Journal of Education and Learning; Vol. 1, No. 1; 2012
ISSN 1927-5250 E-ISSN 1927-5269
Published by Canadian Center of Science and Education

Health Curriculum Policy Analysis as a Catalyst for Educational Change in Canada

Dianne C. Thomson[1] & Lorayne Robertson[1]

[1] Faculty of Education, Institute of Technology, University of Ontario, Oshawa, Canada

Correspondence: Dianne C. Thomson, Faculty of Education, Institute of Technology, University of Ontario, Oshawa, ON, L1G 4R7, Canada. E-mail: Dianne.Thomson@uoit.ca

Received: April 11, 2012 Accepted: May 10, 2012 Published: June 1, 2012

doi:10.5539/jel.v1n1p129 URL: http://dx.doi.org/10.5539/jel.v1n1p129

Abstract

Health curriculum policy development in Canada is a provincial and territorial responsibility that addresses the national agenda of health promotion. Each curriculum policy reflects philosophies about health. This study investigates the health education models found in the research literature and compares them with those used in Health curriculum policies for Grades 4–9 across Canada using a policy analysis framework developed by the authors. This study is also intended to establish the degree of curriculum coherence (Beane, 1995) and knowledge mobilization (Levin, 2008) around health priorities for children and adolescents. Findings show inconsistencies among policies and between philosophies and student outcomes. The most common policy model is that of interactive level of health literacy, positing students as informed recipients of health care and responsible decision makers. This analysis is offered as a catalyst for national dialogue on health education policy coherence.

Keywords: critical health literacy, health curriculum, democratic education

1. Introduction

Current health discourse often centres on the obesity crisis (Wright, 2009) and draws a simplistic equation between health and weight. In this equation, weight is seen both as a determinant of health, as well as its outcome. A new report on obesity by the Public Health Agency of Canada (PHAC) takes a more complex view however, acknowledging an association between obesity and health but clarifying that it is neither simple nor direct and also that there are multiple factors linked to obesity (PHAC, 2011a, p.27). Some factors that can be managed or acted upon are classified as *proximal* or immediate, such as physical activity and diet while others are considered to be *distal* factors, such as community, socioeconomics, and the environment.

An earlier PHAC report (2003) provides evidence that there are many determinants of health–not just diet and exercise. PHAC identifies ten key determinants of health: income and social status; social support networks; education and literacy; employment/working conditions; social and physical environments; personal health practices/coping skills; healthy child development; biology/genetic endowment; health services; gender, and culture. Often these broader determinants of health are ignored in a dominant global discourse claiming that health is threatened by an obesity epidemic (Wright, 2009). This focus on the individual's responsibility has become a driving force behind imperatives for food and exercise regulation in schools. Rich (2011) finds that many surveillance practices have emerged in British schools as a result of this moral discourse, such as snack regulation, lunch box inspections, and measuring of activity and weight. She raises concerns about the emergence of "a new right ideology" (p.68) based on a mediated thin ideal. Good health has come to represent good virtue (Rich, Holroyd & Evans, 2004). Rich concludes that students' current understandings of health are "overwhelmingly" becoming anchored in the global imperatives that equate weight with health rather than the recognition of multiple determinants. Similarly Fullagar (2002) poses the same question in Australia where she argues that a significant shift in Australian health policy is occurring where leisure and recreation have been co-opted to the moral imperative for exercise, instead of recognizing them as individual choice and enjoyable. Rich (2011) asks an important question, "Which health knowledge is worth knowing?" (p.70).

The health knowledge that is deemed to be "worth knowing" in Canada is reflected in the health education policies of the thirteen distinct provinces and territories. These health policies are not neutral but are represent the decisions of different governments about "what is worth knowing" in health curriculum policies. Fowler

reminds us that, "Public policy is the dynamic and value laden process through which a political system handles a public problem" (2004, p.9). She encourages the analysis and critique of education policy to examine the underlying values and to consider how powerful interests and institutions might use policy to promote an agenda. She argues that the purpose of policy analysis is to improve the quality of public policy. She finds that a strength of the policy analysis process is that, "It offers everyone who is interested in policy a variety of frameworks they can use in thinking about it" (p.19). This is the focus of the present study.

In Canada, at the present time, there is a dearth of national educational dialogue and critical analysis surrounding health education policies. It is not known if the health education policies recognize multiple determinants of health or if they have undertaken a shift toward personal responsibility for health similar to what has been noted in England and Australia, At this time, there is also no indication of the degree of coherence (Beane, 1995) across the provincial health messages, nor is there any indication that knowledge mobilization that has taken place between current research and those who formulate health education policy.

Levin (2008) notes that *knowledge mobilization* presents "a huge opportunity to improve human society" (p.4). He defines knowledge mobilization as, "getting the right information to the right people in the right format at the right time, so as to influence decision-making..." (p.12) and he identifies elements that facilitate knowledge mobilization: a disposition toward using the knowledge, and also processes for knowledge exchanges. Knowledge mobilization cannot take place without infrastructures to share knowledge. Multiple or contradictory pressures in direction can be barriers also. If knowledge mobilization is taking place between researchers in health sciences and policy agendas, then this would be reflected in the formal health education policies of the provinces and territories.

The study described here examines the Health curriculum policies of Canada's thirteen provinces and territories to determine the degree of coherence and knowledge mobilization evident around health priorities for children and adolescents. Health Education, like any school curriculum, is not developed in a vacuum. To begin with, each curriculum policy builds on the previous policies, so each iteration of policy builds on its own history (Little, 2003). School curriculum is not neutral; it reflects political and social ideologies (Apple, 2004). As Kincheloe (2005) reminds us, the curriculum, the classroom and the schools are built on decisions shaped by different ideologies, cultural assumptions and historical contexts. Historical power "makes particular practices seem natural, as if they could have been constructed in no other way (Kincheloe, 2005, p.2). Questions arise as to what degree the current focus areas in health curriculum policies are based on history, on current cultural or social norms, or on emergent health research.

With these considerations in mind, the current literature on health education models was synthesized to identify key theories and conceptual frameworks that underlie health curriculum policies and classroom instruction. Four models emerged: 1) Traditional/Functional model, 2) Interactive Health literacy model (including comprehensive school health and; 3) Critical Health Literacy, and 4) Empowerment model. This research-based frame work was used to formulate a policy analysis framework. This health policy analysis framework was the basis for a comparison of the dominant curriculum policy approaches in all currently available online Canadian provincial health curriculum policies. While there is some overlap between health models in the literature, this policy analysis determined that there is evidence of multiple health education approaches both across the provincial and territorial policies and also within them. This presents a national picture of inconsistent messages about health education priorities.

2. A Framework of Health Education Models

2.1 Traditional/Functional Health Model

Traditional health curriculum has its roots in using schools as the vehicle for distributing disease prevention information (Constentino &Howell, 1971). Most notably, the importance of the topic *hygiene* came out of medical knowledge about controlling the spread of communicable disease, and the importance of teaching *diet* emerged from the discovery of the role of vitamins in disease prevention. As behaviours changed, the importance of avoiding risk behaviours such as drugs and smoking were added to the curriculum policies. The primary means of teaching about these issues was the communication of information in the classroom from teacher to student with a goal of increased student knowledge of the factors that inhibit and enhance health (St. Leger, 2001, p. 201).

In the Traditional model of health curriculum, health is seen as a product of individual choices regarding lifestyle and risk avoidance. The purpose of the instruction is to change behaviour (Jensen, 1997, p.420). Learning outcomes are focused on the ability to reproduce the information on demand, on the assumption that such information is sufficient to change behaviour. As Hagquist and Starrin (1997) describe it, the most commonly

used teaching model was "direct dissemination of knowledge on the assumption that, if they were given the facts, pupils would make rational decisions" (p.227).

Nutbeam (2000) calls this model *functional health literacy*; it places the student in the position of a consumer of information who is provided with factual information about health risks and health services. Nutbeam's framework of functional literacy emphasizes the capacity to *understand* the information presented about such issues as hygiene, smoking or sexuality, as indicated by the ability to understand health materials such as prescriptions and medicine labels.

2.2 Interactive Health Literacy Model

Several definitions of interactive health literacy have been developed. Rootman and Ronson(2005) define health literacy as being able to find, understand, assess and communicate health information (p.263). Anderson and Booth (2006) define health literacy more broadly as a mindfulness, or a stepping back from perceived problems and solutions, implying that student plays a more active role, primarily in processing health-related information. Nutbeam (2000) calls this approach *interactive*, or *communicative health literacy* which is "focussed on the development of personal skills in a supportive environment" (p.264).

The intent of an interactive health literacy model is the development of the capacity to seek out and interpret information and act independently on knowledge (Nutbeam, 2000, p.265). Motivation and self-confidence are key components of this increased capacity, and individual health is the goal. Outcomes of interactive health literacy become the development of personal and social skills in addition to understanding factual information. Attitudes, motivation, behavioural intentions, personal skills, and self-efficacy become the indicators of health. For Anderson and Booth (2006), this level of health literacy also implies the assessment of health information by the individual, and the application of the information to decision making. PHAC (2011b) appears to reflect this framework, defining health literacy as, "the ability to access, comprehend, evaluate and communicate information as a way to promote, maintain and improve health in a variety of settings across the life-course".

An extension of the interactive health literacy model is the comprehensive school health model. The World Health Organization's (WHO) Ottawa Charter for Health Promotion (1986) highlighted the impact of the environment on health and paved the way for health promotion that enlarged the focus of responsibility for health as both within and beyond the individual. In 1995, the WHO produced a set of guidelines to characterize health-promoting schools, outlining: school health policies, the physical environment of the school, the social environment of the school, school/community relationships, the development of personal health skills, and school health services (Stewart-Brown, 2006).These health-related areas are also affected by school policies such as: codes of discipline, standards of behaviour, and the attitudes and values both among staff members and implicit in the school's daily operation.

Comprehensive school/holistic health approaches go beyond the scale of teaching about problems or diseases (Stewart-Brown, 2006) and have as goals the promotion of health and the well-being of the school community. This includes the capacity for advocacy (St. Leger, 2001) in a broader forum than the classroom. Numerous meta-analyses cited by St. Leger and Stewart-Brown (2006) conclude that effective comprehensive school health programmes focus on cognitive and social outcomes as well as behavioural ones. Health education curriculum is one component of this coherent framework. Overall, the comprehensive school health model places students in a role as knowledgeable decision makers within a broader context of health that includes the environment and school policies.

2.3 Critical Health Literacy

Nutbeam's definition of critical health literacy reflects components of critical thinking. Critical thinking can be described as reasonable reflective thinking that is focused on deciding what to believe or do (Ennis, 2011). Critical health literacy applies such thinking to health. Critical health literacy in Nutbeam's (2000) framework recognizes that although health status is influenced by an individual's characteristics and behaviours, the social, economic, and environmental circumstances also have a significant impact on individual health (p.260). He describes it in terms of "more advanced cognitive skills, which, together with social skills, can be applied to critically analyse information, and to use this information to exert greater control over life events and situations" (p.264). Anderson and Booth (2006) consider the critical health literacy approach as one that provides students with opportunities to engage in health issues and problems that have wide significance (p.41). *Critical health literacy* is directed at understanding issues of population health and how policies affect it. The intended outcomes of such a focus would be individual resilience to social and economic adversity at the individual level, and improved capacity to act on these social and economic determinants at the community level (p.266).

Nutbeam (2000) also includes an action component of "personal and community empowerment" (p.266), but it is still essentially a teacher/school driven effort to improve capacity to act that frames his critical health literacy model. This study treats the empowerment dimension as a separate model.

2.4 Empowerment Model

An empowerment model of critical health literacy is based on critical pedagogy. Critical pedagogy differs from critical thinking in that its goal is action to address issues of social justice and equality. An important expansion of critical health literacy emphasizes the transition from critical thinking about health issues to empowerment and action. Jensen (1997) frames it as democratic rather than moralistic health education. Democratic health education addresses health as an open concept; it examines living conditions, lifestyle and well-being; its goal is action competence. Jensen differentiates between activity that is provided as a pedagogical technique and activity that is targeted at solving a problem. For example, students may be involved in choosing to address the problem of limited physical mobility during the school day, examining the causes of these limitations and formulating solutions but if student involvement does not include taking action on those ideas, then the exercise is pedagogical and not targeted at solving the physical mobility issue. Jensen further differentiates between those activities in which students are directed, and those in which students are involved in deciding what to do. It is the combination of student involvement in decision making and activities that are targeted at solving a problem that Jensen refers to as the *democratic paradigm* (our emphasis) of health education (p.425). Anderson and Booth (2006) call it taking critical health literacy to the level of action addressing such issues as "what makes life good at school" (p.38).

Hadquist and Starrin's (1997) model of empowerment focuses on the social and economic determinants of health, and provides opportunities to achieve policy and/or organizational change. They describe two dimensions of empowerment: a wide contextual framework that is similar to the scope of Comprehensive School Health models, and a bottom-up approach strategy for change that includes pupil action. It is this expectation of pupil action that distinguishes it from capacity-building for making change referred to by Nutbeam (2000). The empowerment model includes what Kincheloe (2005) calls emancipatory literacy, and includes the critical study of for example, how policies can place responsibility for well-being on the individual in the name of *efficiency* (p.25) rather than acknowledging the larger power structures in place that also limit both access and success. None of the critical health literacy approaches investigated name and address areas of advantage or disadvantage or social structures of power, assumptions, stereotypes or hegemony. For example, none of the critical health theorists who were investigated challenge dominant thinking in HPE policies, e.g., sports as the dominant form of exercise. Hadquist and Starring's (1997) conclusion that little attention has been paid to operationalizing the concept of empowerment, or to implementing a program based on empowerment, still appears to be true.

3. Health Education Models as a Framework

This study uses the Framework of Health Education Models described above to examine all provincial and territorial Health curriculum documents for Grades 4-9. Appendix lists the online documents examined. Because policies and approaches draw on and exist in historical, political, and social contexts, they reflect a variety of assumptions about learning (e.g., that providing relevant information is sufficient for producing behaviour change); about health (e.g., that the state of health of children and adolescents is a result of their individual choices); and about schools (e.g., that schools provide healthy environments). It is therefore not surprising that Canadian health curriculum policies reflect these multiple perspectives.

Table 1 summarizes the Framework of Health Education Models, and provides key words used to aid in determining how various health literacy models in are evidenced in Canadian curriculum policies.

The analysis of the health curriculum policies across ten provinces and three territories was similar to trying to follow a moving target, since curriculum documents are continuously being revised and published. The authors examined curriculum policies available online between November, 2011 and January, 2012. There are varied access points for health curriculum policies: some provinces include health education with physical education; others include it with career education; in still others it is offered as a single subject area. (See Appendix for a list of provincial websites reviewed and documents gathered into the database.) The scope of this review included curriculum policies that addressed K-9 because in many provinces, physical and/or health education is not a mandatory subject or course beyond grade nine. Using a process of blind review, the research team examined three areas of each curriculum document: rationale/philosophy, outcomes/expectations, and, where available, assessment and evaluation. The consolidated findings are reported by province and territory from west to east.

Table 1. Framework of health education models

Model	Characteristics	Key Curriculum Outcomes
Traditional/Functional Literacy	Student as consumer of knowledge	Identify
	Emphasis on the provision and understanding of information	Describe
		List
		Indicate
Interactive Health Literacy	Student as decision maker	Assess
	Assessment of information	Communicate
	Promotion of well-being	Decide
	Comprehensive School Health	Investigate
	Involvement by community	Make informed choices
	Recognition of multiple components of health	Set goals
		Apply
	Decision making and personal skill development	Analyze
Critical Health Literacy	Political action to address social, economic and environmental determinants of health	Analyze critically
Empowerment		Make decisions
Emancipatory Literacy		Empower
	Education as a tool for social change	Advocate
	Orientation to individual and group action	Take action for social change
		Collaborate
		Produce
		Identify power imbalances
		Question assumptions

4. Findings

4.1 British Columbia

British Columbia's (B.C.'s) health curriculum is paired with career education from K-9.The opening statement of goals for the Health and Career Education K-7 policy states that, "Students will learn and apply processes for goal setting and decision making, and will become aware of the effects of their decisions on themselves and others" (B.C. Ministry of Education, 2006, p.13). This statement of goals places the responsibility for health with the individual and implies an interactive health literacy. There is no evidence of a comprehensive school health approach in either this policy, or in the Grade 9 policy (BC Ministry of Education, 2005).

The learning goals appear to reflect a mixture of functional and interactive health literacy approaches. For instance, the Healthy Living strand's twenty-five goals include fourteen that use the words *identify* or *describe*; these are words associated with a functional literacy approach. Some examples of interactive health literacy goals include that Gr.7 students will "demonstrate an ability to access community information and support services for a variety of healthissues" (p.43) and will "analyse factors (including media and peer) that influence personal health decisions" (p.43). Most goals centre around making effective health decisions, such as, "Select a real or simulated situation and apply a decision making model to select an appropriate option" (p.109). Assessments at the Gr. 6 level include: "Challenge students to create a portrait (e.g., diagram, paragraph, poster, 3-D model) of a person with an ideal, healthy lifestyle (p.213).

Goals for the Gr.8-9 curriculum (BC, 2005) focus on decision making, accessing information, personal responsibility, and development of knowledge, skills and attitudes that enable them to plan (p.9). Outcomes are related to obtaining information for making decisions, such as, "Identify school and community sources of information and support for individuals in unhealthy, abusive, or exploitative relationships" (p.20). Outcomes suggest some interaction with the information obtained, such as: "Describe ways in which they can contribute to

a safe and caring school environment." (p.20)

B.C.'s Health education curriculum focus appears to be within both the functional and interactive health literacy paradigms, across its goals, outcomes and assessments.

4.2 Alberta

The aim of the Alberta Health and Life Skills K-9 Program of Studies (2002) is to "enable students to make well-informed, healthy choices and to develop behaviours that contribute to the well-being of self and others" (p.1). The rationale includes the statement that "The health of students is viewed as an integral component of a larger system of health within the home, school and community environment. It involves the establishment of collaborative partnerships among students, parents, educators, health care professionals and other community supports to address social and environmental factors that influence and determine optimal health" (p.2). This statement reflects a focus on *interactive* health literacy including comprehensive school health, and attention to *critical* health literacy by recognizing a need for collaborative attention to health issues and acknowledging factors beyond individual decision-making for a person's wellbeing.

The student outcomes include: 1) making responsible and informed choices to maintain health and to promote safety for self and others, 2) developing effective interpersonal skills that demonstrate responsibility, respect and caring in order to establish and maintain healthy interactions, and 3) making effective use of resources to manage and explore life roles and career opportunities and challenges (p.3).

In general there are few critical health literacy outcomes. Gr. 9 outcomes include the analysis and evaluation of laws and policies that promote personal, community and workplace safety(p.11). Beyond isolated examples, most outcomes stress rational decision-making, sometimes with the help of community experts. For instance, one Gr. 6 outcome is that individuals can choose their own emotional reactions to events and thoughts (p.15).

The Alberta health goals and outcomes generally present an interactive health literacy framework with an emphasis on individual decision-making. A later document, the Framework for K-12 Wellness Education (Alberta, 2006) expands the concept of wellness to include emotional, intellectual, physical, social and spiritual well-being (p.3). Although this policy document expands the definition of wellness and restates the comprehensive school health approach, it does not appear to move beyond the interactive health literacy approach other than in the general statements of program goals.

4.3 Saskatchewan

The goals of the Saskatchewan health curriculum are stated in a series of policy documents (Saskatchewan Ministry of Education, 2009, 2010) that address Health Education by grade. The goals of the K-12 programare: 1) to develop the understanding, skills, and confidences necessary to take action to improve health, 2) to make informed decisions based on health-related knowledge, and 3) to apply decisions that will improve personal health and/or the health of others. The goals include a comprehensive school health approach. In the detailed section explaining this approach, a holistic view of health education is defined as one that addresses physical, mental, emotional and spiritual health. As well, directions to teachers about appropriate instruction refer to "using anti-oppressive and developmentally appropriate learning strategies" (p.7).

Some curriculum outcomes as early as grade three point to student action; for instance, outcomes include to "understand what it means to contribute to the health of self, family and home" (p.17) and to "apply decisions that will improve personal health and/or the health of others" (p.19). Curriculum outcomes also address critical thinking. One Gr. 8 outcome is "to assess how body image satisfaction/dissatisfaction and over-reliance on appearance as a source of identity and self-esteem affects the quality of life of self and family" (p.18). Gr. 9 outcomes address leadership, and ask students to design, implement and evaluate health promotion action plans (p.12).

This curriculum policy reflects consistency between its goals and its outcomes. Both reflect critical health literacy and a comprehensive school health approach. In addition, its emphasis on action in its outcomes and its recognition of the need for anti-oppressive teaching approaches (p.7) point to an empowerment model but fall short of any expectation of student-directed action. For example, evaluation includes assessment of action plans (e.g., Gr. 4, p.4; Gr. 9, p. 34).Most curriculum outcomes (about 70%) require either analysis, evaluation or action, using verbs such as: analyze, apply, evaluate, act, assess, design, appraise, implement, develop, and critique.

The Saskatchewan curriculum fits within the critical health literacy model and a comprehensive school health approach that reflects the interactive health literacy model. The rationale and goals appear to be consistent with the student outcomes.

4.4 Manitoba

In the overview of Manitoba's physical and health education (Manitoba, 2000) the curriculum's stated intent is "to address the 5 major health risks for children and youth. Those risks are: inadequate physical activity, unhealthy dietary behaviour, drug use, including alcohol and tobacco, sexual behaviours that result in STIs and unintended pregnancies, and behaviours that result in intentional and unintentional injuries (p.1). The specific curriculum expectations are presented according to themes, covering all grade expectations related to that theme. For instance, the Healthy Lifestyle Practices K to S4 policy has an overall general outcome which states that "Students will demonstrate the ability to make informal decisions for healthy living related to personal health practices, active living, healthy nutritional practices, substance use and abuse, and human sexuality (p.149). Grade specific expectations focus on decision-making around the five major health risks. For instance, Gr.5students will "identify the physical changes associated with puberty and the importance of personal hygiene practices" (p.5-138). A second strand of Health Education is Personal and Social Management, which addresses "the development of self-understanding in order to make health enhancing decisions, to work cooperatively and fairly with others, and to build positive relationships with others (p.95). For instance, Gr. 9 students are asked to "design, implement and evaluate an action plan for making a decision based on personal values, and beliefs related to physically active and healthy lifestyle practices (p.S1-130).

The Personal and Social Management area of the curriculum includes three strands: Personal Development, Social Development, and Mental-Emotional Development. Outcomes are summarized in terms of knowledge and skills; the skills addressed are goal-setting, decision-making, interpersonal skills, conflict resolution and stress management (p.114). The most frequent learning outcomes in the curriculum involve identifying and describing; 62 of the 140 learning outcomes for Healthy Lifestyle practices involve these, while seven learning outcomes require analysis or evaluation. In the Personal and Social Management strand, roughly half (85 of the 174 outcomes) involve identifying, describing or listing. Manitoba's Healthy Lifestyle Practices policy consistently reflects a health education model that combines the *functional* model level of health literacy with the decision-making emphasis of the *interactive* model, in both its rationale and its learning outcomes.

4.5 Ontario

The rationale for the Ontario Health and Physical Education 1-8 curriculum (Ministry of Education, 2010) states that "students need to be critically literate in order to synthesize information, make informed decisions, communicate effectively, and thrive in an ever-changing global community" (p.5). Health literacy is positioned as a means for students to thrive in a changing world. The stated goals of the program include the factors that contribute to healthy development, a sense of personal responsibility for lifelong health, and an understanding of how living healthy, active lives is connected to the world around them and the health of others. In addition, this policy outlines the components of a comprehensive school health program, which include instruction, a healthy, supportive school environment, and community partnerships. The rationale also includes Health Canada's (PHAC, 2003) twelve determinants of health and defines health as holistic (including physical mental, social, emotional and spiritual).

These statements of philosophy and goals would appear to place Ontario's framework for the development of student health education outcomes as critical health literacy, with the expanded context of comprehensive school health. The statement that "Critically literate students adopt a critical stance, asking what view of the world the text advances and whether they find this view acceptable, who benefits from the text, and how the reader is influenced" (p.62), implies a critical thinking capacity that supports social justice.

The actual specific learning expectations reflect a range of critical and creative thinking skills and processes for the purpose of assisting students in making decisions and evaluating their choices in connection with learning in health and physical education. The rationale that "the ability to think critically and creatively will help students make healthier choices in all aspects of their lives" (p.21) does not include any attention to social, economic or environmental circumstances or any positive actions that students might take. The only acknowledgement of these factors is a statement that it is "important to be aware of them as contributing factors in student performance" (p.8). Although the curriculum rationale includes critical health literacy, neither the K-8 nor the Grade 9/10 curriculum policy (1999) contains learning outcomes that would be considered as critical health literacy. The student outcomes are more consistent with an *interactive* health literacy framework leading to a finding that this province appears to have a mismatch between its general and specific outcomes.

4.6 Québec

The Elementary Health curriculum in Quebec comprises part of a Personal Development curriculum guideline (Québec Ministère de l'Education, du Loisiret du Sport, 2001). The purpose of the Physical Education and Health

section is to:

Help students gain a sense of self-responsibility for their fitness and health by allowing them to develop a repertoire of movement skills, a repertoire of cognitive strategies, a knowledge base in the subject, behaviours consistent with safety and ethical rules, the critical sense they need to manage their health wisely, and positive attitudes in their relationships with others when participating in physical activities" (p.272).

Competencies include adopting a healthy active lifestyle, demonstrated "through regular physical activity and through the capacity to assess the impact of their actions on their health and make consequent choices" (p.282). Evaluation includes providing an explanation of impact of personal lifestyle habits, preparation of a participation plan for physical activity, interpreting the results of a strategy for changing personal lifestyle habits, and identifying desirable improvements. Learning outcomes that address interpersonal skills are included in the Moral Education section of the Personal Development curriculum policy. These outcomes include building relationships between people; between people and the environment; and examining values and guidelines for action (p.292).

As with the elementary curriculum, Québec's Physical Education and Health curriculum document for Cycle One is situated as a subject within the area of Personal Development, and includes the competency: "adopts a healthy, active lifestyle (p.432). That competency is based on the competencies of physical movement skills and interaction with others in the context of physical activities. The policy states that, "Through learning that occurs in different physical activity settings students will be able to observe the impact their choices have on their health and well-being (p.432). The model is one of informed decision-making according to external standards, and reflects an interactive level of health literacy in its emphasis on individual decision making with a goal of reducing identified health risks.

4.7 New Brunswick

The vision statement for each health curriculum policy in New Brunswick states that, "Students will leave public education both understanding and practising wellness, by making wise lifestyle choices which contribute to the development of not only a healthy, caring individual but also to the community" (2005, p.2). Health is defined as multi-dimensional including physical, social, psychological, emotional and spiritual health. It interacts with the physical, emotional and social climate of schools, families and communities, with instruction that provides opportunities for students to acquire knowledge, attitudes and skills to live a healthy life, and with services that support student health (p.2).

Similar rationale and philosophy statements are found in each of the middle school grade specific curriculum policies for New Brunswick (2005). They indicate an *interactive* model of health literacy that involves a decision-making framework for skill development to address health risks. Although most middle school outcomes use the verbs "identify, "describe and "understand, there are some outcomes that require a critical examination of health issues. For instance, Gr. 7 outcomes include describing "the process required to implement and evaluate a change that improves student wellness in school" but the outcome is limited to description. Since these are isolated outcomes, both the K-6 and middle school outcomes appear to be primarily at the *interactive* health literacy model.

The appendices in this document, as well as each of the middle school policies, describe wellness as "a state of being which includes the physical, social, emotional, intellectual and spiritual dimensions of life, which, when working in harmony, lead to a sense of well-being and satisfaction" (p.69). The Wellness Wheel that reflects these aspects of health is referred to in several places in the curriculum. The appendix containing the Wellness Wheel, however, is a questionnaire that asks specific questions about student behaviour and asks them to rate their responses and to produce a score from which to set goals. Reducing the concept of balanced health to a score that is arrived at numerically based on specific questions appears to be somewhat incongruous.

The messages from this curriculum were somewhat difficult to discern because of disconnect between rationale and outcomes; outcomes and resources; and rationale and resources. The most consistent message appears to be an *interactional* level of health literacy, with some attention to *critical* health literacy.

4.8 Prince Edward Island (P.E.I.)

The introduction in all grade-specific health education curriculum policies for P.E.I. states that the aim of the health curriculum is to enable students to make well-informed, healthy choices and to develop behaviors that contribute to the well-being of self and others. (PEI Ministry of Education, 2006, p.20).This rationale appears to focus on personal decision-making, with the acknowledgement of the role of the community in supporting healthy decisions and would appear to be an interactive health literacy approach which includes the outcomes.

The outcomes under Wellness Choices include personal health, relationship choices, and life learning choices. Some outcomes, however, empower students to take action and reflect a critical health literacy framework. The outcome requiring students to evaluate the "impact of environmental factors on personal health, and develop positive environmental health habits" (p.17) includes the assignment of designing a poster for a rally protesting a particular environmental concern. Numerous grade-level outcomes address awareness of the variety of body types within family and groups of friends, and present the position that all body types can be healthy (for example, Gr. 4, p.82, Gr. 6, p.80). The focus on realizing potential without the mention of body weight or shape is an empowering approach to health education.

Gr. 9 curriculum outcomes are organized in a similar way around individual decision-making in the areas of personal health, safety and responsibility, interactions, learning strategies, life goals and career development, and volunteerism. Outcomes using verbs such as *describe* and *identify* constitute over half of the expectations of students. A section on recognizing and responding to abusive relationships, however, implicitly acknowledges a more complex view of health beyond individual decision-making. However, outcomes here also involve describing or identifying. For example, one Gr. 9 expectation is to "identify the ways that laws and community-based services support the treatment of addictions (PEI, 2007, p.13). These expectations reflect a combination of *functional* and *interactive* levels of health literacy, with both levels appearing in various aspects within this curriculum. There are isolated outcomes that reflect a critical health literacy framework. This analysis is based on the documents available online in January 2012. The P.E.I. Elementary Program of Studies and Authorized Materials 2011-2012 indicates that a new elementary physical education curriculum (K-6) was implemented in February 2011 (p.28) but this document was not available online during the research period.

4.9 Nova Scotia

The Foundations for Active, Healthy Living: Physical and Health Education Curriculum policy (Nova Scotia, 1998) outlines priorities for health education for K-12. It states that the health curriculum integrates the concepts of personal health management, health promotion, and health education. It includes a vision statement that active, healthy living is shaped by the vision of learners experiencing purposeful physical activity and developing knowledge of, skills for, and attitudes towards the health benefits of a physically active lifestyle. (p.1). In describing key features of the curriculum, the document states that it "emphasizes the importance of students' active participation and engagement in all aspects of their learning" (p.4), including within the school and in broader contexts. Another feature of the curriculum is comprehensive school health that addresses the availability of support services and safe, health- promoting school environments (p.5). The emphasis is on providing opportunities to learn to "plan, review, and make informed decisions for their personal well-being" (p.11). Curriculum outcomes are overwhelmingly expressed as identifying, demonstrating understanding, and demonstrating knowledge. These expectations reflect a *functional* approach to health that corresponds to the personal decision-making approach of the 1998 policy, while the comprehensive school health framework reflects an *interactive approach*.

Specific outcomes in the 4-6 curriculum policy (Nova Scotia, 2003) reflect a somewhat more *critical* approach to health literacy. Outcomes in these grades expect students to "demonstrate an understanding of how society's values and behaviours related to nutrition, fitness, and lifestyle have changed over time" and to "evaluate various sources of information regarding health and diet" (p.15). There is evidence of a critical approach in these outcomes that is not clear in the earlier foundation document and which is evidenced by learning outcomes such requiring that students "demonstrate proactive strategies for enhancing the social and environmental health of the community" (p.144). The Nova Scotia curriculum appears to be changing in its focus from the earlier 1998 foundation policy to the 2003 Grade 4 to 6 Health Education policy, as the more recent policy reflects a level of critical health literacy that is not evident in the earlier one.

4.10 Newfoundland

The Gr. 4-9 Health education policies for Newfoundland include an Elementary Health Curriculum Guide for Grades 4 to 6 (ND) an adolescent healthy lifestyles curriculum for Gr. 7-9 (ND), and an interim Gr. 9 curriculum guide(2008). The elementary Health policy opens with the statement that "A health program deals with intellectual, social, emotional, physical, spiritual and moral development, and promotes the development of lifelong behaviours (p.1). It states also that "The health instruction component of the program should be coordinated with health services, within a healthful school and community environment (p.9). These statements of rationale point to an interactive model of health literacy, including a comprehensive school health approach. Outcomes in Gr.4 range from a functional approach to dental care (p.26) to identifying ways to improve an aspect of one's neighbourhood (p.27). Most outcomes, however, use the words "describe", "identify", or

"discuss".

The Gr. 7-9 Health curriculum draws on several national and provincial health attitude and behaviour surveys, as well as the Ottawa Charter (WHO, 1986). The conclusions drawn from the cited literature focus on health-risk behaviours and comprehensive health programs to address those risk behaviours, although it seems to be at odds with the Ottawa Charter, which views health determinants in broader terms. Specific outcomes are primarily worded as: "identify, "examine, "understand, "be aware of, and "define. For instance, a Gr. 7 outcome is "to be aware of how HIV infection is transmitted and not transmitted (p.41). Other outcomes reflect a more critical approach to health however. For instance, Gr. 8 outcomes include "to define 'healthy weight' and to have an understanding of cultural pressures which promote unrealistic images of desirable body shape (p.55)

The interim Gr. 9 policy (Newfoundland, 2008), reflects a more deliberate health literacy framework; in its introduction, it states that "The ability to assess the reliability of the source of health information is an important skill to have. Outcomes range from identifying types of communication, and steps in the decision-making process (p.29) to reflecting on the "decisions, choices, actions, and words and the effect these may have on themselves and others (p.79). No outcomes call for action or go beyond decision-making in their scope.

The picture of the Newfoundland health curriculum policies is one of a combination of *functional* and *interactive* health literacy, with recognition of the importance of a comprehensive school approach in the rationale and a focus on individual decision-making in the outcomes.

4.11 Northwest Territories and Nunavut

Both Nunavut and Norwest Territories (NT) follow the NT health curriculum. The vision that introduces each grade level policy document states:

Health is a state of complete physical, mental and social well-being. It is the result of a dynamic interdependence of these elements, as well as cultural and spiritual elements. Any change which occurs in one dimension will affect the others. To reach a state of complete well-being, an individual must be able to realize aspirations, satisfy needs and change or cope with the environment. (NT, 1995, p.4).

This statement implies a holistic approach and an empowerment to address environmental factors. In addition to this statement, a diagram of the seven units of the health program places Mental and Emotional Well-Being as the "major skill-building unit" (p.10). Specific goals within this unit focus on self-awareness, decision-making, communication skills, coping skills, and the maintenance of mental and emotional health. However, the first goal of the curriculum is to provide factual information. Other goals include the development of decision-making skills and attitudes which lead to positive lifestyle behaviours (p.9). The scope and sequence table includes the following topics: Mental and Emotional, Growth and Development, Family Life, Alcohol and Other Drugs, Nutrition, Dental, and Safety and First Aid (p.17). These areas of focus reflect the territory's response to research on health attitudes and behaviours, and thus address what was seen at the time of writing as the most pressing health issues among children and adolescents.

Many of the outcomes reflect the stated goal of providing factual information. For instance, sixteen of the eighteen learning objectives in the Grade 8 curriculum use the word *identify* or *define*. There are, in addition, a number of outcomes that address analysis and evaluation, suggesting an interactive approach. For instance, one Gr. 9 learning objective referring to nutritional guidelines, expects that students will "design a personal nutrition program based on a behaviour which promotes one of the recommendations (p.N5-24). There did not appear to be any student outcomes that addressed the vision statement's recognition of the need to challenge the environment, or the need to address spiritual health; these omissions presented a disconnect between the rationale and the expectations. The overall focus of the policy, however is *functional* health literacy and to some extent, an *interactive* health literacy approach that is consistent with the stated goals.

5. Discussion

The provinces and territories take different approaches to health literacy, not only among provinces, but within each provincial curriculum. Health curriculum policies are frequently revised and replaced with new policies that attempt to improve how children and adolescents learn about health, but each iteration reflects philosophies of health education.

Table 2. Provincial and territorial health literacy level of student outcomes

Province/Territory	Functional Health Literacy Model	Interactive Health Literacy Model	Critical Health Literacy Model	Empowerment
British Columbia and Yukon Territory	X	X		
Alberta		X		
Saskatchewan		X	x	
Manitoba	X	X		
Ontario		X	x	
Québec		X		
New Brunswick		X	x	
Prince Edward island	X	X	x	
Nova Scotia	X		x	
Newfoundland	X	X		
Nunavut and Northwest Territories	X	x		

X = Clear model of the curriculum x = Curriculum includes some aspect of this model

This table summarizes the approaches of the overall curriculum policies. It is not intended to be a true reflection of each province's or territory's intent, but rather a point of analysis that gives us a common ground from which to deliberate on curriculum policies that most effectively address the national agenda of health promotion. Several of the provinces, for example the Ontario rationales reflect a critical health literacy framework, but the expectations of students reflect an interactive health literacy level. The relative consistency of approach among the provincial documents is evident from this table; only several provinces venture into critical health literacy, and only one, Saskatchewan, uses critical health literacy as a clear framework of the health curriculum. The question that arises is whether or not an interactive health literacy model is sufficient for policies that need to address complex health issues. Finding more complex ways of defining and addressing issues of health may be a somewhat counter-cultural idea, as our popular culture presents much simpler answers.

6. Conclusion

This review of pan-Canadian health curriculum policies indicates that the provincial approaches to health policy reflect an orientation that health is individually determined than reflecting that health is determined by multiple factors including lifestyle, heredity, and social and environmental factors. Decision-making and healthy choices have a focus in all of the provincial health education policies. What is missing is any significant attention to social and environmental factors. Teaching students to be informed decision-makers who are passive consumers of healthcare is a different agenda than teaching them to challenge the school, community, and policy factors that influence health, and to act on those challenges. Is an approach of individual responsibility the most effective

one for health promotion in Canada, or does such an approach, as Kirk and Colquhoun (1989) suggest, promote "an individualistic conception of health, a view that health can be sustained and illness prevented through the sheer effort of will and determination of individuals (p.419)? Kirk and Colquhoun note that this view of individual effort and discipline is most often directed at regulating the size and shape of the body (p.419). Although individual decision-making is a component of a healthy lifestyle, and body size and shape are components of health, such a simplistic view is not supported by the health promotion documents from which provincial health curriculum policies appear to draw their rationales.

This study is intended as a tool for knowledge mobilization and as a catalyst for change. If provincial curriculum policy designers have a common point of reference, such as this framework, for discussing how best to teach health literacy to children and adolescents, then it will encourage a comprehensive approach to a national critical health literacy agenda. That would enable conscious decisions between, for instance, viewing health as a result of rational decision-making and discipline; or viewing it as a complex issue requiring action at many levels. It could also enable conscious decisions between policies such as surveillance measures described by Rich (2011) at the beginning of this study, and policy efforts to empower students to challenge and change both their own lives and the world in which they live. Such a dialogue would require the development of enabling education policies to address these priorities. Let's talk.

References

Anderson, A., & Booth, D. (2006). Health literacy. In Singleton. E., Varpolotai, A., (Eds)*Stones in the sneaker: Active theory for secondary school physical and health educators*. London, ON, TheAlthouse Press.

Apple, M. (2004). *Ideology and curriculum*. New York: RoutledgeFalmer.

Beane, J. (1995). Introduction: What is a coherent curriculum? In J. A. Beane (Ed.), *Toward a coherent curriculum: 1995 yearbook of the Association for Supervision and Curriculum Development* (pp.1-14). Alexandria, VA: Association for Supervision and Curriculum Development.

Constentino, F., & Howell, M. (1971). *A history of physical education in Canada*. Toronto: General publishing.

Ennis, R. (2011). Robert H Ennis' academi web site. Retrieved from http://faculty.ed.uiuc.edu/rhennis/index.html

Fowler, F. (2004). Policy studies for educational leaders: *An introduction.* (2nd Ed.). Columbus, Ohio: Pearson.

Fullagar, S. (2002). Governing the healthy body: discourses of leisure and lifestyle within Australian health policy. *Health: An Interdisciplinary Journal for the Social Study of Health, Illness and Medicine, 6*(1), 69-84.

Hagquist, C., & Starrin, B. (1997). Health education in schools-from information to empowerment models. *Health promotion International, 12* (3), 225-232. http://dx.doi.org/10.1093/heapro/12.3.225

Jensen, B. (1997). A case of two paradigms within health education. *Health Education Research: Theory & Practice, 12* (4), 419-428.

Kincheloe, J. (2005). *Critical pedagogy*. New York: Peter Lang.

Kirk, D., & Colquhoun, D. (1989). Healthism and physical education. *British journal of Sociology of Education*, *10*(4), 417-434. http://dx.doi.org/10.1080/0142569890100403

Levin, B. (2008). Thinking about knowledge mobilization. Paper presented at the *An Invitational Symposium Sponsored by the Canadian Council on Learning and the Social Sciences and Humanities Research Council of Canada, Vancouver, Canada.*

Little, J. (1993). Teachers' professional development in a climate of educational reform. *Educational Evaluation and Policy Analysis, 15*, 129-149.

Nutbeam, D. (2000). Health literacy as a public health goal: a challenge for contemporary health education and communication strategies into the 21st century. *Health Promotion International, 15*(3), 259-267. http://dx.doi.org/10.1093/heapro/15.3.259

Public Health Agency of Canada. (2003). Retrieved from www.phac-aspc.gc.ca/hp-ps/hl-mvs/oic.index-eng.php

Public Health Agency of Canada. (2011a). Health literacy. Retrieved from www.phac-asoc.gc.ca/cd-mc/hl-ls/index -eng.php

Public Health Agency of Canada (2011a). Obesity in Canada: A joint report from the Public Health Agency of Canada and the Canadian Institute for H Obesity in Canada: A joint report from the Public Health Agency

of Canada and the Canadian Institute for Health Information © Her Majesty the Queen in Right of Canada, 2011. Retrieved from http://www.phac-aspc.gc.ca/hp-ps/hl-mvs/oic-oac/assets/pdf/oic-oac-eng.pdf

Public Health Agency of Canada (2011b). Health Literacy. Retrieved from www.phac-aspc.gc.ca/cd-mc/hl-ls/index-eng.php

Rich, E. (2011). Obesity assemblages and surveillance in schools. *International Journal of Qualitative Studies in Education, 23*(7), 803-821. http://dx.doi.org/10.1080/09518398.2010.529474

Rich, E., Holroyd, R., & Evans, J. (2004). 'Hungry to be noticed': Young women, anorexia an schooling. In J. Evans, B. Davies, J. Wright (Eds), *Body knowledge and control,* (pp.173-191). London: Routledge.

St. Leger, L. (2001). Schools, health literacy and public health: possibilities and challenges. *Health promotion International, 16* (2), 197-205. http://dx.doi.org/10.1093/heapro/16.2.197

Stewart-Brown, S. (2006). *What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting schools approach?* Copenhagen, WHO regional Office for Europe Health Evidence Network Report. Retrieved from http://www.euro.who.int/document/ e88185.pdf

World Health Organization. (1986). *The Ottawa Charter for Health Promotion*: *First International Conference on Health Promotion.* Retrieved from http://www.who.int/healthpromotion/conferences/previous/Ottawa/en/

Wright, J., & Burrows, L. (2006). Re-conceiving ability in physical education: a social analysis. *Sport, Education and Society, 11*(3), 275-291. http://dx.doi.org/10.1080/13573320600813440

Appendix

Online Provincial Health Curriculum Documents

Link	Document Name	Format
British Columbia/Yukon Territory		
www.bced.gov.bc.ca/irp/pdfs/health_career_education/2006hcek7.pdf ISBN 0-7726-5552-9	Health and Career Education K to 7: Integrated Resource Package, 2006	PDF
www.bced.gov.bc.ca/irp/pdfs/health_career_education/2005hce_89.pdf ISBN 0-7726-5364-X	Health and Career Education 8 and 9: Integrated Resource Package, 2005	PDF
http://www.bced.gov.bc.ca/perf_stands/healthy_living/k-3/pdfs/hlps_k-3_quick_scale.pdf	BC Healthy Living Performance Standards. Quick Scale: K-3 Healthy Living	PDF
http://www.bced.gov.bc.ca/perf_stands/healthy_living/4-6/pdfs/hlps_4-6_quick_scale.pdf	BC Healthy Living Performance Standards Quick Scale: 4-6	PDF
http://www.bced.gov.bc.ca/perf_stands/healthy_living/7-9/pdfs/hlps_7-9_quick_scale.pdf	BC Healthy Living Performance Standards Quick Scale:7-9	
http://www.bced.gov.bc.ca/perf_stands/healthy_living/background/health_literacy.htm	New IRP Profile Health and Career Education K-7	PDF PDF

http://www.bced.gov.bc.ca/irp/pdfs/health_career_education/support_materials/hce89_irp_profile.pdf	BC Health Literacy Framework	PDF
Northwest Territories		
http://www.ece.gov.nt.ca/Divisions/kindergarten_g12/Health%20K-9%20Single%20Files/Health1.htm	K-9 NWT School Health Program, 1991 NWT Skills for Healthy Relationships, 1996 e.g., Example: Gr. 3, Growth and Development, 1991	HTTP
Alberta/(Nunavut uses these resources)		
http://education.alberta.ca/teachers/program/health/resources/k-9health.aspx	Alberta Health and Lifestyles K to 12, 2002	HTTP to PDF
Saskatchewan		
http://www.education.gov.sk.ca/health-ed-curricula	Health Education (specific grade) Curriculum 2010/2009	HTTP to PDF
Manitoba		
http://www.edu.gov.mb.ca/k12/cur/physhlth/foundation/index.html ISBN 0-7711-2619-0 http://www.edu.gov.mb.ca/k12/cur/physhlth/framework/index.html	K-4 Physical Education/Health Education, 2001 K-12(K-S4)Physical Education/Health Education: Manitoba Curriculum Framework of Outcomes for Active Healthy Lifestyles, 2000	HTTP to PDF
http://www.edu.gov.mb.ca/k12/cur/physhlth/foundation/5-8/index.html ISBN 0-7711-2453-8	Grades 5 to 8 Physical Education/Health Education, 2002	HTTP to PDF
http://www.edu.gov.mb.ca/k12/cur/physhlth/foundation_s1-2/index.html ISBN 0-7711-3147-X http://www.edu.gov.mb.ca/k12/cur/physhlth/c_overview.pdf http://www.edu.gov.mb.ca/k12/cur/physhlth/grade_7.html	Grades 9 and 10 (Senior 1 and Senior 2) Physical Education/Health Education, 2004 Manitoba Physical Education/Health Education Curriculum Overview (N.D) Manitoba Curriculum Framework of outcomes for active healthy lifestyles (N.D)	HTTP to PDF HTTP

Link	Document Name	Format
Ontario		
http://www.edu.gov.on.ca/eng/curriculum/elementary/healthcurr18.pdf ISBN 978-1-4435-3530-4 (Print) ISBN 978-1-4435-3531-1 (PDF) http://www.edu.gov.on.ca/eng/curriculum/secondary/health910curr.pdf ISBN 978-1-4249-5793-4 (PDF)	The Ontario Curriculum, Grades 1-8: Health and Physical Education, 2010 Interim version (revised) The Ontario Curriculum Grades 9 and 10 Health and Physical Education, 1999	PDF
Quebec		
http://www.mels.gouv.qc.ca/DGFJ/dp/programme_de_formation/primaire/pdf/educprg2001/educprg2001-091.pdf (weblink disabled April 2012) http://www.mels.gouv.qc.ca/DGFJ/dp/programme_de_formation/secondaire/pdf/qep2004/chapter91.pdf (weblink disabled April 2012)	Quebec Education Program: Preschool and Elementary Education: Ch. 9: Physical Education and Health, 2001 Quebec Education Program Secondary School Education Cycle 1 Chapter 9.1:Personal Development-Physical Education and Health, 2004	PDF
New Brunswick		
http://www.gnb.ca/0000/publications/curric/hcgr8.pdf DOI: 842570	Health Education Curriculum Gr. 8, 2005	PDF
http://www.gnb.ca/0000/publications/curric/hcgr7.pdf DOI 842560	Health Education Curriculum Gr. 7, 2005	PDF
http://www.gnb.ca/0000/publications/curric/hcgr6.pdfDOI 842550	Health Education Curriculum Gr. 6, 2005	PDF
http://www.gnb.ca/0000/publications/curric/healthk-5.pdf DOI 840110 http://www.gnb.ca/0000/publications/curric/PhysicalEducationHealthGrade9-10.pdf DOI 844270	Health Education Curriculum K-5, 2001 Health Education Curriculum 9-10	PDF PDF
Prince Edward Island		
http://www.gov.pe.ca/photos/original/eecd_11-12Elem.pdf	Elementary Program of Studies and Authorized materials	PDF
http://www.gov.pe.ca/eecd/index.php3?number=1026202&lang=E	P.E.I. Health Curriculum: Gr. 1-3, 2006	HTTP to PDF
http://www.gov.pe.ca/eecd/index.php3?number=1026202&lang=E	P.E.I. Health Curriculum: Gr. 4-6, 2009	HTTP to PDF
http://www.gov.pe.ca/eecd/index.php3?number=1026202&lang=E	P.E.I. Health Curriculum: Gr. 7-9, 2007	HTTP to PDF

Nova Scotia		
http://www.ednet.ns.ca/pdfdocs/curriculum/ActiveHealthyLiving2005_sec.pdf ISBN: 0-88871-512-9	Foundation for Active, Healthy Living: P.H.E Curriculum K-12, 1998	PDF
http://www.ednet.ns.ca/pdfdocs/curriculum/Health4-6_web.pdf ISBN: 0-88871-815-2	Health Education Curriculum Gr. 4-6, 2003	PDF
Newfoundland		
http://www.ed.gov.nl.ca/edu/k12/curriculum/guides/health/index.html#primary	Towards a Comprehensive School Health Program: A Primary Health Curriculum – [n.d.]	HTTP to PDF
http://www.ed.gov.nl.ca/edu/k12/curriculum/guides/health/index.html#elementary	Towards a Comprehensive School Health Program: An Elementary Health Curriculum – [n.d.]	HTTP to PDF
http://www.ed.gov.nl.ca/edu/k12/curriculum/guides/health/index.html#adolescence http://www.ed.gov.nl.ca/edu/k12/curriculum/guides/health/index.html#gl	Adolescence: Healthy Lifestyles (Health and Personal Development Curriculum) – [n.d.] Grade 1 Health Curriculum guide, Grade 2 Health Curriculum Guide, Towards a Comprehensive School Health Program: A Primary Health Curriculum Guide (Grade 3 only), Towards a Comprehensive School Health Program: An Elementary Health Curriculum Guide, Adolescents: Healthy Lifestyles (Health and Personal Development Curriculum) Grade 9 Health Curriculum Guide (Interim Guide)	HTTP to PDF