Health, Personal & Social Development (HPSD) Education
Possibilities, Pitfalls, Practical

FRESH webinar, 16 July 2018
Introduction/Purposes

1. Recall, Review Scope of Health, Personal & Social Development (HPSD)

This scoping exercise is intended to inform the work of the FRESH Working Group on Health Literacy, Life Skills and Social Inclusion. This working group is supported by a parallel International Research Network formed in partnership with the World Education Research Association as well as a by Global Consortium of Education and Other Faculties. These two networks are focused, respectively, on research and the development of a work force capable of delivering the education necessary for HPSD education and the social role of schooling.

2. Examine & Discuss Possibilities of Community and Extra/Co-Curricular Learning

There are several examples and experiences with teaching/learning opportunities outside of the classroom and formal subjects/curriculum.

3. Examine & Discuss Some of the Pitfalls and Practical Issues in classroom-based HPSD Education that have been neglected in practice & research

Despite decades of work, we appear to have ignored/avoided some huge practical issues; including time, structure and learning of core skills, attitudes and beliefs

4. Discuss Policy Issues and Directions from an Education System Perspective

How does HPSD education fit within the current educational landscape of 21st century learning, macro-competency-based curriculum frameworks and personalized/problem-based/flipped learning favouring cross-curricular, inter-disciplinary strategies?
HPSD as part of SH & 2030 Education Goal

• Health-Personal-Social Development (HPSD) Education is part of most multi-component approaches (FRESH, HPS, SH&N, Essential Package, Child-Friendly Schools, Social & Emotional Learning, Life Skills etc.)

• In 2015, as part of the development of the UN 2030 Sustainable Development Goals, the world’s educational leaders and countries met to articulate the kind of education that should be offered in schools. The Incheon Declaration and the ensuing 2030 Framework for Action to accomplish this high quality education provide clear directions that health, and life skills need to be part of the core curricula and student learning opportunities. HPSD education is the means to achieve that goal.
The **FRESH Working Group on Health Literacy, Life Skills and Social Inclusion** will examine several leading paradigms that have been and are being used to guide teaching and learning in health, personal and social development education. It is likely that this list will evolve as the work of the group proceeds. The initial list of paradigms includes:

- **Basic literacy in health and safety**, including functional general basic knowledge as well as the ability to access/use reliable information and support from parents, peers, health and other services, protection/police services, trusted adults related to various issues such as child sexual and economic exploitation, hygiene, infectious diseases, abuse & neglect, nutrition, substance abuse, mental health, accidents, environmental hazards, disasters and many others.

- **Life skills**, including life/social skills, coping skills related to resilience, conflict resolution skills, social and emotional intelligence, essential family life skills, financial/economic and media/consumer literacy, decision-making, youth development, engagement & empowerment.

- **Social inclusion**, including human rights, global citizenship, peace education, gender equity, social responsibility, ethics/morals/faith/spirituality, education to prevent extremism, violence, bullying, and discrimination, education to promote diversity and inclusion of students with disabilities/special needs and alleviating disadvantages caused by social and economic inequities.
Scope of HPSD Education
Stretching Curricular Time: An Integrated Approach to Disaster Risk Reduction and Climate Change Education

Health, Personal & Social Development Education & Learning: The Possibilities, the Pitfalls & the Practical, 16 July 2018

Dr David Selby
Founding Director
Sustainability Frontiers
Source:
Source:
http://www.huffingtonpost.com/dr-reese-halter/earths-new-normal-wild-we_b_4543416.html
Content and Scope of Disaster Risk Reduction Education (DRR)

- Initially and predominantly covering climatological and geo-seismic ‘disasters caused by hazards of natural origin’ such as floods, storms (cyclones, tornados, typhoons, hurricanes), tsunamis, earthquakes, volcanoes

- Now increasingly extended to human-caused hazards such as landmines, biohazards

- In conflict-affected societies DRR is being integrated with peace building education (‘DRR-plus’ or ‘CDRR’)

- Also extended to cover ‘slow-onset’ disasters such as biodiversity loss, desertification, and crucially increasingly linked with climate change education

- DRR increasingly seen as a key dimension of Education for Sustainable Development (disaster and sustainability as in negative correlation, resilience and sustainability in positive correlation)
DRR Learning Dimension 1: Understanding the Science and Mechanisms of Hazards

• Happens in Geography and Natural, Physical and Earth Sciences

• This dimension has been predominant
DRR Learning Dimension 2: Learning and Practicing Safety Measures and Procedures

- Moves DRR learning away from the Physical and Natural Sciences
- Links classroom learning to extra-curricular learning
DRR Learning Dimension 3: Understanding Risk Drivers and how Hazards can Morph into Disasters

- Brings idea of ‘natural disaster’ under critical scrutiny
- Focuses on key concept of vulnerability
- Takes DRR learning firmly into the social sciences
DRR Learning Dimension 4: Building Community Risk Reduction Capacity

- Focuses on key concept of resilience

- Introduces ideas of adaptation to and mitigation of hazard

- Takes learning out into the community

- Asks students to tap into local and indigenous disaster knowledge and wisdom
DRR Learning Dimension 5: Building an Institutional and Community-wide Culture of Safety and Resilience

• Links children’s learning to safe school initiatives

• Seeks to make the school the hub of community resilience building

• There are implications for localization of curriculum development
The Four-C Model
• Children find out about past patterns of hazards and present threats by interviewing older members of the community and local experts (hazard assessment)

• Children carry out hazard mapping by group walks along multiple transects across their community and add findings to a collective map (vulnerability assessment)

• Children find out about defenses and safeguards in place (and not in place) to cope with potential adverse effects (capacity assessment)

• Children find out about seasonal cycle of hazards and develop local hazard calendar

• Children present findings to school community and local community
Child/Youth-led Action: Learning Examples
The Sandwatch Project
(various islands/coastal countries)

Child/Youth-led Action: Learning Examples
Child/Youth-led Action: Learning Examples

France (Student Risk Ambassadors)
Child/Youth-led Action Learning: Examples

Sierra Leone (Community Radio Programs)

Source:
<table>
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<tr>
<th>Modes of Contribution</th>
<th>Examples</th>
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| Analyzers             | - Social Studies: conducting school and community hazard surveys, mapping, assessments, transects  
|                       | - Mathematics: analyzing hazard and disaster statistics  
|                       | - History: drawing DRR lessons from past hazard events  
| Designers and         | - Agriculture: designing, planting, tending a preventative health garden  
| implementers          | - Science: collaborating with experts on campus resilience measures  
|                       | - Geography: mapping out, measuring and signposting evacuation routes  
| Communicators         | - Expressive Arts: posters, displays, photography, videography, models to draw attention to risks and potential resilience growth points  
|                       | - Language Arts: newsletters, prose and poetry, oral presentations on DRR issues  
|                       | - Performing Arts: in-school and in-community formal and ad hoc drama, sketches, puppetry  
| Mobilizers            | - Citizenship: actively contributing to DRR committees, councils and at public sessions  
|                       | - Language Arts: reporting on DRR events and sessions through postings and presentations  
|                       | - Social Studies: public awareness campaigns on DRR fault lines  
| Constructors          | - All Subjects: creating DRR dedicated social networks to exchange DRR ideas and initiatives  
|                       | - Geography: building/maintaining open lines of communication with NDMO and other relevant bodies  
|                       | - All Subjects: peer tutoring of younger students on DRR issues  

Child/Youth-led Action Learning: Examples
Curriculum – the totality of student experience in the process of learning
Creating space for a wider and deeper DRR/CCE Curricular Experience

- Student involvement in fostering and maintaining an institutional ‘culture of safety’
- Student engagement in and with the community (school as hub of DRR/CCE)
- Shifting the perception of the school as a teaching community to school as a learning community (monitoring and evaluation function)
How to calculate ‘time available’?
Is it calculable?
Whose time?
Time for what?
Planned/token time or actual/quality time?
Measured time versus diffused time (and where is the demarcation)?
Thank you!

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Pitfall: Way too many H&S Issues: Countries/states need to Focus their Resources

Each country and community will need to identify the specific issues, conditions and behaviours that they need to address based on data-driven analysis and consultations as well as select the educational/development paradigms that best suit their context. Policies, curricula/education programs and services delivered through schools will then need to focus their resources and educational capacity on those issues and paradigms within a broad approach that includes capacity-building and systemic planning of their core HPSD education program.
Many excellent and proven education programs on specific topics have been developed, tested and used. Pitfall: Rarely do these programs refer to or are positioned within an overall, core HPSD curriculum.

The classroom instructional time devoted to HPSD education is unknown in almost all national reporting, in global survey instruments, in topic-focused research and in practice.

The curriculum structures (health, life skills, Health & PE, PSHE etc.) used to deliver HPSD education are unknown and not compared for effectiveness of coverage.

Some curricula have defined some general, generic skills as part of the HPSD program but they are not used to report on or evaluate the effectiveness of HPSD curricula. Most reports (and research studies) are on the coverage of topics or on specific topics but not on HPSD learning overall. (Health literacy is different than health skills)
Dose, Duration, Intensity of HPSD Education: Time is of the Essence

Time Matters:

• Connell DB, Turner RR, Mason EF. (1985) Summary of findings of the School Health Education Evaluation: health promotion effectiveness, implementation, and costs, J Sch Health. 1985 Oct;55(8):316-21. concluded that while a few hours can have an impact on knowledge, 40-50 hours is necessary for attitudes and behaviours.

• FRESH Core Framework asks about frequency of health lessons delivered at school level. (Also asks about time spent in cross-curricular and non-classroom time) But this self-assessment tool has not been used in many countries. The WHO SHPPS survey and the World Bank SABER surveys do not ask about time.

The Picture is Sketchy: Our searching through national/state curricula documents thus far has found:

• Some have required or recommended instructional time for HPSD as part of their curriculum documents but leave the final decision to local education authorities, schools or teachers. Some studies show that local school districts or schools do not follow or do not know if their teachers follow those instructional times.

• Many curriculum documents include a minimum time for physical education but not for HPSD education.

• When asked, practitioners appear to be mystified or unable to answer this simple question

• A “guesstimate” of instructional time can be made for high resource countries based on the US SHHPS survey. For primary schools, the average time per year seems to be about 20 hours per year. For secondary schools, the time is about 30 hours. Each topic seems to take 4-5 hours of instructional time.

• Guesstimates for low resource countries would likely be lower because of less schooling time per year. Guesses for conflict/disaster-affected countries (which have unreliable time for schooling) would be far less.

• Two classes of 45 minutes or three classes of 30 minutes = 150 minutes per week x 40 weeks equals 100 hours
Practical Issue: Curriculum Structures will Affect Time & Impact

There are a number of curriculum structures to deliver HPSD education. They include:

• Stand-alone health education (emphasizing health topics)
• Stand-alone Life Skills (emphasizing social behaviours)
• Health education combined with physical education (usually less than 1/3 HE)
• Health Education combined career/personal planning
• Personal-Social-Health Education (HPSD)
• PSHE combined with Home economics/financial literacy
• Cross-curricular approaches (with or without an over-arching student competencies framework)

Very few reports or studies (if any) report on the comparative effectiveness of the choices made among these curriculum structures.
List of Generic Skills, Attitudes, Beliefs & Functional Knowledge

A list of general student learning goals:  (Most definitions of functional health literacy focus on B and G)

A. Knowing the ground rules/vocabulary for in-class and small groups discussions and disclosures (as well as other discussions with parents, peers, partners etc.)

B. Functional or practical knowledge geared to daily living (as opposed to interesting or sensational facts about the health issue)

C. Developing general life/decision-making/social/emotional/coping skills as well as relevant, specific situational skills or scripts

D. Developing specific normative beliefs, awareness of social influences, attitudes, and accurate perceptions/beliefs about the issues

E. Developing self-knowledge, self-concept and anticipating and handling related adolescent life challenges including actions plans or behavioral intentions about the issue

F. Being aware of/being able to access social support from parents, friends, trusted adults

G. Being aware of and being able to access health, social, youth and other services

H. Increasing willingness to help others with health or social problems in appropriate ways

I. Addressing the needs of specific populations and higher risk situations

J. Making connections with other curriculum areas and subjects/ parts of their lives for reinforcement and elaboration of health content/messages
HPSD Education Currently is “Topic-based Education”

Our investigation of HPSD curricula thus far has found that generic skills, attitudes and functional behaviours are not used as organizing device in HPSD curricula:

• The FRESH Framework has a general definition of generic skills but there is confusion about “health content” & “skills-based pedagogy. Out of 25 recommended topics three are skills-focused.
• The draft WHO questionnaire has six skills and 15 health content topics.
• The World Bank SH Questionnaire asks about four health topics, a list of other “issues” and another question on “life skills for health behaviours”.
• Some curricula perceive a “balanced curriculum” as one that covers a variety of health topics.
• Rigorous content analysis is needed on representative samples of national/state curricula
### Illustrating the challenge: Substance Abuse

| A. Prepare students to discuss substance abuse/addictions | 1. Setting ground rules for class discussions  
2. Establishing a process for student disclosures |
|----------------------------------------------------------|----------------------------------------------------------------------------------|
| B. Acquire& use functional or practical knowledge about substance abuse/Addictions | 1. Recognize that harmful use can occur with legal substances or addictive behaviours as well as illegal substances  
2. Recognize signs of abuse  
3. Understand meaning of addiction, dependence, addictive behaviours  
4. Understand relationship between substance use, abuse and mental health  
5 Understand short-term, social, and school-related risks  
6. Understand long-term risks to health  
7. Understand personal and societal economic costs of use and abuse  
8. Recognize and understand specific risks or consequences  
   a) drinking/cannabis use while driving or operating machinery  
   b) other accidents and injuries  
   c) making poor decisions about having sex or relationships  
   d) participating in dares or contests  
9. Knowing and avoiding specific situations or behaviours  
   a) Binge drinking, b) Leaving drinks unattended in bars, c) abuse of prescription drugs  
   d) Using while depressed or lonely & suicide,  
   e) drinking while pregnant/FASD  
10. Knowing about legal rights and responsibilities  
   a) Under-age drinking, b) impaired driving, c) possession of marijuana  
   d) Search and seizure procedures in school, community and home  
11. Knowing the types, properties, street names, health risks, characteristics, and other behaviour relevant features of substances  
   a) Non-prescription and prescription medicines, b) alcohol, c) cannabis, d) hallucinogens (LSD, etc), e) Mixed action drugs (Meth, PCP), f) Inhalants, g) cocaine/heroin, h) gambling  
   i) Other addictive |
| C. Develop general and specific skills | 1. General social and life skills  
a) Emotional intelligence skills (eye contact, group skills etc.)  
b) Decision-making skills  
c) Assertiveness skills  
d) Critical thinking skills  
e) Stress management skills, coping skills, resiliency  
f) Conflict management/negotiation skills  
g) Emotion/anger management skills/self-regulation  
h) Media literacy skills  
2. Specific skills related to substance abuse/risk behaviours  
a) Avoiding risky situations  
b) Refusal skills  
c) Reading medication labels |
| --- | --- |
| D. Develop health promoting attitudes, perceptions, normative beliefs | 1. Awareness of social influences  
a) Awareness, attitudes re media role  
b) Awareness, attitudes re corporate advertising to increase consumption of substances  
c) Beliefs, awareness about families, parents, and their use of substances  
d) Awareness, beliefs about community norms related to substances  
e) Awareness of youth culture, peer group and role of close friends  
f) Awareness of societal or cultural norms, beliefs about substances  
g) Awareness of impact of part time work on consumption of substances  
2. View/perceptions about laws, government role, rules  
a) regulation/control of use  
b) regulation of advertising  
c) taxation/government use of taxes, gambling, etc  
d) enforcement and youth/privacy/rights  
e) substance use and society  
3. Beliefs, awareness of popular misconceptions and myths about substances |
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<th>E Develop self-knowledge, awareness, concept</th>
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<tbody>
<tr>
<td>1. Anticipate, understand their adolescent challenges and transitions</td>
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<tr>
<td>a) Forming healthy peer relationships</td>
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<td>b) Taking risks</td>
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<td>c) Being recognized by peers</td>
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<td>d) Being recognized as an adult or for being responsible</td>
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<td>e) Dealing with boredom due to age restrictions or lack of resources for varied recreation, life pursuits</td>
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<td>f) Dealing with lack of disposable income or privacy</td>
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<td>2. Dealing with normal, life events specific to youth</td>
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<td>a) Family stress or divorce</td>
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<td>b) transition into high school, moving to a different school/neighbourhood</td>
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<td>c) Bereavement</td>
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<td>d) Development of a sexual identify, love relationship, gender awareness and roles</td>
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<td>3. General awareness of self</td>
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<tr>
<td>a) knowing own strengths and weaknesses</td>
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<td>b) having life goals</td>
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<td>c) knowing when to get help</td>
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<td>4. Develop a personal action plan/behavioural intentions about substance use</td>
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<td>a) Using healthy alternatives to non-prescription medicines</td>
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<td>b) Careful use of prescription medicines</td>
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<td>c) Moderate or non-use of caffeine, energy drinks, other stimulants</td>
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<td>d) delay experimentation or abstain from alcohol use</td>
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<td>e) Avoiding situations that involve use of alcohol or drugs</td>
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<td>f) Reducing harm if using (eg don’t drink or use while driving)</td>
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<td>F Be aware of and know how to access Social Support</td>
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<tr>
<td>1. Seek or secure support from friends</td>
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<td>2. Seek or secure support from parents</td>
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<td>3. Seek or secure support from a trusted adult</td>
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<td>4. Participate in healthy social or sports activities/clubs</td>
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<td>5. Reduce or set aside stigma related to addiction (individual, family, school)</td>
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<th>G. Be aware of and know how to access health, addictions and other Services</th>
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<tr>
<td>1. School or community peer helper programs</td>
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<tr>
<td>2. In-school support services (guidance counsellor, social worker, psychologist, police officer, addictions worker)</td>
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<td>3. Family physicians or clinics</td>
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<td>4. Local addictions clinics</td>
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<td>5. Local mental health clinics or professionals</td>
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<td>6. Family counseling services</td>
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<td>7. Child Protection services</td>
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<td>8. Pastoral counselling</td>
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<td>9. Youth or family self-help groups</td>
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<td>10. Workplace assistance programs</td>
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<td>11. Awareness of availability of local services</td>
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<td>12. Awareness of on-line services</td>
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<td>13. Reducing stigma associated with use and seeking help</td>
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| H Increase willingness to help others | 1. Critical thinking/action on school policies (suspension, etc.)  
2. Critical thinking/action/willingness to support friends/siblings and peers  
3. Advocacy skills/knowledge/tips/ to organize health promoting projects  
4. Advocacy on improving school drug education programs/policies  
5. Participation in youth, school or neighbourhood activities  
6. Advocacy for improved health and treatment services for youth |
| I. Lessons, activities for vulnerable, at-risk or special needs populations | 1. Children of alcoholics/addicts  
2. Children with FASD  
3. Students recovering from addictions  
4. Students in conflict with the law  
5. Students with intellectual, physical or learning disabilities  
6. Gay and lesbian youth  
7. Ethnic minority youth  
8. Aboriginal youth  
9. Students working part-time  
10. Youth living in rural communities  
11. Children with chronic diseases or conditions |
| J. Cross-curricular Lesson Plans and Activities | 1. Language Arts  
2. Art/Literature/Creative Writing  
3. Communications/Media Studies  
4. Mathematics  
5. Science/Technology  
6. Music/Dance  
7. Physical Education  
8. Home Economics/Family Studies  
9. Technical-Vocational/Career Education  
   a) Health related careers  
   b) Automobile & Machinery/Industrial Shop  
   c) Sports/Recreation  
   d) Other |
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