Getting to the heart of the matter: Well-being and ESD 2011

Cresantia Frances Koya Vaka'uta
Getting to the ‘Heart’ of the Matter: Health, Well-being & ESD
Health Promoting Schools in Fiji

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Introduction

*Education for Sustainable Development* (ESD) is based on a global vision of ‘sustainability’ as (a) a goal; (b) a value; and, (c) a philosophy. It provides an overarching umbrella framework that is encompassing with opportunity for interconnectivity of all other mainstream educational instruments which have been ratified and which form the basis for educational development in Fiji. These include the *Millennium Development Goals 2000 - 2015*, *United Nations Literacy Decade 2003 – 2012*, and *Education for All* (Jomtein, 1990; Dakar, 2000).

Despite the fact that the UN Decade of Education for Sustainable Development is nearing its end (2005 – 2014), for many ESD remains poorly defined and reserved for scholarly and developmental discourse. For others it is seen as separate and distinct from other educational instruments and in this view may be cumbersome – an additional instrument that needs to be mainstreamed or integrated. Still others, believe that ESD has the potential to bring together diverse interests and agendas under one principle vision – that of sustainability and education for the future. However, one chooses to view ESD, it is undeniable that the movement has become a dominant discourse in education with focused international, regional and national debates on how best to devise Curricula for mainstreaming Sustainable Development in basic education both formally and non-formally.

It may be argued that ESD is both a philosophy and a methodology. As a philosophy it guides our vision and helps to set the broader goals of education. This is relatively easy to do. As a methodology however, there are real implications for pedagogy – that is what and why teachers’ do what they do and how they do this. In the wider Pacific context, the challenge of *curriculum-full and resource-empty* realities poses a threat to realizing the vision of education for a sustainable future. A potential outcome of such a reality may very well be “Education about Sustainable Development” rather than “Educating for Sustainable Societies”.

From the onset, it should be obvious that a “Healthy” society is at the heart of ESD. Healthy populations are essential to ensure, Sustainable Societies, Economies and Environments – the three pillars on which Sustainable Development and ESD are constructed upon. This short presentation will provide some insight into *Health and Well-being* as central to the broader ESD Mainstreaming effort within formal education. It also provides a theoretical framework for curriculum mapping of ESD within the *Health Promoting Schools* Program in Fiji.

UNESCO defines the vision of ESD as providing opportunities for people to develop attitudes, skills and knowledge to make informed decisions – for personal and community benefit both now and in the future. Pacific leaders have reiterated this vision in the *Pacific ESD Framework* (2006) which expresses its goal: “To empower Pacific peoples through all forms of locally relevant and culturally appropriate education and learning to make decisions and take actions to meet current and future social, cultural, environmental and economic needs and aspirations” (PIFS 2006, p3). [Emphasis added]
Pacific Health Priority in ESD

The Pacific ESD framework (PESDF) is premised on the UNDESD goals whilst carefully building on the ideals of the Pacific Plan. To this end it emphasizes the need for “transformative education” stating that “Education is critical for promoting sustainable societies and improving our capacity to address environment and development issues” (p4). [Emphasis added] It states:

ESD provides a critical mechanism for achieving long term change to improve environmental sustainability, health, education and training, gender equality, youth involvement and the recognition and protection of cultural values, identities and traditional knowledge (p2).

PESDF highlights eight specific areas of relevance in the region including health. These are, “…poverty, gender equity, human rights, education for all, health, peace and human security, and intercultural dialogue” (p4). The Pacific Plan (PP) identifies “Improved health” as a major priority under the “sustainable development” pillar. It argues for the development of national “…initiatives to enhance the health of Pacific people, and support the fight against HIV/AIDS and STI, non-communicable diseases and other health threats” (PIFS 2007, p36).

In 2008, an Action Plan for the Implementation of the PESDF was endorsed by Pacific Leaders presenting a guiding action framework for national efforts in the Pacific islands. Under Formal Education, Objective 1 focuses on ESD Mainstreaming and reads “[To] Provide ESD input to national curriculum development initiatives”. In addition to developing courses and materials covering ESD content in schools at all levels (ECE to Tertiary level), it also highlights the need to “Enhance the capacity of curriculum developing units to integrate ESD input into curriculum reforms factoring in the views of different stakeholders; e.g. health, gender, HIV/AIDS…” (PIFS 2008, p6).

In the Pacific, health is a serious issue of concern. Eight of the ten most obese countries in the world are Pacific islands – Nauru, FSM, Cook Islands, Tonga, Niue, Samoa, Palau and Kiribati (Streib, 2007). Diabetes is said to be nine to ten times more prevalent in PICS than in the developed world (WHO, 2003). Malaria, Filariasis, Cervical cancer, Breast cancer, Heart disease, mental illness and suicide are also on the rise. WHO (2002) indicate that six out of ten deaths in the western Pacific are attributed to diabetes, heart disease, stroke and cancer (cited in Dorovolomo 2010, p127). Even more alarming is the fact that STIs, HIV and AIDS numbers continue to grow (Sladden, 2009).

What about Fiji?

In Fiji, the Roadmap for Democracy and Sustainable Socio-Economic Development 2009 – 2014 – A Better Fiji for All (Ministry of National Planning, 2009) provides a bleak picture of the socio-cultural situation. It stresses,

Most of the social indicators have worsened in Fiji over the past three decades. These include the Human Development Index (HDI) and the Millennium Development Goals (MDGs) in relation to the proportion of the people living in poverty, maternal and child mortality rates. The HDI is a widely accepted measure of a country’s progress in attaining satisfactory levels of education, health and income. Fiji’s ranking was 42nd in 1975 but dropped to 61st in 1997. Its position further eroded in the late 1990s. Based on the 2007/08 UNDP Human Development Index, Fiji currently is placed 92nd out of 177. Samoa and Tonga — which had rankings similar to those of Fiji in the 1970s — have performed much better than Fiji in recent years, with rankings of 77th and 55th in 2007/08 respectively (pxii).

1 The 2007 version of the PP is referenced here.
A more telling depiction is provided in the excerpt below:

Health continues to be a growing and increasingly complex field of competing priorities from all perspectives – from the individuals to governments, businesses, health professionals and the health services system. A healthy and productive population is a key for sustainable economic development. Despite consuming a major portion of governments budget (>3% of GDP and 9% of total budget), health care funding continues to be lower as compared to other countries in the region.

Inadequate allocation of resources has now led depilitated state of facilities in the health sector. There is a need to reallocate resources in response to areas with greatest burden to the economy and the only possible way is for the need to have evidence to support effective decision making. As such, the importance of National Health Accounts (NHAs) is increasingly becoming important in management of resources and review of health policies.

The key development constraints and challenges in the health sector include: efficient and effective use of resources in health service delivery; responding to the increasing numbers of HIV/AIDS and STIs cases; reversing the deteriorating rates of child mortality, infant mortality and maternal mortality; reduction in the incidence of Non-Communicable and life-style diseases; emigration of skilled health care professionals; limited capacity for policy analysis and research; improving physical and financial access to good-quality health services in depressed domestic and global economy; the increasing demand and cost for health care; the need to improve stewardship over policy formulation, health legislation, regulation, resource mobilization, coordination, monitoring, and evaluation, strengthen the national health system and improve its management, and to improve the availability and management of health resources (financial, human, infrastructure, and so forth); reducing the disease burden attributable to priority diseases and health problems; increasing consumers’ awareness of their health status and poor lifestyle, and fostering effective collaboration and partnership with all health actors, NGOs and CSOs (ibid, pxiii). [Emphasis added]

Strategic Goal 2, after ‘reducing poverty’ is an educational goal aimed at “Making Fiji a Knowledge Based Society”

Access to quality education for all will remain a priority for Fiji. Improved quality of teaching supplemented by progressive and responsive curriculum will ensure the achievement of an educated and skilled workforce. School dropouts and skills gaps will be addressed through initiatives such as the strengthening of the National Youth Service Scheme, enhancement of vocational and community based informal education, and alignment of training to national priorities. Critical will be the need to establish a Modular System of education at secondary schools to provide broad based education for all students while at the same time giving students choice to develop their potential along their areas of interest (pxv). [Emphasis added]

The Ministry of Education vision2 highlights an ESD – Education for all philosophy that is future-based and critical consciousness3 focused.

To provide a holistic, inclusive, responsive and empowering education system that enables all children to realize their full potential, appreciate fully their inheritance, take pride in their national and cultural identity and contribute fully to sustainable national development (Ministry of Education, 2009).

This philosophy of critical consciousness is central to the discussion of Health Education and Health Promoting Schools as mechanisms for empowerment through education. Given the time constraints, a full theoretical examination of education for empowerment of the masses is not permissible. However, it is relevant in this discussion of Health Promoting Schools in Fiji, to contextualize the notion of ‘critical consciousness’ which is an educational theory presented by Paulo Freire who refers to the need for conscientization within a broader discussion of ‘education for liberation’. Sanders (1968), provides a definition of conscientization with the Freireian literacy method:

an ‘awakening of consciousness’, a change of mentality involving an accurate, realistic awareness of one’s locus in nature and society; the capacity to analyze critically its causes and consequences, comparing it with other situations and possibilities; and action of a logical sort aimed at transformation. psychologically it entails an awareness of one’s dignity (p. 12). (cited in Nyirenda 1996, p5)4 [Emphasis added]

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2 See http://www.education.gov.fj/

3 Theoretically based on Brazilian Philosopher and Educational Theorist Paulo Freire who referred to ‘Conscientization’ as the outcome of education for empowerment and critical thinking premised on life-long learning, life skills and transformative societies.

4 See http://digital.lib.msu.edu/projects/africanjournals/html/issue.cfm?colid=100
Equally significant is the need to situate this discussion within the wider conversation of Education for All (EFA). The Delors’ report\(^5\) provides the four pillars of Education for the 21st Century as ‘Learning to ‘know’, ‘do’, ‘be’ and ‘live together’” all critical to this discussion.

Health Promoting Schools (HPS) in Fiji

The HPS Initiative is a reinforcement of the commitment by the Ministry of Education to provide a meaningful learning experience for students in Fiji. That the symposium is a multi-sectoral effort between the Ministries of Health, Education and Agriculture is even more promising. It brings to the fore the national vision for ‘holistic, inclusive, responsive and empowering education’.

From a curriculum perspective, there are three main phases which require attention. These are Conceptual, Planning and Implementation. Porter (2004) provides a useful categorization of curriculum which enables careful planning and delivery. These are (1) Intended Curriculum – (syllabus/manifest curriculum incl. curriculum documents and materials); (2) Enacted Curriculum (instruction or pedagogies for teaching and learning); and (3) Assessed Curriculum – incl. student achievement tests and standardized testing).

Figure 1. Curriculum Planning issues in HPS

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\(^{5}\) See “Learning the Treasure Within” \(\text{http://unesdoc.unesco.org/images/0010/001095/109590eo.pdf}\)

These theoretical guides are essential for curriculum planners as they will ultimately inform the curriculum reform process. It is easier to devise the intended curriculum in isolation of the enacted and assessed and unfortunately this is often the case. As a word of caution, we need to recognize that a well constructed curriculum package may be developed but if implementation, assessment and evaluation are not considered during the earliest conceptual phase, they have the potential to compromise the overall success of the program. Figure 1 below presents the idea of HPS within the curriculum context.

Gocotano, et.al (2003) provides an interesting perspective of Sustainable Health within the ESD discussion. They argue,

Sustainable health is the state of complete physical, spiritual, mental, emotional, social and environmental well-being and not just the absence of infirmity and disease at the personal, family and community level, but within the context of local, national and global – *economic equity*  
*good politics and governance*  
*cultural and social accords*  
*gender and education equality*  
*security, peace and human rights, and*  
*biosphere balance and harmony* (p22).

They go on to conceptualize Sustainable Health at personal, family, community, local government and national levels. A summary of this is provided below (Ibid, pp9, 11, 13,15 & 17). This holistic mapping of National health needs, barriers and strategies is essential to identifying the Health educational needs in Fiji.

**Figure 2. Sustainable Health**

<table>
<thead>
<tr>
<th>Components</th>
<th>Barriers</th>
<th>Strategies</th>
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<tbody>
<tr>
<td><strong>SUSTAINABLE HEALTH AT THE PERSONAL LEVEL</strong></td>
<td></td>
<td></td>
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<tr>
<td>Healthy Lifestyle, regular exercise, family planning</td>
<td>Smoking, alcohol, dangerous drugs, physical inactivity</td>
<td>Health promotion, personal wellness &amp; health scorecards</td>
</tr>
<tr>
<td>Personal Hygiene, safe sex, hand washing, use of toilet</td>
<td>High risk sex behavior, lack of safe water and sanitation</td>
<td>family oriented counseling, family behavior change communication,</td>
</tr>
<tr>
<td>Good diet and Nutrition eating a variety of food daily and in moderation, plant based diets</td>
<td>Overconsumption, fast food &amp; junk food, processed food, pesticide &amp; organo-phosphate laden food</td>
<td>education scholarships, vocational and technical training for job creation,</td>
</tr>
<tr>
<td>Emotional Integrity</td>
<td>Lack of personal security, lack of economic &amp; educational opportunities, personal isolation</td>
<td>tobacco free policies, animal companionship</td>
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<tr>
<td>Body-mind-spirit integration (inner peace)</td>
<td></td>
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<tr>
<td><strong>SUSTAINABLE HEALTH AT THE FAMILY LEVEL</strong></td>
<td></td>
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<tr>
<td>Family beliefs</td>
<td>Formal education at times contradictory to family belief systems</td>
<td>Family health promotion, family wellness &amp; health scorecards</td>
</tr>
<tr>
<td>Genetics and genealogy</td>
<td>Lack of access to newborn screening and genetic screening, family ‘shame’ for hereditary disabilities – tendency to hide disabled family member</td>
<td>family oriented counseling, family behavior change communication,</td>
</tr>
<tr>
<td>Family interaction and harmony</td>
<td>Absence of one parent due to overseas work or far from ancestral home</td>
<td>education scholarships, vocational and technical training for job creation,</td>
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<tr>
<td>Household Economic wellbeing</td>
<td>Lack of education and job opportunities</td>
<td>female headed households, production of family medicines practitioners,</td>
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<tr>
<td>Family Food gardens</td>
<td>Massive advertisements of fast food, junk food &amp; processed food, lack of indigenous seeds for local fruits, vegetables and nuts</td>
<td>family kitchen learning demonstrations of healthy foods, bio-intensive</td>
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<tr>
<td>Family Food basket</td>
<td>Low cost prices of junk and processed foods versus naturally grown food</td>
<td>family gardening promotion</td>
</tr>
<tr>
<td>Inter-generational Learning</td>
<td>Extended households now becoming nuclear households due to rapid urbanization and population pressure</td>
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<tr>
<td><strong>SUSTAINABLE HEALTH AT THE COMMUNITY LEVEL</strong></td>
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</tbody>
</table>
| Indigenous Knowledge (customs, norms, traditions)                                | Lack of resources for documentation of indigenous knowledge and practices,  
practica; prejudice against indigenous peoples                      | Universities as loci for research on traditional indigenous knowledge and medicine, community led water, sanitation and environmental health approaches, public-private-community investments in water, sanitation and environmental health, promotion of community biodiversity, continuing education and capability building of community volunteer health workers, community organizing, public policy recognition |
| Water Sanitation & Environmental Health                                           | Lack of investment in safe drinking water systems, sanitary toilets with desludgeable septic tanks, lack of community action on solid waste management |                                                                           |
| Food Production & Food Security                                                  | Take over production of traditional (bio diverse) foods by large scale mono crops and cash crops plantation |                                                                           |
| Occupational Safety and Health (OSH)                                             | Failure to implement laws and regulations mandating companies to apply OSH |                                                                           |

Availability, accessibility & affordability of health care
Lack of health personnel at the village level, lack of essential machines at the village level, high cost of health care and essential medicines
of traditional healers.

Community managed and based health programs
Lack of investments in community based and managed programs

Traditional Medicine
Dominance of North American and European medicine (allopathic), dominance of multi-national pharmaceutical companies and milk formula companies of the commercial health markets

**SUSTAINABLE HEALTH AT THE LOCAL GOVERNMENT LEVEL**

| Local policies, laws, ordinances | There may be enough laws but these are not uniformly implemented and enforced | Political will to re-evaluate existing policies for proper implementation and perhaps movement, training of individuals for health systems management, proper implementation of laws and ordinances, prioritization of health in the local budget, pilot partnerships with small scale projects to build up confidence in both parties (Govt & NGOs), pilot curriculum for transdisciplinary partnerships maintaining open-mindedness, improvement of documentation and process evaluation of data collection. |
| Health Systems Development | Lack of capacity of local Governments to manage various aspects of health systems development | |
| Road Safety | Lack of transportation and road safety laws and ordinances seat belts, no drinking when driving, traffic rule enforcement, etc... | |
| Local Health Investments | Health not a major priority of local governments, health valued as an expenditure rather than an investment | |
| Inter-sectoral linkages | Turfing of government agencies and even NGO’s, fear of partnerships on both sides, government and NGOs | |
| Multi-disciplinary & Transdisciplinary partnerships | Fear of partnerships, difficulty in integrating established curriculum | |
| Health Management Information System | Insufficient documentation, faulty data collection | |

**SUSTAINABLE HEALTH AT THE NATIONAL LEVEL**

| Health Policy Development | There may be sufficient policies but with improper implementation | Political will to re-evaluate existing policies for proper implementation and perhaps improvement, sufficient budget allocation for health, Commitment of LGUs in ensuring availability of health service to their locality, or sponsoring a local resident for health education with return of service, continuing advocacy, reproductive health education, initiatives to attract investors for local drug manufacturing, process evaluation for disease surveillance system and with focus on preventative care. |
| Health Standards, regulations and licensing | Substandard health condition probably due to lack of sufficient budget | |
| Quality and Equity in Health | Geographical challenges in terms of service delivery | |
| Health Human resource development | Substandard schools, health professionals perceived as a means of economic advancement | |
| Health research and development | There may be a lot of ongoing researches by there is a lac in advocacy and support from local government | |
| Health Financing and Social health insurance | Coverage is still for those who can afford, highest share of reimbursement claims come from rich, private institutions | |
| Demographics and population management | Population growth at a faster rate than economic progress | |
| National medicinal drug development | Lack of local capacity to produce the drugs | |
| National Disease surveillance systems | Improper documentation, fault data collection | |

The importance of Curriculum Mapping

Curriculum mapping was first introduced in the 1980s and focused primarily on teachers treatment of content – what to teach, when, where and how. Within the last three decades however, the definition and application of CM has expanded to include national planning and continuous curriculum review and development. O’Malley (1982) explains that “Curriculum mapping can serve as both an instrument and a procedure for determining what the curriculum is and monitoring the planned curriculum” (cited in Association for Supervision and Curriculum Development 2001, p1).

Hale (2008) presents what she terms “two fundamental academic questions” in CM.

- What learning expectations or instructional practices are in place that consistently prove to be in our students’ best interest?
- What learning expectations or instructional practices need to be started, stopped, or changed to enable or enhance our students’ success? (Hale 2008,p5).

She cites Jacobs (2004) to remind us that “…as a genuine 21st-century shift in our practice, mapping requires knowledge and courage” (Ibid).

For more see [http://www.curriculummapping101.com/about-janet-hale](http://www.curriculummapping101.com/about-janet-hale)

The question that we need to ask is “HPS for what?” and “for whom?” If the intended outcome is a transformed society, as expressed within the general vision of ESD and EFA, then it is essential that we revisit our own curriculum practice, from development at the Ministry level to enactment in the classroom.

CM is critical if we are to determine the current situation. It provides an overview or a ‘snapshot’ of current content, practice and assessment. A comprehensive CM process will uncover gaps, overlaps and potential areas for integration. In the case of HPS, the ensuing map enables developers to identify specific content areas which already cover health issues. Such areas may include Home Economics, Physical Education, Health Science, Human Geography, Biology, Basic Science, Values Education and others. The next phase then is determining how to build on what currently exists. This includes additional content, pedagogy (approaches to teaching and learning) and assessment tools, resources and so on. CM may also lead to the discovery of knowledge heavy and skill deficient learning opportunities or to uncovering un- and less-successful pedagogical and assessment practices, as well as good practice efforts which may be documented as case-studies for teachers and schools within a resource toolkit on HPS in Fiji.

The next section presents a brief overview of a three step process that may prove useful in both curriculum mapping as well as in the curriculum development process.

**Educating for Healthy Societies**

As a final offering, I would like to present a three-fold construct as a platform for the development of HPS. The three ideas within this construct as Education about; Education for and Education through (adapted from Kerr 1999). This triad poses a series of questions at all levels of Curriculum work from the philosophy or vision, as well for content selection, pedagogy and assessment. It is argued that a holistic education system should invariably include aspects of all three ‘about’, ‘for’ and ‘through’. The three notions of education are related to Habermas’ theory of learning in which he describes three cognitive interests; technical knowing, hermeneutic or communicative knowing and, critical knowing.

**Education about Health**

In the interest of education for ‘critical consciousness’ through ‘empowerment’ for transformed societies, HPS must move beyond knowing facts and figures. While this is a critical first step, knowing about something does not necessarily imply an impact on beliefs, attitudes, values or behavior. Education about Health captures content-selection on the basis of what is deemed most relevant, useful and how these all piece together into the whole curriculum. The intended curriculum within this stage of HPS should include issues such as general well-being, basic hygiene, dental (oral) health, diabetes, dengue, malaria and filariasis, nutrition, malnutrition, obesity, physical exercise, mental health, substance abuse including glue sniffing, smoking, alcohol and marijuana, sexual and reproductive health, STIs, HIV/AIDS, teenage pregnancies, stress, and balanced healthy meals. Discussions about the increase in noodle consumption and the risks of eating raw noodles and consuming large amounts of fizzy drinks should also be incorporated into the syllabus. These may include a chemical analysis of nutritional value of foods and drinks. Predicted Outcome = knowledgeable individuals who know about healthy choices but don’t necessarily make them. For example, being aware that unprotected sex may lead to unplanned pregnancy, STI or HIV contraction but choosing not to take precautions; or, knowing that there is a correlation between mental health problems and marijuana but making the decision to smoke regularly with friends.
Education for Health

If the major intended outcome of HPS is a society where people are concerned about well-being and healthy living, a significant component of the program should include life-skills. This approach assumes a skills-for-life or lifelong learning philosophy and must therefore provide an opportunity for dialogue and debate about healthy life choices. Education for Health implies a strong stakeholder collaborative effort which may in this case include Ministry of Health representatives providing health school health talks as guest presenters, or health counseling services. Other resource persons may be drawn from the community to share their stories such as those living with HIV, those affected by Diabetes or living with mental health problems, and the like. These stories may be compiled into multi-media resources or in student and teacher workbooks. Examples of these are available through FJN+ - the Fiji Network of Positive Persons and PIAF – the Pacific Islands AIDS Foundation. Predicted Outcome = Critical thinkers who are able to apply what they ‘know’ with what they have ‘seen’ and ‘experienced’ to real life choices.

Education through Health

This approach is seen as a connector between Education about and Education for Health. Education through Health would incorporate into the HPS program, health promotion initiatives. Some of these already exist in Fiji schools such as the dental health program and hand washing campaigns. Similar programs may be initiated that provide real life experiences for students, such as site visits to the School for the blind, Disabled Society, Special School, CWM hospital or visits by community members living with diabetes, HIV, Filarisis and so forth. The Education through approach requires a community service or community engagement component. Predicted Outcome = Increased awareness and concern about health issues and how these have concrete impact on a person’s daily life, as well as that of the family and the wider community. Other examples may include a ‘walk for life’ initiative within the school program or aerobics, swimming and other fun activities that provide opportunities for students to become more active without a seemingly imposed ‘exercise’ regime that few if any enjoy. It is important to note student interest in such physical activity programs and it is equally crucial that students of all abilities are included such as students with disabilities, under- and over-weight children and others.

The question of Assessment

There is increased discussion about Assessment for learning (AfL) with many perceiving that the value of AfL supersedes that of Assessment of learning (AoL). From a curriculum standpoint, both forms of assessment are significant to the teaching-learning process.

AoL which is a summative approach to assessment takes place at the end of a specified period of time. They provide both the teacher and the student with essential information about how much of the intended curriculum has been learnt. AoL includes unit tests, quizzes, term tests and final examinations. An overemphasis of AoL within the HPS would mean that the main approach is Education about Health and assessment then prioritizes low order thinking levels of ‘memory-recall’ and ‘comprehension’.

AfL, on the other hand, refers to the formative assessment strategies that are put in place to help strengthen or enhance the student learning experience. If devised effectively, students are presented with research projects, debate, presentations, creative tasks and so forth, which engage higher order thinking, moving beyond recall and comprehension, to ‘application’ and ‘synthesis’. An overemphasis of AfL leads to student fatigue in the sense that they are burdened with excessive project work and tasks to the point that it
is no longer an enjoyable, skill or knowledge building experience, but rather a situation of ‘completing the tasks’ in order to get it done. In these instances, AfL does not correlate to the development of critical thinking or knowledge acquisition and in fact simply reverts to a ‘rote-learning’ pedagogy.

**Searching for Sautu – the good life**

**ESD as a philosophy** provides the basis of sustainable living and livelihoods. **ESD as a goal** presents a future-oriented focus for life-long learning and to preserve and conserve limited resources for the betterment of all. And, **ESD as a value**, promotes a perspective of ‘quality life’ through a sustainability lens. As a methodology, it further promotes a message of HOPE which is reflected in the Tokyo HOPE Declaration (2009) which outlines a four item checklist in planning, implementation and assessment – stating that good practice in ESD are by definition Holistic, ensures community Ownership, is Participatory and is aimed an Empowerment.

In western thought, the notion of the ‘common good’ is a recurring theme that has also been applied to ESD discourse – with sustainability seen as the basis of catering for the ‘common good. In the Fiji context, the iTaukei concept of ‘Sautu’ defined by Nabobo (2006) simply as ‘the good life’ can be applied to the discussion of sustainability and sustainable societies. Baba (2010) argues that Sautu is the “basis of sustainability” (p38).

Health is an essential component of Sustainable Societies. Education, awareness and advocacy are all critical to this goal. In education, it is important that students are provided with the necessary knowledge, skills and attitudes required for behavioral impact in their daily lives and life choices. HPS has the potential to provide these essentialities to Fiji students. It may even be argued that Health is an essential literacy within the basic education framework where education is viewed as a basic human right and health awareness and education is viewed as a critical literacy required by all for living sustainable, healthy lives. A quality education for the 21st century must provide educational opportunities for empowerment so that everyone has an equal opportunity to achieve a basic ‘quality of life’.

From my humble perspective, the HPS initiative is filled with promise and premised on the hope for a better future. A future where all Fiji nationals have access to quality basic education that contributes positively to the development of a critical national consciousness towards a shared vision of a sustainable future that ensures quality of life for all.

**References**


