooling, the controversies about sexuality education, the development of school based health programmes, the mixing of discourses from the health and education sectors, and the tradition of involving outside groups in school Health Education.

Two historical discursive strands in New Zealand secondary education relevant to contemporary Health Education were (i) that schools and teachers should take an interest in students' health, and (ii) the development of an academic tradition. The role of schooling in producing healthy citizens was signalled in early syllabi (e.g., 1920), as was secondary schooling's role in providing an academic education intended for a select group of young people (McGeorge, 1992). The strength of the academic tradition is relevant to perceptions of the low status of Health Education and the difficulties that have been encountered when Health Education policy makers tried to gain acceptance for Health Education as an academic (i.e. NCEA assessed) subject in recent years. The resulting discursive tensions of attempting to gain academic recognition for a subject that arose out of a social issues discourse were evident in this study.

The data exemplified the teachers' pedagogical focus on health issues, particularly in junior and non NCEA assessed Health Education. This health issues focused discourse was the contemporary expression of a long standing social issues discourse. A social issues discourse was illustrated in early concerns about unplanned pregnancies (e.g., Butcher, 1930) and was increasingly linked to education as politicians and educational policy makers responded to community concerns. Anxiety about social issues was often linked in public consciousness with perceptions of adolescence as a vulnerable

developmental phase (e.g., Pearson, 1958). As increasing numbers of adolescents stayed on at school during the 1970s, secondary schools became a primary focus for attempts to address social issues (particularly sexuality) through education.

Political responses to moral panic discourses (both historical and contemporary⁷⁵) were characterised by a mixture of legislation and education (Shuker, 1990). From the 1970s, there was increasing pressure on politicians and educators to take action on the social issues and the adolescent problem in particular. Health Education as a recognisable subject was eventually created through the protracted and often controversial development of the 1985 syllabus. Controversy was in most cases associated with sexuality education (e.g., Clark, 2001; Snook, 1990) and syllabus development was accompanied by legislation which protected parental rights (Weir, 2000). Sensitivities around sexuality education and parental rights were illustrated in the interview data in this study. There were additional tensions about sexuality evident in the data: different beliefs and attitudes relating to gender orientation and reports of homophobic attitudes amongst staff and students.

Those teachers in the study who were teaching Health Education during the 1980s referred to the growth of school based initiatives in secondary schools which developed in a non-prescriptive climate and in the absence of strongly framed and classified (Bernstein, 1996) professional development. Some of these initiatives had begun in the 1970s (Department of Education, 1981) and included sexuality education in a variety of site based life skills and social education programmes (Weir, 2000).

Teachers in this study reflected an intermingling of health sector and education sector discourses in their talk about their work. This discursive mix was embodied in one who had left a career as a nurse to become a Health Education teacher. One of the teachers in this study had participated in the

⁷⁵ For example the raft of legislation associated with the Mazengarb Report in the 1950s (see 3.3) and the increasing pressure for schools to address social issues. In the 21st century, there has been a range of legislation and policies aimed at addressing issues such as alcohol abuse and the expectation that schools will have an educative role.

professional development associated with the education sector's response to the HIV/AIDS crises of the late 1990s. This sector response illustrated the way discourses migrate from one part of the public sector to another. In addition to the largely health sector aim of increasing understanding about AIDS transmission and prevention, the professional development also provided opportunities for reflection on the effects of attitudes and values about heterosexism and homophobia (Tasker, 2001).

School Health Education has a history of involving national and community groups who have an interest in health. These groups have informed curriculum development and have also been involved in teaching health in schools (Weir, 2000). This tradition continues and was illustrated through the teacher talk in this study. Outside groups have also produced resources and funded professional development for teachers. This practice was also reported with teachers talking about courses and resources funded by non-education sector groups.

In this last section of discussion of the findings of this study, the contemporary experiences of Health Education teachers were located within Health Education's socio-political and historical discourses. The following continuities with present-day experiences were revealed in these discourses: the long established link between health and schooling and the role of secondary schools in attempting to address health issues, an enduring secondary academic discourse, the stability of a social issues discourse, sensitivities and legislation associated with sexuality education, links between the health and education sectors, and the involvement of outside groups in school Health Education.

10.6 Chapter summary

This chapter drew on the data discussed in Chapters Six to Nine in order to provide an overview of the study's findings about teaching Health Education. These findings were then analysed in relation to the theories and literature that

informed this study. The analysis was structured according to the micro/mezzo/macro layers identified in Chapters Three to Five. The analysis also included findings about agency. The theoretical tools for discussing agency were mainly located in Chapter Two. An overview of the major findings across the three layers are summarised below. The findings about agency are included in the first part of the section that follows.

Power and knowledge, power and sexuality, gender, emotionality and agency

Health Education pedagogy was shown to be shaped by two main discourses: Health Education that was assessed by the NCEA and Health Education that was not part of the NCEA system. These two discourses both positioned teachers but also provided opportunities for them to position themselves. Although there was variation in the ways teachers positioned themselves in relation to these discourses, their positioning was affected by the different ways Health Education knowledge was selected, structured, transmitted and valued (Bernstein, 1971, 1996).

The relationship between sexuality and power was analysed from a Foucauldian perspective (Foucault, 1978). Sexuality discourses noted in this study were a reproductive health discourse and a regulative discourse. There was also, however, evidence of teacher and student agency in relation to sexuality and sexuality education.

The teachers in this study were limited by hegemonic gender discourses. The main basis of teachers' analysis and positioning was biological difference. The dominance of this essentialist discourse (MacNaughton, 1998) restricted the teachers' (and by implication, students') access to the diversity of masculinities and femininities.

The emotional investment and consequences of teaching Health Education were evidenced in Health Education pedagogy and in school politics. The emotionality of teaching (Hargreaves, 2001) was revealed as responses to

policy changes in curriculum and assessment in Health Education at the micro level; that is the struggles largely involved individual teachers trying to effect changes in their schools. Emotionality was evident in political struggles for resources (made particularly difficult at the junior level by having to compete with Physical Education). Issues which generated emotionality sometimes reflected the hierarchical structures of secondary schooling. The experiential basis of Health Education, particularly in non-NCEA assessed classes, also contributed to the emotionality of teaching Health Education.

Agency was shown to have been exercised as the teachers positioned themselves in relation to pedagogical discourses over time. There was variation in how teachers expressed agency and this was associated with their different career histories, experiences and personal values. The weakly framed and classified curriculum (Bernstein, 1996) of junior school and non-NCEA Health Education encouraged agency.

Policy into practice for Health Education

The enduring social issues discourse of Health Education was evident both in the 1999 curriculum and in the teachers' accounts of their work. This social issues discourse was also evident in teachers' attempts to extend student participation in Health Education into the senior school through the NCEA system. The facilitative roles for teachers and the student centred pedagogies that were reported were consistent with literature about the intent of the 1999 curriculum. Tensions resulting from the integration of Health and Physical Education discussed in the literature were also illustrated in the findings. Health Education pedagogies were constructed in a curriculum vacuum due to factors such as the delay in producing the 1999 curriculum and the lack of a strong subject organisation. The analysis of the accounts of the teachers in this study indicates that they positioned themselves primarily within individualistic and experiential discourses. There was also some evidence that those who taught NCEA Health Education were not familiar with the more conceptual and socially critical discourses that were required at Levels Two and Three.

Socio–political and historical discourses

In this last section of the discussion about the findings of this study, the contemporary experiences of Health Education teachers were located within Health Education's socio-political and historical discourses. The following continuities with the reported present-day experiences were evident: the long established link between health and schooling and the role of secondary schools in attempting to address health issues, an enduring secondary academic discourse; the stability of a social issues discourse, sensitivities and legislation associated with sexuality education, links between the health and education sectors, and the involvement of outside groups in school Health Education.

The next chapter brings together the findings of the study and concludes the thesis.

Chapter Eleven

Conclusion

This chapter consists of: **11.1 Reprise of the purpose, approach, theory and main findings**; **11.2 Strengths and limitations**; **11.3 Suggestions for further research**; **11.4 Implications for policy and practice**; and **11.5 Final words**.

11.1 Reprise of the purpose, approach, theory and main findings

The purpose of this thesis was to study the policy and practice of Health Education teaching in New Zealand secondary schools. The main question for the study was: —**How is the current policy environment affecting the practice of Health Education and the well-being of Health Education teachers in New Zealand secondary schools?**”

The research was guided by the three questions:

- How do teachers make meanings about Health Education in the current policy environment?
- How do teachers practise Health Education in the current policy environment?
- How is the current policy environment affecting the personal well-being of Health Education teachers?

The study had two dimensions: education policy, with its associated historical and socio-political discourses, and what teachers reported they did including the ways in which they negotiated practice. These two dimensions required a multi-

faceted approach, one that addressed and connected both parts of the main research question. The metaphor of a toolbox' (Ball, 2005) provided a rationale for using a careful selection of methodologies and theories in order to achieve this.

The methodological approach was located in a qualitative research paradigm and used discourse and the related theories of subjectivity and agency. Questions about individual practice set the study within an interpretive/hermeneutic framework and validated the choice of face-to-face interviews as a research method. Thirteen teachers were interviewed and a form of content analysis (Berelson, 1952) was used to analyse twelve of the thirteen interviews (one teacher withdrew from the study). The involvement of a second person in the first part of the data analysis (paraphrasing the interviews into content units) ensured that nothing that the teachers said was overlooked. The teachers talked about curriculum and assessment policy and the interview data also revealed some unanticipated themes relating to gender and emotionality.

Policy and practice were examined discursively, that is in terms of their language, behaviour and relations over time. A discursive analysis contextualised the study by examining the macro historical and socio-political discourses and the mezzo discourses evident as educational policy was put into practice. The theoretical toolbox was completed with the addition of a discussion of teachers' work in terms of discourses of power and knowledge, power and sexuality, gender, and emotionality. Aspects of Bernstein's (1971, 1996) theories about how power works in the selection and shaping of knowledge were used to analyse contemporary policy and practice. His concepts of classification, framing and knowledge codes were particularly useful in analysing Health Education curriculum and assessment discourses. These concepts helped explain tensions in the integrated knowledge code of the 1999 curriculum and in the new knowledge code created when Health Education became part of the NCEA system in 2002. The principles of classification and framing were also helpful in exploring the relationship between commonsense' knowledge and uncommonsense' knowledge. Further theories with

explanatory value were concerned with sexuality and power, gender, and theories about the emotionality of teaching.

The methodological and theoretical 'toolbox' raised issues that were examined in the four data chapters. The main findings from these chapters are summarised here: social issues were of primary importance to those teaching Health Education; junior and non-NCEA assessed Health Education were weakly classified and framed in comparison with senior Health Education; there were pedagogical tensions resulting from the combination of previously separate subjects into one learning area; teachers positioned themselves in relation to two main sexuality discourses – a reproductive health discourse and a regulative discourse; teachers drew on a biologically essentialist gender discourse; there was an emotional cost of teaching Health Education and different life and career histories, values and dispositions affected teacher agency. The main findings were analysed in relation to the literature and theory that had been discussed in the study. An overview of this analysis follows.

Health Education has a long informal history in schools and this study highlighted the historical continuities that extended back to the early twentieth century. The reported practices of the teachers reinforced these continuities. They were deeply concerned with the issues that they perceived their students were facing and saw Health Education as a means of helping students address these issues, particularly those associated with sexuality and mental health. The following continuities with the reported present-day experiences were also evident: the long established link between health and schooling and the role of secondary schools in attempting to address health issues; a secondary academic discourse, which contributed to low status for Health Education; sensitivities associated with sexuality education; links between the health and education sectors; and the involvement of outside groups in school Health Education. The enduring social issues discourse of Health Education was evident both in the 1999 curriculum and in the teachers' accounts of their work. This social issues discourse was also evident in teachers' attempts to extend student participation in Health Education into the senior school through the NCEA system.

Contemporary Health Education pedagogy was shown to be shaped by two main discourses: Health Education that was assessed by the NCEA, and Health Education that was not part of the NCEA system. These two discourses both positioned teachers and also provided opportunities for them to position themselves. Although there was variation in the ways teachers positioned themselves in relation to these discourses, their positioning was affected by the different ways Health Education knowledge was selected, structured, transmitted and valued.

The facilitative roles for teachers and the student centred pedagogies that were reported were consistent with literature about the intent of the 1999 curriculum. Tensions resulting from the integration of Health Education and Physical Education discussed in the literature were also illustrated in the findings. Health Education pedagogies were shown to have been influenced by the ‘curriculum vacuum’ that was the result of factors such as the delay in producing the 1999 curriculum and the lack of a strong subject organisation. The analysis of the accounts of the teachers indicated that they positioned themselves primarily within individualistic and experiential discourses. There was also some evidence that those who taught NCEA Health Education were not familiar with the more conceptual and socially critical discourses that were required at Levels Two and Three.

Sexuality was analysed from a Foucauldian perspective. Sexuality discourses noted in this study were a reproductive health discourse and a regulative discourse. There was also, however, evidence of teacher and student agency in relation to sexuality and sexuality education. The teachers in this study were positioned by hegemonic gender discourses. The main basis of teachers’ analysis and positioning was biological difference. The dominance of this essentialist discourse restricted the teachers’ (and by implication, students’) access to the diversity of ‘masculinities’ and ‘femininities’.

The emotional investment and consequences of teaching Health Education were evident in Health Education pedagogy and in school politics. The emotionality of teaching was revealed as responses to policy changes in

curriculum and assessment in Health Education at the micro level; that is the struggles largely involved individual teachers trying to effect changes in their schools. Emotionality was evident in political struggles for resources (made particularly difficult at the junior level by having to compete with Physical Education). Issues which generated emotionality sometimes reflected the hierarchical structures of secondary schooling. The experiential basis of Health Education, particularly in non NCEA assessed classes, also contributed to the emotionality of teaching health.

Agency was shown to have been exercised as the teachers positioned themselves in relation to pedagogical discourses over time. There was variation in how teachers expressed agency and this was associated with their different career histories, experiences and personal values. The weakly framed and classified curriculum of junior school and non-NCEA Health Education encouraged agency.

This section has discussed the purpose, approach, theory and main findings of the study. Consideration is now given to the study's strengths and limitations.

11.2 Strengths and limitations of the study

The study provides some unique insights about the work of a small group of secondary school teachers who were teaching Health Education just after the introduction of the NCEA. The study therefore makes a useful contribution to the small body of New Zealand research that illuminates teachers' responses to policy change. Rather than better answers, however, a significant contribution this study makes is that better questions can now be asked about teachers' work. These questions are identified in Section 11.3 below, after the study's limitations are discussed.

Some of the limitations associated with the methodology of this research were raised in Chapter Two. My reflexive account, for example, discussed the imbalance of positive to negative statements that were the basis for the interviews and I explained the reasons for this. I also probed the familiarity and neutrality of the interview. Some other limitations of the study that also need to be considered are discussed below.

The small number of teachers involved in this study limited the generalisability of the findings; but then the purpose of this study was not to produce a theoretical framework that could be applied to contemporary Health Education teaching. The teachers who were interviewed self selected into the study. The sample was heavily gender biased and indicates the need for further research with male health educators. The study generated data only from those who were enthusiastic about teaching Health Education, not those who might have had different perspectives. Another limitation was that data about the teachers' practices were derived from the teachers' own accounts and were not supplemented by observations of their practice.

I also had to scrutinise my participation in the research because of my experiences as tertiary health educator. A central assumption of hermeneutics is that human actions can never be pure and objective because of what each of the participants brings to the process. I had to be especially careful about my actions because of my enthusiasm for Health Education. Finally, the well-being of the teachers in this study became less of a focus than I had originally intended. This was because my search for evidence about teacher well-being in the interview data yielded a discourse of emotionality rather than evidence about the more holistic concept of well-being. My findings on the emotionality of teaching could contribute to a more structured study of well-being in the future. Other areas for future research are identified below.

11.3 Suggestions for further research

One significant outcome of this study has been gaining a better understanding of secondary Health Education teachers' work. The result of this enhanced understanding is my ability to ask increasingly precise questions about this work. Questions to guide further research are identified below:

- How do Health and Physical Education *and* Home Economics pedagogical discourses relate to each other at the present time?
- What is the current pedagogical relationship between NCEA Health Education' and non-NCEA Health Education? '
- How do Health Education teachers position themselves in relation to sexuality and gender discourses at the present time?
- Are the tensions in practice identified in this study prevalent across a range of secondary schools in other regions of New Zealand?
- How is teacher agency developed and exercised in other marginalised subjects?
- Do gender discourses vary between male and female teachers?

11.4 Implications for policy and practice

Teachers

It was apparent in the interviews that the teachers enjoyed talking about their practice and that the interviews had provided a rare occasion when they could discuss the whys' of Health Education pedagogy rather than technical considerations of how to go about teaching Health Education. There seemed to be no time in their busy and demanding schedules in which they could pause and reflect on their practice and the effects their pedagogies were having on their students. Provision for this to occur is desirable, as unquestioned

pedagogies are likely to have negative effects on school and pre-service students.

The teachers' basis for gender analysis and positioning was an essentialist discourse based on biological difference. This binary discourse denied teachers and students opportunities to take up a range of creative and productive masculine and feminine positionings. That this discourse was unquestioned by the teachers is perhaps indicative of differential access to discourse resources and may also account for the largely individualistic interpretation of Health Education. It is recommended that teachers have opportunities to engage with new ideas through a professional development process that is both respectful and challenging.

The political struggles to improve Health Education's standing in relation to other subjects, including in some cases Physical Education, were often undertaken by individual teachers within their own schools. This had emotional consequences, particularly for young or inexperienced teachers who were isolated and had limited understanding of the power relations within their schools. There are implications here for work at a national level (e.g., the NZHTA or the secondary teachers' union, the NZPPTA⁷⁶).

Students

Health Education was included in the curriculum of New Zealand schools because it was hoped that learning in Health Education would have an on-going positive effect on young people's lives. The teachers' accounts indicated that the students they taught were indeed benefiting from taking Health Education. Given the reported benefits of Health Education for students, it is important that adequate time be given to Health Education in the junior school and consideration be given to offering non NCEA health modules to all senior students.

⁷⁶ New Zealand Post Primary Teachers' Association.

Policy makers

Policy makers must take account of the implications of radical aspects of curriculum change, such as the development of an integrated curriculum. The 1999 curriculum was imposed on a secondary school culture that is dominated by hierarchical organisation into single (Bernstein's, [1996] collection code) subjects. The implications of a discursive gap' (Bernstein, 1996) created when the three previously separated curriculum areas were brought together was not acknowledged and the teachers in this study operated within a counterproductive Physical Education/Health Education binary. This twofold division (Home Economics was not mentioned) was further emphasised by an essentialist gender discourse.

Policy makers should perhaps have considered the potentially divisive message that was given by establishing separate achievement standards in Health Education and Physical Education for the NCEA and offering separate subject professional development. The 1999 curriculum proposed an overarching conceptual framework (the underlying concepts') but then handed this over to schools to implement as if there were no discursive tensions which needed time and reflection to work through. There appeared to have been no opportunities for discussion amongst practitioners in this study of the implications of an integrated curriculum. It may be too late for discussion to occur at a national level, but it is hoped that fruitful dialogues can still occur in schools in future.

There was a significant shift in the conceptualisation of Health Education which was assessed by the NCEA, particularly at the upper levels of the senior school (Years 12 and 13). The teachers alluded to the more academic' nature of Health Education at these levels and suggested that those students who benefited most from Health Education found NCEA Health Education challenging. Professional development for the implementation of the NCEA may have been partially successful in explaining the technicalities of assessment, but the content of senior Health Education posed an additional challenge for some teachers. The Beacon Project was an attempt to promote understanding of the different content but appears not to have made much impact, at least for

the teachers in this study. The current learning needs of those who teach senior health should be evaluated and appropriate support given.

The teachers in this study were recipients of policy and had not been involved in producing or critiquing curriculum and assessment policy. This was especially obvious for those who taught senior NCEA assessed Health Education. The effects of this gap between policy makers and teachers was of less importance at the junior level as teachers developed school and community based curricula which were meaningful in their local contexts. Ideally, more inclusive mechanisms should be developed to involve teachers in policy design and implementation.

Teacher educators

The discursive tensions between Health and Physical Education evident in this study should be debated by teacher educators and their students. These debates would hopefully lead to creative and productive ways of realising an integrated knowledge code (Bernstein, 1996).

Researchers

Teachers' work is a valuable area of study. This is because insights gained through this kind of research make available aspects of teachers' thinking and practice to other educational communities. This is very important because it goes some way towards bridging the gaps between schools and the tertiary education and state education sectors. Increased understanding of the complexities of teachers' work will hopefully increase constructive and informed discussion across these sectors.

11.5 Final Words

Throughout this study, I was struck by the strong subject loyalty expressed by the teachers who participated. Despite the tensions of practice that beset Health Education, they were all enthusiastic about the contribution their subject could

make to young people's lives. Indeed, some were passionate in this belief. The teachers' talk about their commitment reflected a fundamental conviction that Health Education could enhance the quality of their students' lives both at school and beyond. This commitment to enhancing the quality of life is an enduring characteristic of health education across the decades. The study has shown that teachers' commitments, to their subject and to students, may be shaped in quite specific ways by the pedagogical demands of official curricula and assessment at any given time, but that they endure nevertheless.

The timeless quality of these teachers' aspirations for their students, through teaching and learning in Health Education, is one of the important contributions this study makes to our understanding of contemporary secondary school teachers' work. As a result of the study, we also know a little more about the routine ways teachers are positioned, and position themselves, in relation to personal, educational and societal discourses. This study provides insights into the ways teachers talk about transforming curriculum and assessment policy into practice, and suggests some more precise questions for researchers to ask in future about policy and practice in the teaching of Health Education in New Zealand secondary schools.

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Appendices

Appendix A: Ethical Procedures

Appendix A1: Massey University Ethics Committee –Approval for research

Massey University Human Ethics Committee (MUHEC)
Old Main Building, Turitea Fax: 64 6 350 5622 <http://www.massey.ac.nz/~muhec>
Professor Sylvia V Rumball Chair Miss Karen A Kahukoti, Secretary
Telephone: 64 6 350 5249 Telephone: 64 6 350 5573
Email: S.V.Rumball@massey.ac.nz Email: K.A.Kahukoti@massey.ac.nz



10 July 2003

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099

Mrs Kama Weir
No 1 RD
PALMERSTON NORTH

Dear Kama

Re: The impact of the current policy environment on the teaching of health education in secondary schools

Thank you for the MUHEC Checklist and Section A of the MUHEC Application Form that was received on 30 June 2003.

As specified in the Code of Ethical Conduct for Research, Teaching and Evaluations involving Human Participants, persons who submit the MUHEC Checklist with every question answered with a 'no', together with Section A of the MUHEC Application Form (including a signed Declaration), may proceed with their research without approval from a Campus Human Ethics Committee. You are reminded that this delegated authority for approval is based on trust that the Checklist has been accurately filled out. Please notify me if situations subsequently occur which cause you to reconsider your initial ethical analysis.

Please ensure that the following statement is used on all public documents, and in particular on Information Sheets:

"This project has been reviewed, judged to be low risk, and approved (note to applicant: include the process below that is most appropriate to practice within your Department, School or Institute)

by the researcher
by the researcher and supervisor
by peer review (if you followed that process)
by other appropriate process (outline the process appropriately)

under delegated authority from the Massey University Human Ethics Committee. If you have any concerns about the conduct of this research, please contact Professor Sylvia Rumball, Assistant to the Vice-Chancellor (Equity & Ethics), telephone 06 350 5249, email S.V.Rumball@massey.ac.nz "

Please note that if a sponsoring organisation, funding authority, or a journal in which you wish to publish requires evidence of Committee approval (with an approval number), you will have to provide a full application to a Campus Human Ethics Committee.

Yours sincerely

Professor Sylvia V Rumball, Chair
Assistant to the Vice-Chancellor (Equity & Ethics)

cc Dr John O'Neill
Social & Policy Studies in Education
HOKOWHITU PN900

Massey University Human Ethics Committee
Accredited by the Health Research Council

Te Kūmenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

Appendix A2: College of Education Ethics Committee – Research proposal review



Learning and Teaching
Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 351 3383

College of Education Ethics Committee RESEARCH PROPOSAL REVIEW

Name of Applicant(s) Kama Weir

Title of Research The impact of the current policy environment on the teaching of health education in secondary schools

Reference Number COE 03/017

The Proposal has been reviewed, as follows:

- No change
- Minor amendments (as listed at Amendments below)
- Major amendments (as listed at Amendments below) to be reviewed by Committee
- Submit to MUHEC

AMENDMENTS

- Amendments noted, 20.06.03

NOTES

- The present review applies only to the interview phase of the study.

This project was reviewed by the Massey University College of Education Ethics Committee and found to meet the university's ethical guidelines.

Signature *p.p. Helen Smedley* **Date** Friday, June 20, 2003

Professor Joy Cullen
Chairperson
College of Education Ethics Committee

Phone 06 351 3355

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

Appendix A3: Correspondence with the Ministry of Education

Letter of 2nd April, 2003



2 April 2003

National Office

Pedagogy and Learning Materials
45-47 Pipitea Street
Thorndon
PO Box 1666
Wellington
New Zealand

Phone: 0-4-463 8000
Direct: 04 464 8037
Fax: 0-4-463 8001
www.minedu.govt.nz

Ms Kama Weir
Lecturer
Massey University College of
Education
Private Bag 11035
PALMERSTON NORTH 5301

Dear Kama

Personal Research in Health Education

Thank you for your email of 26 March requesting our agreement to your using teachers from the Health Education Beacon School within the 20 teachers in your sample for your doctoral research. You appear to have already thought of the potential areas in which there could be confusion and ethical difficulties.

We would want assurance that your methodology ensures a clear separation between the data/information that you are collecting for the Ministry and the data you are collecting for yourself. This also needs to be made clear to the schools. It is also important that schools are clear that there are two distinct projects and who each is for.

It has been suggested that the easiest way forward would be for you to send us a copy of your ethics application. We imagine that the research proposal would be included within this. Having gained assurance from your application, we would write back confirming our agreement to your approaching the schools.

Yours sincerely

Barbara Hollard
Curriculum Facilitator



Letter of 29th July 2003



29 July 2003

National Office

Pedagogy and Learning Materials
45-47 Pipitea Street
Thorndon
PO Box 1666
Wellington
New Zealand

Phone: 0-4-463 8000
Direct: 04 464 8037
Fax: 0-4-463 8001
www.minedu.govt.nz

Ms Kama Weir
Lecturer
Massey University College of
Education
Private Bag 11035
PALMERSTON NORTH 5301

Dear Kama

Personal Research in Health Education

Thank you for sending me a copy of your ethics application for your research, *The impact of the current policy environment on the teaching of health education in secondary schools*.

It appears from your proposed methodology that there will be a separation between the data/information that you are collecting for the Ministry and the data you are collecting for yourself.

I understand that while the teachers you will be liaising with in relation to the Beacon Schools project are pre-determined, you will be approaching teachers via letter and an intermediary for involvement in your research. I would be expecting that the interviews with the teachers would be held at a time that is different from the visits to the teachers in relation to the Beacon Schools. Could you call me to confirm that please.

I wish you well with your research and will be very interested to read the resulting thesis.

Kind regards

Barbara Hollard
Curriculum Facilitator



Email of 4th August 2003

Hollard Barbara, 07:51 a.m. 4/08/2003 +1200, RE: Research

Page 1 of 1

>From barbara.hollard@minedu.govt.nz Mon Aug 4 07:52:04 2003
Date: Mon, 04 Aug 2003 07:51:57 +1200
From: Hollard Barbara <barbara.hollard@minedu.govt.nz>
Subject: RE: Research
To: "Kama Weir" <k.j.weir@massey.ac.nz>

Thanks Kama

-----Original Message-----

From: Kama Weir [<mailto:k.j.weir@massey.ac.nz>]
Sent: Sunday, 3 August 2003 10:46
To: Hollard Barbara
Subject: Re: Research

Hi Barbara

Thanks for your letter regarding my personal research in health education. In relation to my doctoral research ('The impact of the current policy environment on the teaching of health education in secondary schools') I'd like to confirm that the interviews with any of the Beacon teachers who volunteer to take part in the research will be held at times that are different from visits to the teachers in relation to Beacon school matters.

Kama

At 12:29 p.m. 1/08/2003 +1200, you wrote:

>Hi Kama
>Thank you for your voice message. Could you please send an email about
>your gathering of the data at different times so I can keep it on record..
>Many thanks
>Barbara

Printed for Kama Weir <k.j.weir@massey.ac.nz>

4/08/2003

Appendix A4: Letter inviting participation for principals

FILE COPY



28 August 2003

«name»
The Principal
«school»
«street»
«city»

Dear «full_name»

The impact of the current policy environment on the teaching of health education in secondary schools

I am a lecturer in health education in the Department of Health and Human Development at Massey University College of Education. I am currently engaged in a doctoral study funded by Massey University Research Fund. My supervisors are Doctor John O'Neil (telephone 06 356 9099, ext 8635, email J.G.ONeil@massey.ac.nz) and Professor John Codd (telephone 06 356 9099, ext 8965, email J.A.Codd@massey.ac.nz). In my research I hope to explore how teachers make meaning of health education in the current educational environment and also how the current environment is affecting the personal wellbeing of those who teach a health promoting subject.

I intend to begin fieldwork for this research in Term Four of 2003 and, with your approval, would very much like to invite teachers from your school to volunteer to be part of this study. I understand that before making any decision you would wish to discuss the proposed research with you Board of Trustees and gain their approval.

In 2004 a subsequent request may be made as I begin to second stage data gathering; I intend approaching up to four schools for permission to use them as case studies for the implementation of senior health education programmes.

I enclose an information sheet outlining my proposed study. I would like to emphasise that information from the research will be kept confidential and the names of participating schools and teacher will not be used.

If you would like to discuss this project with me please do not hesitate to contact me. (My contact details are below).

Thank you for taking the time to read this letter and I look forward to hearing from you.

Yours sincerely

Kama Weir
Lecturer, Health Education
Telephone 06 356 9099, extn 8887
Email k.j.weir@massey.ac.nz

Encl

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey



Department of Health &
Human Development

- Physical Education
- Guidance & Counselling
- Health Education
- Human Development

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 351 3353

Appendix A5: Information sheets inviting participation for teachers



Department of Health & Human Development

- Physical Education
- Guidance & Counselling
- Health Education
- Human Development

Private Bag 11 222,
Palmerston North,
New Zealand
Telephone: 64 6 356 9099
Facsimile: 64 6 351 3353

The impact of the current policy environment on the teaching of health education in secondary schools.

INFORMATION SHEET

I am a lecturer in health education in the Department of Health and Human Development at Massey University College of Education. I am currently engaged in a doctoral study funded by Massey University Research Fund. My supervisors are Doctor John O'Neill (telephone 06 356 9099, email J.G.O'Neill@massey.ac.nz) and Professor John Codd (telephone 06 356 9099, email J.A.Codd@massey.ac.nz).

Below I describe the project and the level of involvement you could expect if you agree to participate.

Purpose of this study:

The study is an exploration of how teachers make meaning of health education in the current educational environment and how the current environment is affecting the personal well-being of those who teach a health promoting subject.

The research objectives are as follows:

1. How do teachers of secondary health education make meaning of health education in the current policy environment?
2. How do teachers practice health education in the current policy environment?
3. How is the current policy environment affecting the personal well-being of health education teachers?

Volunteer teachers will self select into the research using a 'snowball' sampling approach until a sample of twenty is achieved. (Twenty provides a reasonable number for the requirements of qualitative research).

The fieldwork is planned for Term 4 of 2003. With your consent, I intend to tape all interviews in the course of the research.

Please note that I am only interested in gathering data related to your understanding and experience. There are no right or wrong answers and I intend to make no judgements about the quality of teaching or programmes.

Te Kunenga ki Pūrehuroa

Inception to Infinity: Massey University's commitment to learning as a life-long journey

If you agree to take part in the study, I anticipate a maximum commitment of five hours per person, spread through Terms 4 of 2003. Each interview will last for an hour and take place at a venue, (school, or elsewhere) selected by you.

What can you expect from me?

In addition to offering you the opportunity to reflect in depth on your understanding of health education, you can also expect that:

- all data will be gathered on an anonymous and confidential basis
- I shall endeavour to faithfully represent your experiences and perceptions in any publications which arise from the research study
- I shall return interview transcripts promptly for your verification
- I shall provide you with a copy of the conclusions and recommendations from the completed study
- I shall offer to lead a meeting at each participating school at which I will discuss the completed research study and major findings
- after five (5) years I shall destroy all data (unless directed otherwise by you).

Your participation

If you participate in this study you have the right to:

- refuse to answer any particular questions, and to withdraw from the study at any time
- ask any further questions about the study that occur to you during your participation
- provide information on the understanding that it is completely confidential to the researcher. All information is collected anonymously, and it will not be possible to identify you or your school in any reports that are prepared from the study
- be given access to a summary of the findings from the study when it is concluded
- ask for the tape to be turned off at any time during the interview.

If you want further information about the study, please contact me:

Kama Weir

Department of Health and Human Development
College of Education
Massey University
Phone: 3569099 (ext 8887)
Email: K.J.Weir@massey.ac.nz

Thank you for taking the time to read this information sheet.

Appendix A6: Consent form for teachers



Massey University
COLLEGE OF EDUCATION
Te Kōwhiri o Te Mātauranga

SCHOOL OF ARTS, DEVELOPMENT
AND HEALTH EDUCATION
• Arts Education
• Counselling & Guidance
• Early Years
• Health Education
• Human Development
• Physical Education
Private Bag 11 222
Palmerston North 4442
New Zealand
T +64 6 356 9099
F +64 6 351 3353
www.massey.ac.nz

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CONSENT FORM

I have read the Information Sheet for this study and have had the details of the study explained to me. My questions about the study have been answered to my satisfaction, and I understand that I may answer further questions at any time.

I also understand that I have the right to withdraw from the study at any time, and to decline to answer any particular questions in the study.

I agree to provide information on the understanding that it is completely confidential and anonymous.

I agree/do not agree [DELETE ONE] to the [interviews] being audio taped. I also understand that it is completely confidential and anonymous.

I understand that at the completion of the study I will be asked to choose from three options for the disposal of data gathered from me during the course of the research:

1. Data returned to me
2. Data destroyed by the researcher
3. Data are kept under lock and key conditions by the researcher for future use in related research.

I wish to participate in the study under the conditions set out on the Information Sheet.

Signed:Date



Te Kōwhiri
o Te Mātauranga

Appendix A7: Transcribers Confidentiality Agreement

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TRANSCRIBER'S AGREEMENT

I (Full Name - printed) agree to transcribe the tapes provided to me.

I agree to keep confidential all the information provided to me.

I will not make any copies of the transcripts or keep any record of them, other than those required for the project.

TRANSCRIBER

Signature: **Date:**

WITNESS

Signature: **Date:**

Full Name - printed

Appendix A8: Authority for release of tape transcripts



DEPARTMENT OF HEALTH
AND HUMAN DEVELOPMENT

- Physical Education
- Guidance & Counselling
- Health Education
- Human Development

Private Bag 11 222
Palmerston North
New Zealand
T 64 6 356 9099
F 64 6 351 3353
www.massey.ac.nz

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AUTHORITY FOR THE RELEASE OF TAPE TRANSCRIPTS

This form will be held for a period of five (5) years

I confirm that I have had the opportunity to read and amend the transcript of the interview/s conducted with me.

I agree that the edited transcript and extracts from this may be used by the researcher, Kama Weir in reports and publications arising from the research.

Signature: _____ Date: _____

Full Name (*printed*): _____

Appendix B: Interview Questions

Interview questions – tell me about a time

- When you discovered that you had a different view about some aspect of health education than someone else....
- When you discovered that you had a different view about the **purpose** of health education than someone else.....
- When you made an important decision about health education.....
- When you discovered something new about yourself while you were thinking/planning/doing health education.....
- When you were talking to someone else about health ed and you discovered you were ‘both on the same wave length’.....
- When you felt angry/resentful/annoyed about a decision made about health ed
- When you made a mistake in relation to health ed
- When a change of direction in your life made you think about something in health ed
- When you were on your own about something to do with health ed and hardly anyone supported you
- When you began to take taking seriously something to do with health ed that had not previously mattered to you.....
- When you felt confused about the content/ teaching/ assessment of health ed

- When you were disappointed with yourself about an event to do with health ed
- When there was a misunderstanding between you and someone else (or several others) about health ed
- When you felt you really sure of your ground in an issue to do with health ed
- When you read something/ heard someone/ that was confirmation of an understanding you have about health education
- When you felt you had done something really well in teaching health education