Health(y) talk: pupils’ conceptions of health within physical education

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Health(y) Talk: Pupils' Conceptions of Health within Physical Education

By

Oliver Robin Hooper

A doctoral thesis submitted in partial fulfilment of the requirements for the award of Doctor of Philosophy of Loughborough University

October 2018

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Abstract

Schools, and in particular physical education (PE), have been increasingly recognised for the role that they play in promoting healthy, active lifestyles amongst children and young people in light of the public health agenda (Armour and Harris, 2013). However, whilst schools have been recognised for the role that they can play in promoting health to children and young people, concerns have been expressed with regard to the status of health in PE and the approaches and practices used to address health-related learning (Cale et al., 2016). A particular concern in this regard is what children and young people know and understand about ‘health’, and how they come to conceive this within PE, with a growing body of literature suggesting that pupils’ conceptions are relatively superficial and simplistic (see Harris et al. (2016) for an overview). Accordingly, the purpose of this research is to explore pupils’ conceptions of ‘health’ within PE.

The research was comprised of four phases which took place over an 18-month period within the East Midlands region of England. Phase one involved an online survey being distributed to all state secondary schools (n = 293) and with a total of 52 schools responding. Phase two involved semi-structured interviews being conducted with 13 PE teachers at two case study schools and focus groups with 117 pupils (aged 11-12) at the same schools. A participatory approach underpinned the study and relevant methods/techniques were employed within pupil focus groups to generate discussion and elicit pupils’ conceptions of ‘health’. Examples of the methods/techniques employed included: drawings, concept cartoons and statement sheets. Pupils worked interactively with one another to undertake and discuss tasks/activities in line with the youth voice agenda that underpinned the research. This agenda is often allied with participatory methods (Heath et al., 2009) and seeks to privilege the voices of younger participants, recognising that children and young people are competent social agents, capable of both understanding and articulating their own experiences (Christensen and James, 2008). Phase three involved follow-up focus groups with the same pupils who participated during the preceding phase, and a similar participatory approach was employed. Phase four involved semi-structured focus groups being conducted with the same PE teachers at each school. Data generated were analysed using a Foucauldian-inspired discourse analysis.
The findings of the study highlight that the vast majority of pupils’ conceptions of ‘health’ were reductive, limited and limiting. These conceptions of ‘health’ were identified as being underpinned by: corporeal notions, aesthetic orientations and healthist influences. In addition, they aligned with normative conceptions of ‘health’, that were evidently influenced by public health discourses, which may well have been promulgated by and through PE. Whilst pupils did not necessarily consider that PE influenced their conceptions of ‘health’, there were evident links, which PE teachers themselves acknowledged and problematised. Positively, it was highlighted that there were some pupils who were able to disrupt normative conceptions of ‘health’ and, in doing so, they demonstrated their capacity for criticality. As such, the challenge for PE is now to consider how it might support pupils to develop their capacities to receive, interpret and be critical of health-related information. If it can do so, it may well be that critically-inclined conceptions of ‘health’ can be fostered within, through and by the subject.
Acknowledgements

There are many people to whom I owe a debt of gratitude for their contribution to my PhD journey. It has been a challenging endeavour, particularly the development of this thesis, and I could not have done it if it were not for the guidance, support and encouragement that so many people have provided along the way.

It seems important to first acknowledge, and express my gratitude to, those who made the work within this thesis possible, namely, the pupils, teachers and schools who so kindly participated in the research. It is their thoughts, feelings and experiences that make this thesis what it is, and I am grateful for their willingness to have been a (significant) part of it. Credit must also be given to Jamie Kirkland, whose talented design work helped to realise one of the most innovative aspects of this thesis.

I must thank my wonderful supervisors, Dr. Jo Harris and Prof. Lorraine Cale, for their unwavering support throughout my PhD journey. They have not ‘just’ helped me to work towards completing my PhD but have supported me to develop into the aspiring academic that I am today. They have very much ‘schooled’ me in the ways of academia, and I could not have asked for better ‘teachers’ to have helped me along the way. I hope that one day I can ‘pay it forward’ and supervise my own students as well as they have supervised me.

I must also thank (or perhaps, blame) my Director of Research Studies (and examiner), Dr. Rachel Sandford, without whom I may well have not even started this journey. I was inspired by her teaching and her research as an undergraduate student, and it challenged me to think in ways that I had not thought before. It was the interest that she sparked that led me to pursue postgraduate studies, culminating in the development of this thesis. It seems most fitting, therefore, that the person who helped me to commence this journey is one of those who helps me to conclude it. Thanks must also go to Prof. John Evans – whilst we might not always have been in agreement, his critical insight proved invaluable in the development of this thesis.

A special mention must also go to the many fantastic colleagues (and friends) at Loughborough University who have been there for me throughout this journey. In particular, thanks must go to Estelle Damant, Dr. Julie Stirrup and Dr. Rebecca Duncombe. They have
provided me with many a much-needed ‘break’ during my PhD journey and have kept me grounded throughout – which was no mean feat at times! In addition, I have been fortunate to meet many wonderful colleagues (and friends) from further afield over the course of my PhD and so I must also thank them for their continued interest in my work; their interest has made it all seem that little bit more worthwhile. In particular, thanks go to Dr. Fiona Chambers for her continued encouragement and for always helping me to put things in perspective.

It goes without saying that I must thank my wonderful family, and in particular my mother and grandmother. I know it has not always been easy, but I thank them for helping me get to where I am today, and for always supporting me in whatever I pursue; I appreciate everything that they have done for me and I hope I have made (and will continue to make) them proud.

Lastly, thanks must go to my loving partner, Matthew Wallace, who has been unflagging in his support of my endeavours. He has been with me throughout this journey and has experienced the highs and lows of it with me, showing unrelenting faith in me, even at times when I did not have faith in myself. I really could not have completed this journey without him, and his commitment to me, and to us. I hope that we can continue to support one another throughout our lives together, just so long as he does not choose to do a PhD… one has been more than enough for the both us!
Presentations and Publications

The work contained within this thesis has been (or is due to be) presented at/published in the following locations/sources:

Conference Presentations:


- **Hooper, O., Harris, J. and Cale, L. (2017)** Talking it through: Using youth voice to explore pupils’ knowledge, understandings and conceptions of healthy, active lifestyles. Paper
presented at the European Educational Research Association (EERA) Conference, August 2017, University College Copenhagen, Denmark.


**Publications:**


# List of Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>ACARA</td>
<td>Australian Curriculum, Assessment and Reporting Authority</td>
</tr>
<tr>
<td>aHT</td>
<td>Assistant Head Teacher</td>
</tr>
<tr>
<td>BERA</td>
<td>British Educational Research Association</td>
</tr>
<tr>
<td>BMA</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>BOS</td>
<td>Bristol Online Surveys</td>
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<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CRC</td>
<td>Convention on the Rights of the Child</td>
</tr>
<tr>
<td>DBS</td>
<td>Disclosure and Barring Service</td>
</tr>
<tr>
<td>DfE</td>
<td>Department for Education</td>
</tr>
<tr>
<td>dHoD</td>
<td>Deputy Head of Department</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>DRC</td>
<td>Declaration on the Rights of the Child</td>
</tr>
<tr>
<td>EAL</td>
<td>English as an Additional Language</td>
</tr>
<tr>
<td>FDA</td>
<td>Foucauldian Discourse Analysis</td>
</tr>
<tr>
<td>GCSE</td>
<td>General Certificate of Secondary Education</td>
</tr>
<tr>
<td>HBSC</td>
<td>Health Behaviour in School-aged Children</td>
</tr>
<tr>
<td>HoD</td>
<td>Head of Department</td>
</tr>
<tr>
<td>HoPE</td>
<td>Head of Physical Education</td>
</tr>
<tr>
<td>HPE</td>
<td>Health and Physical Education</td>
</tr>
<tr>
<td>HRE</td>
<td>Health-Related Exercise</td>
</tr>
<tr>
<td>HRE-CPD</td>
<td>Health-Related Exercise Continuing Professional Development</td>
</tr>
<tr>
<td>HRF</td>
<td>Health-Related Fitness</td>
</tr>
<tr>
<td>HSCIC</td>
<td>Health and Social Care Information Centre</td>
</tr>
<tr>
<td>HSE</td>
<td>Health Survey for England</td>
</tr>
<tr>
<td>ITT</td>
<td>Initial Teacher Training</td>
</tr>
<tr>
<td>KS</td>
<td>Key Stage</td>
</tr>
<tr>
<td>MoE</td>
<td>Ministry of Education</td>
</tr>
<tr>
<td>NC</td>
<td>National Curriculum</td>
</tr>
<tr>
<td>NCPE</td>
<td>National Curriculum for Physical Education</td>
</tr>
<tr>
<td>NEMP</td>
<td>National Education Monitoring Project</td>
</tr>
</tbody>
</table>
NHS - National Health Service
OECD - Organisation for Economic Cooperation and Development
PE - Physical Education
PETE - Physical Education Teacher Education
PGCE - Postgraduate Certificate in Education
PGDE - Postgraduate Diploma in Education
PHE - Public Health England
PRQ - Primary Research Question
PSHEE - Personal, Social, Health and Economic Education
QTS - Qualified Teacher Status
SEND - Special Educational Needs and Disability
SRQ - Secondary Research Question
UN - United Nations
WHO - World Health Organisation
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Chapter 1: Introduction

1.1 Background to the research

The position of health within curriculum physical education (PE) has been a topic of continued debate and in recent decades there has been growing pressure on school curricula to effectively support children and young people to lead healthy, active lifestyles (O’Sullivan, 2004; Stratton et al., 2008; Cale and Harris, 2011a; Armour and Harris, 2013; Cale, Harris and Chen, 2014). Whilst it has been acknowledged by Cale (2017) that PE has a significant role to play in the promotion of healthy, active lifestyles, she and others argue that the subject has not maximised the potential it has for this (Laventure, 2000; Harris, 2010; Cale, Harris and Hooper, forthcoming). This ‘failure to meet expectations’ is arguably evidenced through, for example, the low proportion of children and young people meeting physical activity recommendations (Riddoch et al., 2004); the privileging of the able (Haycock and Smith, 2011); and the enduring dominance of games within the curriculum (Green, Smith and Roberts, 2005; Kirk, 2010). In addition, pupils’ knowledge, understandings and conceptions of ‘health’ have been problematised by many researchers (see Harris et al. (2016) for an overview).

It is reasonable to assume that, in response to societal concerns over health, and in particular the health status of children and young people, schools generally and PE specifically, would be looked to as means of addressing such ‘problems’. Arguably, PE has been in what Green (2002, p. 95) refers to as a ‘taken-for-granted role’. Penney and Evans (1999) asserted that PE was a marginal subject within the National Curriculum (NC) and has continually had to justify its position. In working towards legitimising its position, Kirk (1992) proposes that the subject leant itself to science. This, in combination with a need to preserve the health of the nation, may have led PE in its current direction, working towards a public health agenda. Such a direction is arguably necessary now more than ever, with consideration of the current educational climate, whereby all subjects are seemingly having to legitimate their position within curricula (Kirk, 2011). Debatably, PE could be seen to be legitimising its position solely on how well placed it is, or rather could be, to address societal concerns over public health (Penney, 2008), with Harris and Cale (2012) highlighting that the subject is well placed to do so, given the ‘captive audience’ that it provides. However, the direction that PE has taken in
line with the public health agenda has been posited as leading schools to become sites through which narrow conceptualisations of ‘health’ are transmitted (Evans, Davies and Rich, 2008; Evans et al., 2011). Indeed, Penney and Harris (2004) commented on the (possible) detrimental effects of health being defined as ‘an established and agreed (rather than socially, culturally or historically specific) entity’ (p. 99) as opposed to a multifaceted concept. This has led to criticism of the expression of health in PE, notably centred on the potentially inimical and deleterious impact that such a limited focus could be having on children and young people (Gard and Wright, 2001; Evans, Evans and Rich, 2003).

Young (1998) asserts that curricula are reflections of what is known to society at a particular point in time, with ‘valued’ information being transmitted through these. Building on this, Kirk (1992) notes that knowledge within the PE curriculum is not fixed or neutral, but rather changes to reflect social, cultural and political agendas. On this note, Gard and Leahy (2009) posit that the overriding agenda permeating PE curricula in recent times is that of public health. It may be assumed, therefore, that children and young people would be relatively familiar with concepts relating to leading a healthy, active lifestyle. However, as alluded to, evidence would suggest that this is not the case (Harris et al., 2016).

Early research by Harris (1994) identified that children and young people considered health almost exclusively in the physical sense and demonstrated a preoccupation with food and exercise as moderators of health. This led her to suggest that children and young people had narrow and limited conceptions of what it meant to be healthy (ibid.). Further and more recent studies have equally found that children demonstrate superficial and simplistic knowledge, understandings and conceptions related to ‘health’ (Dixey et al., 2001; Placek et al., 2001; Burrows, Wright and Jungersen-Smith, 2002; Stewart and Mitchell, 2003; Burrows, 2008; Burrows, Wright and McCormack, 2009; Keating, 2009; Rail, 2009; Roth and Stamatakis, 2010; Brusseau, Hodges Kulinna and Cothran, 2011; Powell and Fitzpatrick, 2015; Harris et al., 2016). It is also apparent that this is a global ‘problem’, with the aforementioned evidence emanating from England, Australia, New Zealand, Canada and America. Therefore, despite disparities between contexts, it is apparent that children and young people’s conceptions of ‘health’ have consistently been found to be limited.

The shift within contemporary society to one in which information is readily and widely available to children and young people means that health information can be acquired
outside of the classroom and the school, and independent of curricula, via ‘public pedagogies’ (Ellsworth, 2005; Giroux, 2004a, 2004b). Learning is no longer closely bound to formal education, in what Evans and Rich (2011, p. 361) describe as a ‘totally pedagogised society’. This means that children and young people can be subject to messages that are contrasting, conflicted and disconnected and they can understandably have difficulty in comprehending these (Powell and Fitzpatrick, 2015; Harris et al., 2016). It would seem apparent that when educating children and young people about healthy, active lifestyles, PE faces the challenge of addressing multiple and complex misunderstandings. Accordingly, Burrows (2008), amongst others, has advocated a move towards a critical approach to teaching health through PE. On this note, she argues that it is important to support children and young people to challenge, contest and question what have come to be accepted health imperatives promoted by society (ibid.).

Whilst there is a growing body of literature exploring the ways in which pupils conceptualise ‘health’, much of this has emanated from contexts outside of England. In addition, that which has been conducted within England was undertaken at a time that pre-dated the current NCPE. Given the assertion of Penney and Harris (2004), that ‘health’ is socially, culturally and historically situated, it is therefore important to consider the context in which children and young people live when exploring their conceptions of ‘health’. There are further issues with some of the research conducted to date (as discussed within chapter 2), largely relating to the ways in which pupils have been engaged within the research and the relative lack of engagement of teachers in this regard. As such, it is the intention of this research to explore pupils’ conceptions of ‘health’ in light of the current NCPE. The influence of curricular PE within this will be duly considered and distinctively the study will present the findings to PE teachers to ascertain their perceptions of these. Burrows (2008) would support such an approach, as she advocates the need for practitioners to reflect on, and where necessary address, short-comings in pupils’ health-related learning. The research questions of the study are outlined in the following section.
1.2 Research questions

The study has one primary research question (PRQ) and two secondary research questions (SRQ-1 and SRQ-2), as outlined below:

**Primary research question:**
- What are pupils’ conceptions of ‘health’ within PE? (PRQ)

**Secondary research questions:**
- How is pupils’ health-related learning addressed within PE? (SRQ-1)
- What are PE teachers’ perceptions of pupils’ conceptions of ‘health’ within PE? (SRQ-2)

1.3 Background of the researcher

In setting the context for this thesis, it is important to outline my own background and explain how I have come to undertake this research. I graduated from Loughborough University in July 2014 with a BSc (Hons) degree in Sport and Exercise Science. Over the course of my time at the institution, I came to realise just how much of an interest I had in PE and the completion of various related undergraduate modules further compounded my will to undertake higher study within this area. As such, when a PhD studentship arose at Loughborough University towards the end of my degree, I applied and was successful in attaining the position.

As a child making the transition from primary to secondary school, I was excited at the prospect of engaging with PE and eagerly awaited my first lesson, PE kit in hand. However, the aspirations that I held for PE were swiftly dashed and much to my dismay, secondary PE was not as I had anticipated. I was privy to an experience that I would argue embodied many of the poor practices that those interested in PE continually strive to overcome. The experience that I had of secondary school PE as a child was located within a narrow curriculum in which I was rarely offered any activity other than football, and in which fitness testing (in the name of health) became a termly experience that I came to loathe, given that I was forced to complete tests to confirm whether or not I was ‘healthy’. Following what was an arduous year of PE during my first year at secondary school, I received a report that, in contrast to all
other aspects of my schooling, stated that my performance within PE was ‘very unsatisfactory’. It was at this moment that I wanted to lose faith in PE. How could I be the one deemed to be ‘very unsatisfactory’ when PE, in my eyes, was not providing what it should? At that point, I became disengaged by PE and entered what was on reflection a relatively ‘unhealthy’ period of my life. I became inactive, overweight and not at all motivated to engage in activity. I felt that PE, a subject that I had awaited with eagerness to take part in at secondary school, had failed to deliver.

It may now seem fairly contradictory, after such negative experiences, that I am completing doctoral research centred on PE. But rather, I consider this to be very apt. It is my aspiration that this work goes some way to ensuring that children and young people have positive experiences within PE and I hope that this research can make a meaningful contribution to the field. I entered this knowing that I am researching within education, though am not myself a qualified teacher of PE. However, this study concerns itself not so much with teachers of PE, but more so with the children they are educating. It is my intention to make this their thesis, from their perspective, and for it to make a meaningful contribution on their behalf. I hope that I can approach this research with ‘different eyes’ to those that may traditionally study within the field and that this enables another perspective to be shared with the profession.

1.4 Thesis structure

This chapter has introduced the thesis and set the context for the forthcoming chapters, in addition to outlining the research questions that guided the study. Chapter 2 subsequently provides a critical review of the literature relevant to the study, and, in doing so, positions the current study within it. A considerable body of literature is reviewed and key topics within this include: the (potential) role of PE and schools in public health; the current (and former) manifestations of health within PE and schools; and the PE curriculum and teachers’ approaches and practices associated with health-related teaching. In addition, given the focus of the study, existing literature relevant to children and young people’s knowledge, understandings and conceptions of ‘health’ is reviewed.

Chapter 3 provides an overview of the research process and outlines the methodology adopted and the methods employed within the study. It outlines the research paradigm
within which the study was located, and its underpinning assumptions are discussed. The study design and research strategy are considered, and the methodology adopted is explained and justified. Following this, the research process is described phase by phase, with the methods employed to generate data in each phase being discussed. The analytical technique employed to analyse these data is subsequently described. Finally, ethical considerations relevant to the study are outlined.

Chapter 4 critically reflects upon the research process, focusing on the ways in which it facilitated pupils’ involvement within the study. It outlines the context of research with children and young people, with a particular focus on the perspectives that can be adopted in relation to them. The voices of children and young people within research are also considered and the youth voice agenda is debated. Participatory approaches to research with children and young people are discussed and two methods/techniques employed within the study, namely drawings and concept cartoons, are examined. Following this, ethical considerations in research with children and young people are contemplated and the stances that can be assumed with regard to ethics are outlined. Ethical sensitivities that can be evoked in research with children and young people and ethical considerations including consent, anonymity and confidentiality, and access are explored. A reflexive account of ethical dilemmas encountered within the research process is also provided.

Chapter 5 provides an overview of the current context of health-related teaching within PE in secondary schools in England, addressing the SRQ-1 and providing the necessary background information for the subsequent chapter which focuses on addressing the PRQ. It initially outlines demographic information pertaining to the participants and their settings. Subsequently, findings related to a number of key topics are presented and discussed including policies and practices associated with health-related teaching within PE, including teachers’ philosophies, and teaching approaches/strategies used by teachers to address pupils’ health-related learning. In addition, the notion of performativity, and how this manifests within teachers’ health-related teaching practice, is considered. Further within the chapter, the messages that teachers convey to pupils are examined, with particular attention paid to the healthist discourses that surround these messages and the influences these might exert on pupils’ conceptions. Teachers’ health-related knowledge and their perspectives
on/experiences of CPD\(^1\) in this area are considered, as are their perceptions of pupils’ conceptions of ‘health’ in PE. The chapter also considers the ‘bigger picture’ of health and examines the role of extra-curricular PE in supporting pupils to lead healthy, active lifestyles, as well as the influence of whole-school approaches. Additionally, it reflects on teachers’ perceptions around who should be deemed responsible for pupils’ health and the extent to which they feel they should contribute to this.

Chapter 6 explores pupils’ conceptions of ‘health’ within PE and addresses the PRQ. It initially explores pupils’ conceptions of ‘health’ in PE broadly, before the most prevalent features of their conceptions are considered in detail. Specifically, the corporeal focus and aesthetic orientations of their conceptions are examined. With regard to the former, the role of diet and exercise within pupils’ conceptions is described, and in relation to the latter, the notion of weight and its position within pupils’ conceptions is debated. The discourses that have influenced pupils’ conceptions are explored and, accordingly, the sources of information that pupils draw upon in formulating their conceptions of ‘health’ are outlined. The chapter additionally considers the potential for pupils to develop critically-inclined conceptions of ‘health’.

Chapter 7 provides an outline of teachers’ perceptions of pupils’ conceptions of ‘health’, addressing the SRQ-2. It explores how teachers’ expectations of their pupils’ knowledge, understandings and conceptions of ‘health’ contrast with the findings of the study, as discussed within the preceding chapter. Teachers’ perspectives on how pupils’ conceptions might have been influenced by their PE curricula and their practices are outlined and consideration is also given to the wider influences that may have impacted on pupils’ conceptions. Teachers’ perceptions of their own knowledge and understanding relevant to health-related teaching are examined and the support that teachers felt they might require to better address health-related learning within (and beyond) PE and the potential need for CPD in this regard is deliberated. Additionally, teachers’ recommendations for enhancing pedagogical practices with regard to health-related teaching and learning are presented.

\(^1\) CPD refers broadly to any activity, from the point of initial teacher training that “increases the skills, knowledge or understanding of teachers, and their effectiveness in schools” (DFE, 2000, p.3).
Chapter 8 concludes the thesis by returning to the research questions and providing an overview of the key findings of the study. It also outlines the implications for practice with regard to health-related learning that have resulted from the study and recommendations for future research are outlined. The thesis closes with concluding remarks on its contribution to research within the field of PE.
Chapter 2: Literature review

2.1 Introduction

This chapter provides a critical review of the literature relevant to the study and positions the current study within it. Initially, health as a concept is defined, before the positioning of health within contemporary society is explored. Specifically, children and young people, physical activity and health (and the links between these) are discussed before the influences of neoliberalism and healthism are considered. The (potential) role of PE and schools in public health is subsequently problematised. Next, the current (and former) manifestations of health within PE and schools are explored and the PE curriculum is considered, along with teachers’ approaches and practices associated with health-related teaching. Finally, the chapter examines children and young people’s knowledge, understandings and conceptions of ‘health’. Taking into consideration the literature reviewed, the chapter concludes by positioning the current study within it, outlining how the study addresses current ‘gaps’ within the literature, and making links to the study’s research questions (as outlined in section 1.2).

2.2 Health as a concept

A central concept to this study is that of health and consequently this warrants particular consideration. Health has been defined in varying degrees of complexity, though as O’Sullivan (2004) notes, differing definitions of health can be problematic and lead to tensions. As such, it is necessary to consider what is meant by the term ‘health’.

A widely accepted definition of health is that proposed by the World Health Organisation (WHO) who consider health to constitute ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity’ (1948, p. 1). This contrasts positively with former and more inadequate conceptualisations of health that were narrowly defined around the absence of disease (Naidoo and Wills, 2000). However, despite this definition being widely accepted (Hardman and Stensel, 2009), it has been criticised on the basis that it is not considered ‘fit for purpose’ (Huber et al., 2011, p. 1).
Huber et al. (2011) contest that the attainment of complete health is ideological, and that health should instead be considered in terms of ‘the ability to adapt and to self-manage’ (ibid., p. 2). In line with this, Bouchard and Shephard (1994, p. 9) propose that health can be considered as:

a human condition with physical, social and psychological dimensions, each characterised on a continuum with positive and negative poles. Positive health pertains to the capacity to enjoy life and to withstand challenges; it is not merely the absence of disease. Negative health pertains to morbidity and, in the extreme, with premature mortality.

This conceptualisation represents an attempt to move beyond the 1948 WHO definition of health and addresses criticisms of the definition propounded by Huber et al. (2011). The multi-dimensionality of health, as explicitly referenced by Bouchard and Shephard (1994), is an important notion as health tends to be conceptualised reductively, with a particular focus on the physical dimension. The notion of multi-dimensionality was endorsed by Corbin et al. (2010) who described health in terms of five interacting and inextricably linked dimensions, namely: physical, emotional/mental, intellectual, social and spiritual. Arguably, such a conceptualisation would be supported by researchers within physical education (PE), given that they too have explicated that health should not be considered reductively in terms of the physical (Penney, 1998; Evans, 2003; Penney and Jess, 2004; Kirk, 2006; Rail, 2009; Burrows, 2010).

In 1986, the WHO redefined health as ‘a resource for everyday life, not the object of living. It is a positive concept emphasising social and personal resources as well as physical capabilities’ (WHO, 1986, p.1). This better encapsulates the multi-dimensional and non-static nature of health and considers health from a positive perspective. However, it could be argued that implicit within this definition are notions of neoliberalism (Crawford, 2006) in the sense that, by terming health as ‘a resource for everyday life’, it is being inferred that a person needs to be ‘healthy’ in order to lead their life, and to actively participate as a citizen within society. This may lead persons who are considered ‘unhealthy’ to be polarised, which has been the case with marginal groups within society in line with the pervasive neoliberal agenda (Hill and Kumar, 2009).
Accordingly, the present study adopts the definition of health proposed by Bouchard and Shephard (1994) which conceptualises health as multi-dimensional, non-static and complex. In doing so, it seeks to recognise that health spans multiple domains (such as the physical, emotional/mental, and social) and that, whilst being inextricably linked, how ‘well’ a person is may vary depending on which domain is being considered (though it is difficult to consider domains independently of one another). Further, adopting such a definition of health goes some way to recognising that a person’s ‘wellness’ will likely differ at different points within their life course given that it is a dynamic concept influenced by various factors. In addition to being multi-dimensional and non-static, it is also important to acknowledge that ‘good health’ is relative and perceptions of what constitutes this may vary significantly amongst different individuals, making it an inherently complex concept. It is acknowledged, therefore, that it is difficult to present a definitive definition of health and any definition is likely to be contestable on account of it also being socially, culturally, historically and politically positioned (Penney, 1998).

2.2 Health within contemporary society

Given that health is socially, culturally, historically and politically positioned (Penney, 1998), it is important to consider its current position within contemporary society. Presently, children and young people’s health has become a particular concern as a result of evidence suggesting that they are becoming less active. Consequentially, concerns have also been expressed with regard to their increased risk of overweight and obesity (Hardman and Stensel, 2009) in what has been termed the ‘obesity epidemic’ (Wright, 2009). However, it is important to consider the evidence surrounding such claims and children and young people’s current ‘state of health’, as discussed within the following sub-section.

2.2.1 Children and young people, physical activity and health

The health of children and young people has become somewhat of a preoccupation within contemporary society amidst a seemingly increasing evidence base alluding to decrements in children and young people’s physical activity levels (Hardman and Stensel, 2009; Organisation for Economic Cooperation and Development [OECD], 2013; Health and Social Care Information Centre [HSCIC], 2016; WHO, 2016a). Globally, the WHO’s Health Behaviour in
School-aged Children (HBSC) survey reported that less than half of children and young people met their physical activity recommendation of at least 60 minutes of moderate to vigorous physical activity per day (WHO, 2016a). Within the context of the United Kingdom (UK), and England specifically, the Health Survey for England (HSE) reported that the physical activity recommendation for children and young people is met by even less, with about a fifth of children and young people being sufficiently active by these guidelines (HSCIC, 2016). In addition, the HSE identified that between 2008 and 2015, children and young people’s physical activity levels in England declined (ibid.).

The concerns about children and young people’s declining physical activity levels are compounded by evidence suggesting that health-related behaviours are acquired and established during childhood and adolescence with Reilly *et al.* (2004, p. 212) suggesting that ‘modern British children establish a sedentary lifestyle at an early age’. In addition, it has been proposed that children and young people’s physical activity levels track into adulthood (Twisk Kemper and Van Mechelen, 2000; Biddle, Gorely and Stensel, 2004; Duncan *et al.*, 2004; Brodersen *et al.*, 2007) meaning that, if children and young people are inactive during their childhood and adolescence, it is likely that they will be inactive during adulthood. With evidence suggesting that regular physical activity reduces risk factors for chronic conditions and, if maintained into adulthood, reduces the risk of morbidity and mortality from several diseases (Stensel, Gorely and Biddle, 2008; Hardman and Stensel, 2009), it is perhaps unsurprising that children and young people’s physical activity levels are of growing concern.

However, whilst the evidence base surrounding children and young people’s physical activity levels and its impact on their health status is growing (Boreham and Riddoch, 2001), much of the evidence relating to the links between physical activity and health is yet to be proven with children, with Cavill, Biddle and Sallis (2001) indicating that the evidence base is considerably weaker relative to the adult population. Furthermore, evidence relating to the trend of physical activity tracking throughout the life course is weak to moderate and, therefore, not certain (Boreham and Riddoch, 2001). Despite the evidence base relating to children, physical activity and health being contestable, and though associations between these are often weak, they are nonetheless, associations. As such, these should be given due consideration and, as Jakes and Wareham (2003) endorse, it is better to remain ‘sceptically positive’ about the contribution that physical activity can, or could, make to health (p.34) as opposed to
disregarding it. However, there is likewise a need to remain critical of the evidence base and to be cognisant of the fact that epidemiological evidence only provides part of what is a much bigger picture in relation to children and young people’s health.

2.2.2 Health and the ‘obesity epidemic’

A health condition that has been positioned as a particular concern in relation to children and young people’s health is obesity. In the context of England, obesity levels for children and young people stood at 15% for girls and 16% for boys in 2013 (HSCIC, 2016). However, obesity is not simply a phenomenon within the UK, but one that is ostensibly prevalent in developed and developing countries globally, with the WHO (2016b, no page number) now recognising it as a ‘global problem’. The concern generated around this ‘global problem’ has led to what has been termed the ‘obesity epidemic’ (Wright, 2009). Rather unsurprisingly, obesity (or rather, its prevention) is now the premise on which many physical activity and health interventions are based.

However, some academics challenge the very existence of an ‘obesity epidemic’ (e.g. Gard, 2004; Gard and Wright, 2005; Mark, 2005; Campos et al., 2006; Wright, 2009; Gard, 2010). Indeed, Gard (2004) veraciously attempts to dispel supposed myths relating to this, and casts considerable doubt on much of the evidence relating to the ‘obesity epidemic’ referring to it as a ‘phenomenon without a cause’ (ibid., p.72). Gard (2004), drawing on the work of Marshall et al. (2002), explicates how the premise on which the ‘obesity epidemic’ is founded is that being involved in sedentary activities limits the time available for participation in health-enhancing physical activity and as such puts individuals at risk of overweight and obesity. Yet, a study by Marshall et al. (2002), involving children in England, suggested that the more sedentary children are, the more active they are, with children who recorded higher physical activity levels being those who also recorded higher levels of screen-based sedentary behaviour and/or sedentary social activities. This somewhat paradoxical finding seems to confound the arguments of proponents of the ‘obesity epidemic’.

2.2.3 Neoliberalism and health

Within contemporary society there has been a shift towards individual responsibility for health which has arguably been bolstered by governments in Western and Westernised countries, given the reduction of the state and the freeing of the market (Ball, 2007). The
latter has been associated with the concept of neoliberalism which can be broadly considered as ‘an approach to governing society in such a way as to reconfigure people as productive economic entrepreneurs who are responsible for making sound choices in their education, work, health and lifestyle’ (Macdonald, 2011, p. 37). Neoliberalism provides governments with what could be considered a convenient route in terms of governance given that the individual focus it places on citizenship leads to enhanced allegiance to the state, whilst concomitantly promoting practices that reduce the demand placed on state services (Hall and Coffey, 2007). These practices are promoted to bring about what Bennett et al. (2007, p. 536) consider to be ‘voluntary compliance’ and are seen to contribute to positive state governance.

The benefit of adopting a neoliberal approach in terms of health, therefore, and in the context of the UK government, may be that the demand placed on the National Health Service (NHS) is reduced as the population, through the adoption of healthy practices, become less dependent on medical care. The origins of such a movement in terms of health are placed by Macdonald, Wright and Abbott with Sinclair (1818, cited in Macdonald, Wright and Abbott, 2010) who argued that ‘people seldom attend to their health til it be too late’ and that ‘the attainment of longevity, if accompanied with good health, is not only an important consideration to the individual, but also to the community to which he belongs’ (p. 12). Such a perspective places the responsibility for an individual’s health predominantly with the individual, and implicitly relates the maintenance of their health to their citizenship and contribution to the state. This implies that, in order to be a ‘good citizen’, an individual must also be healthy and must ensure that their practices, in terms of how they lead their lifestyle, positively contribute to this.

Whilst a neoliberal society may seem sapient to some, in that it may be considered logical that individuals take responsibility for their own lives, this approach to governance has both its critics and its consequences. Hill and Kumar (2009) posit that neoliberalism leads to generalisation in terms of both citizens in society (being considered as a one-of-a-kind as opposed to individual and different) and dominant discourses that pervade through it. This generalisation can lead to a loss of critical thought and can mean that dominant discourses are accepted as ‘truths’ amongst society. However, when considered critically, these ‘truths’ may not be all that they seem, as may be the case with the ‘obesity epidemic’. Indeed, Gard (2004) anecdotally poses the notion that ‘you need only stroll along the streets ... of Sydney,
New York and London to see how simplistic the idea of a generalised global ‘obesity epidemic’ is’ (p. 73), questioning whether or not one would see one in two of the people on the street being ‘so fat as to endanger their health’ (ibid., p. 74). Another danger of an increasingly neoliberal society is that, as Hill and Kumar (2009) note, equity amongst the population can be reduced. For example, Gard (2004) alludes to how the very language of an ‘obesity epidemic’ seems to ‘preclude any serious discussion of social division and, in fact, serves to conceal it’ (p. 73).

It would seem that in what is becoming an age of neoliberalism there are serious consequences for society (Giroux, 2008), with its effects pervading the governance of various aspects of an individual’s life, including schooling and health. The notion of ‘healthism’, a term coined by Crawford (1980), is arguably allied to neoliberalism and reflects many of the characteristics of it, as discussed within the following sub-section.

2.2.3.1 Healthism

‘Healthism’ refers to a particular view of what Crawford (1980) refers to as the ‘health problem’ (p. 365). He explains that the concept refers to the medicalisation of health, and as such (as is the case within medicine), ‘situates the problem of health ... at the level of the individual’ (ibid, p. 365), with the solution situated here also. Evidently, this aligns with neoliberal notions given the individual responsibility that it assumes individuals hold for their health within society. The notion of ‘healthism’ is problematic not only in that it regards health corporeally, but also because of its individualistic nature (Kirk and Colquhoun, 1989).

If such a notion pervades schools, which contestably it has (Lee and Macdonald, 2010; Johnson, Gray and Horrell, 2013), this has the potential to lead to children being considered responsible for their own health. Whilst this might be acceptable to an extent, children are clearly only ‘so responsible’ and cannot control all the factors which contribute to the assemblage of their health (Purcell, 2010). This may, therefore, be problematic in terms of educating children about healthy, active lifestyles within schools. Indeed, whether or not schools are the most appropriate site through which children should be taught about health is itself contested (Laventure, 2000; Corbin, 2002; O’Sullivan, 2004; Harris, 2005; Quennerstedt, 2008; Armour and Harris, 2013; Tinning, 2015), as discussed within the subsequent section.
2.3 Schools and their contribution to the public health agenda

It is perhaps to be expected that, given the concerns expressed over children and young people’s health (as discussed in sub-section 2.2.1), schools would be recognised for the role that they could play, in promoting health to children and young people (Shephard and Trudeau, 2000; O’Sullivan, 2004; Cale and Harris, 2005a; Stratton et al., 2008; Webb et al., 2008; Cale and Harris, 2011a; Armour and Harris, 2013; Cale, Harris and Chen, 2014; Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming). Cale and Harris (2011a) acknowledge how various governmental policies, strategies and initiatives have highlighted the role that schools should be playing in health promotion, noting how PE is mentioned explicitly within these. For example, within the context of the UK, ‘Sporting Future’: A New Strategy for an Active Nation (HM Government, 2015) and Childhood Obesity: A Plan for Action (HM Government, 2016) provide recent examples citing the role of PE within the public health agenda. On this note, Armour and Harris (2013) suggest that governments are increasingly turning to schools as a convenient means of public health promotion.

The PE curriculum is evidently a further means by which governments can promote public health and, in many countries, health features explicitly within (H)PE curricula (e.g. Australian Curriculum, Assessment and Reporting Authority [ACARA], 2012; Department for Education [DfE], 2013a; Ministry of Education [MoE], 2014a). In England specifically, the position of health within the PE curriculum has arguably been strengthened with each successive revision of the National Curriculum for PE (NCPE) (Fox and Harris, 2003; Cale and Harris, 2005a; Cale, Harris and Chen, 2014; Cale, Harris and Hooper, forthcoming). Within the current NCPE, ensuring that all pupils ‘are physically active for sustained periods of time’ and ‘lead healthy, active lifestyles’ represent two of the four overarching aims of the subject across all age groups (DfE, 2013a, p. 1). However, despite these aims indicating that health is a significant feature of PE, explicit references to health-related learning within the corresponding programmes of study are somewhat limited. Notwithstanding this, it is evident that the PE curriculum in England reinforces a relationship between PE and public health. However, as discussed within the following sub-section, that is not to say that this relationship is necessarily a straightforward one.
2.3.1 The contested role of PE in public health

The position of health within PE has been a subject of continued debate and there has been much contestation over the extent to which PE can, or perhaps should, contribute to the public health agenda (Laventure, 2000; Corbin, 2002; Evans, Rich and Davies, 2004; O’Sullivan, 2004; Quennerstedt, 2008; Armour and Harris, 2013; Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming). Within this debate, there are those who are positive about the role that PE could assume and the contribution it could make to public health (e.g. Cone 2004; Tappe and Burgeson, 2004; Trost, 2004). However, there are also those who express a degree of scepticism (e.g. Fardy, Azzollini and Herman, 2004; Armour and Harris, 2013) and some concerns (e.g. Harris, 2010; Cale, Harris and Chen, 2014) in this regard. Finally, it would be remiss to not acknowledge that there are also those who have levied criticisms at the relationships between PE and health (e.g. Evans, Rich and Davies, 2004; Azzarito, 2007; Evans, 2007; Wright and Dean, 2007; Evans, et al., 2008; Wellard, 2012). O’Sullivan (2004) argues that the position of health within PE is one of the key tensions within the profession as it struggles to confirm objectives for the subject. Armour and Harris (2013) concur, suggesting that there is much uncertainty within the profession about ‘the proper role for PE in health and the level of responsibility the profession should accept for children’s (let alone adults’) health outcomes’ (p. 209).

The contribution of PE to public health has been argued by some researchers as one of, if not the most, important objective for the subject (Shephard and Trudeau, 2000; Cardon and Bourdeaudhuij, 2002; Green, 2002; Fox et al., 2004; Trost, 2004; Fairclough and Stratton, 2005). The arguments proposed by such advocates of a public health agenda within PE are largely related to the potential contribution that the subject can make to children and young people’s health, and the potentially negative consequences that can result from inactivity (Tappe and Burgeson, 2004; Trost, 2004), as discussed within sub-section 2.2.1. Accordingly, given that it has been proposed that health-related behaviours are acquired and established during childhood and adolescence (Reilly et al., 2004), and that physical activity levels track into adulthood (Twisk, Kemper and Van Mechelen, 2000; Biddle, Gorely and Stensel, 2004; Duncan et al., 2004; Brodersen et al., 2007), it is understandable as to why schools would be identified as sites for health promotion and education.
It is reasonable to assume that PE (and schools more broadly) could positively contribute to public health for several reasons (Cale and Harris, 2005a; Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming). Within the context of England and the UK, as in many countries globally, primary and secondary schooling are a compulsory requirement for all children and young people, and 40-45% of a child or young person’s waking time is spent within the school context (Fox and Harris, 2003). Further, as Fox et al. (2004) note, schools ‘reach’ children and young people across socioeconomic stratifications. Therefore, it could be argued that schools provide a ‘captive audience’ at a time of high receptiveness, given that the core purpose of schools is to educate children and young people (Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming). Ultimately, this means that public health messages can receive broad coverage within through PE and schools.

The potential effectiveness of PE (and schools) in promoting health is additionally supported by a growing evidence base alluding to the positive impact it can have on children and young people’s physical activity levels, amongst other outcomes (Cale, 2017). A number of studies have evaluated the effectiveness of PE (and other school-based physical activity interventions) over the past few decades and these have been summarised within various reviews (e.g. Harris and Cale, 1997; Almond and Harris, 1998; Stone et al., 1998; Kahn et al., 2002; Cale and Harris, 2005, 2006; van Sluijs, McMinn and Griffin, 2007; De Meester et al., 2009; Dobbins et al., 2009; Kriemler et al., 2011; Demetriou and Honer, 2012; Dobbins et al., 2013; Cale, 2017). Early work by Harris and Cale (1997) and Almond and Harris (1998) evaluated health-related PE programmes, with the findings suggesting that positive learning and developmental outcomes resulted across the cognitive, affective and psychomotor domains of learning. Accordingly, this led Harris and Cale (1997, p. 99) to conclude that the evidence was ‘encouraging and sufficiently convincing’. Later work has similarly resulted in positive findings related to the potential impact of school-based physical activity interventions on children and young people’s physical activity levels. For example, a review by De Meester et al. (2009) found that interventions were effective in improving physical activity levels within the school context, whilst reviews by Dobbins et al. (2009, 2013) concluded that interventions increased the proportion of children engaging in moderate to vigorous physical activity during the school day. Collectively, these reviews (and the studies which they encompass) highlight that school-based physical activity interventions, many of
which include PE as a key component, can lead to positive outcomes for children and young people, particularly with regard to increasing physical activity levels. Whilst the majority of the reviews demonstrated that interventions had limited influence on children and young people’s physical levels outside of the school, the converse was found in a review by Kriemler et al. (2011). Evidently, this provides evidence in support of the potential role that PE (and schools) could play in public health.

Whilst it might seem plausible that PE can make a positive contribution to the public health agenda, as has been noted, a degree of scepticism and some concerns have been expressed, and criticisms have been levied (Cale and Harris, 2005a; Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming). It must be acknowledged that whilst 40-45% of a child or young person’s waking time is spent within the school context, PE accounts for less than 2% of this (Fox and Harris, 2003) and much of this may well justifiably involve only light physical activity (Stratton, Fairclough and Ridgers, 2008). Further, within England, and many countries globally, PE time is arguably being eroded on account of competing demands for curriculum time (Cale, Harris and Hooper, forthcoming). In addition, scepticism has been expressed with regards to the potential impact PE might have on physical activity levels, in spite of the aforementioned studies and reviews. As highlighted, only one of the reviews conducted found evidence to suggest that school-based physical activity interventions influenced children and young people’s physical activity levels outside of the school (Kriemler et al., 2011) and with the notable exception of the studies of Trudeau et al. (1998, 1999) and Trudeau and Shephard (2008), there has been limited evidence to suggest that such interventions have a lasting impact on children and young people’s physical activity levels (De Meester et al., 2009; Dobbins et al., 2013). On this note, Armour and Harris (2013) state that there is little ‘evidence to suggest that PE in most countries has achieved anything significant in terms of encouraging lifelong engagement in physical activity or improving public health’ (p. 202). Concerns have also been expressed with regard to how health-related learning is addressed within PE, though this is discussed further within sub-section 2.4.3.

Many criticisms have been levied at the relationship between PE and health. For example, it has been proposed that, as PE has become increasingly concerned with the public health agenda, the interpretations of health it promulgates have become increasingly narrow and simplistic (Evans, 2007; Evans et al., 2008a; Wellard, 2012). Further, Evans (2007) argues that
schools have come to adopt features of a performative culture in relation to health. Cale, Harris and Chen (2014) provide an example of this, by highlighting how practices such as fitness testing in schools are commonly used to provide a means of measuring and comparing children and young people’s performances of ‘health’. Criticisms have also been levied at the shift towards individual responsibility for health within PE, which has been argued to have resulted in increased health surveillance in schools, with children and young people’s health being assessed and evaluated (Webb and Quennerstedt, 2010; Evans and Rich, 2011). Allied to this, many have noted the potentially harmful effects that such approaches and practices can have on children and young people (Azzarito, 2007; Wright and Dean, 2007; Evans et al., 2008a, 2008b; Rich, 2010; Cale and Harris, 2011a; Evans and Rich, 2011). For example, Cale and Harris (2011a) suggest that surveillance practices such as weighing may serve only to preoccupy children and young people with their body and, as Cale and Harris (2009a) note, it is not necessary to measure children or young people ‘to tell them something that they already know’ (p. 143). Meanwhile, Rich (2011) notes that surveillance practices can lead children and young people to develop dysfunctional relationships with food and/or exercise.

In their critique of PE’s role in public health, Evans, Rich and Davies (2004) are particularly disparaging, stating that:

No matter how well it is configured or how much time is given to it in schools, physical education has no more capacity or responsibility to make children fit, eat well, and be thin than have maths teachers the capacity or responsibility to make pupils millionaires... [therefore] to reduce the aspirations of physical education to the triumvirate of fitness, exercise, and food and to ask them to be judged on these matters alone is to pursue not only illusory but also dangerous ideals (pp. 384-385).

Evidently, the extent to which PE and schools could and/or should contribute to the public health agenda has been much debated. However, as discussed in the following sub-section, despite this, it would seem that the PE profession has endeavoured to contribute to this agenda.

2.3.1.1 The positioning of health and the legitimating of PE

O’Sullivan (2004, p. 394) posits that ‘over time the PE profession has been assigned, accepted, ignored and rejected various goals’. However, it would seem that the public health goal is one
that has been readily adopted and actively worked towards. There could be a number of reasons for this, though it is likely related to the marginal position that PE has held within the curriculum, in England at least (Penney and Evans, 1999). More recently, curricular subjects have faced increasing demands, at a time of resource withdrawal, and they have seemingly had to legitimate their position within curricula (Kirk, 2011). In working towards this legitimisation, Kirk (1992) argues that the subject of PE may have lent itself to science, and in doing so led it towards a biomedical approach to health, with Locke (2003, cited in O’Sullivan, 2004) explicating how ‘by touting our ability to accomplish such a vitally important goal, we ... hope to sustain our place in the school curriculum’ (p. 18). It is understandable why this might be the case and, on this note, O’Sullivan (2004, p. 401) highlights how it can be ‘intoxicating’ for the profession to have such status, with it being placed ‘centre stage’ in public health debates. However, Locke (2003, cited in O’Sullivan, 2004, p. 397) notes that the profession needs to be considerate of ‘what is required to fulfil that social contract’ and, if PE is to make promises about what it can achieve in terms of children and young people’s health, it must be able to deliver on these.

Whilst PE and schools certainly could contribute to this goal, taking into consideration the evidence (as discussed in sub-section 2.3.2), it would seem that they have not maximised their potential in this regard (Laventure, 2000; Cale and Harris, 2005a; Harris, 2010; Cale, 2017; Cale, Harris and Hooper, forthcoming). Nonetheless, many researchers concur that schools do offer a tenable site for health promotion (e.g. Fox and Harris, 2003; Fox, Cooper and McKenna, 2004; Harris, 2005; McKenzie, 2007; Satcher and Higginbotham, 2008; Harris, 2009; Cale and Harris, 2011a; Cale, 2017; Harris and Cale, 2018; Cale, Harris and Hooper, forthcoming), with Fox and Harris (2003) noting how ‘the contribution of the school as a vehicle for physical activity and public health promotion is too great to be left to chance’ (p. 199). On this note, Cale (2017) asserts that the contribution that PE and schools can make needs to be considered realistically. PE has a range of objectives and educating children and young people about health and promoting physical activity represents one of many (Lounsbery et al., 2011). As such, it is unreasonable to assume that the subject, or schools more broadly, can be responsible for meeting children and young people’s health and physical activity needs in their entirety (Fox, Cooper and McKenna, 2004; McKenzie and Lounsbery, 2009). Cale, Harris and Chen (2014) offer a balanced perspective, suggesting that PE’s
‘responsibility and role with respect to health should be to stimulate interest, enjoyment, knowledge, competence and expertise in physical activity for lifelong participation’ (p. 387). However, it is recognised that, in order to facilitate this, children and young people must be provided with positive, meaningful and relevant experiences within PE (Cale and Harris, 2013). The progress that PE has made in this regard is discussed within the subsequent section.

2.4 Health-related learning and the PE curriculum in England

The prominent position of health in PE in England is presently confirmed by its representation in two of the four overarching aims of the subject across all age groups (DfE, 2013a, p. 1), as discussed in sub-section 2.3.1. However, it is important to note that PE and health have had a long-standing relationship and have been associated within one another since the subject of PE was introduced as part of the education system within England (Kirk, 1992). On this note, Sleap (1990) posited that health was a key motive for the development of the subject at the beginning of the twentieth century. The relationship between PE and health has continued, though arguably, the prominence of health was somewhat diminished by the 1940s, at a time when alternative objectives such as skill development were prioritised (Kirk, 1992). However, during the 1980s, there was somewhat of a resurgence, with Almond (1989) noting the apparent interest that was rising in schools across England. This resurgence has been argued by Tinning (2010, p. 177) as ‘a solution to the problem of improving the unhealthy lifestyles of children’ and starkly contrasted with former manifestations of health within PE (such as the performance of prescribed exercises). Strong, renewed interest in the area was seen in the 1980s, when health-related fitness (HRF) became popular. In England, health-related exercise (HRE) was considered by some to be a more favourable term than HRF, given that it better conceptualised the subject’s relationship with health (Harris, 1997), though there have been many terms for this used internationally, from HRF to health-based PE (Harris, 2000; Harris, 2010). More recently in England, the focus on health-related learning has shifted to the pedagogies that support children and young people’s learning around health within PE (Cale, Harris and Hooper, forthcoming).

Despite this more recent shift in focus, HRE has been the key means through which health has been addressed within PE in England for some time (Cale and Harris, 2005a; Harris, 2010).
Harris (2000, p.2) described HRE as ‘the teaching of knowledge, understanding, physical competence and behavioural skills, and the creation of positive attitudes and confidence associated with current and lifelong participation in physical activity’. Within the NCPE, HRE was initially identified as a theme to be delivered through the different activity areas, such as athletics, games and gymnastics. However, some researchers expressed concern that, with HRE not being afforded the status of a separate activity area, it would be marginalised and not adequately addressed (Cale, 1996; Penney and Evans, 1997). Harris (1997) confirmed this to be the case noting widespread uncertainty with regard to the delivery of HRE and considerable variation in approaches/practices within schools.

Harris and Almond (1994) recognised that HRE was clearly not being addressed as it had been anticipated in schools and advocated that teachers, as professionals, should be delivering HRE in the manner most suitable to their own school context. Subsequently, Harris (2000) identified a number of approaches that could be taken to addressing HRE, namely: permeated, focused and combined. A permeated approach involved HRE being delivered as a theme through the different activity areas, whilst a focused approach involved the delivery of a discrete, distinct health-related unit (ibid.). The strengths of a permeated approach are that it supports children and young people to recognise that health is integral to their PE experiences and encourages them to make links between participation in physical activity and health. However, a permeated approach can be rather ‘ad-hoc’ and ensuring consistent delivery can be challenging, as noted by Harris (1997). Further, such an approach can lead to health being delivered through traditional activities and can result in health becoming marginalised and/or being subordinated to learning outcomes such as skill development (Fox and Harris, 2003; Harris, 2000; Cale and Harris, 2005a; Harris and Cale, 2018). With consideration of a focused approach, whilst it may overcome many of the limitations of a permeated approach, teaching health in isolation may not result in children and young people connecting their learning within PE to other curriculum subjects (Cale and Harris, 2005a; Cale and Harris, 2009a; Harris and Cale, 2018). As such, it is perhaps to be expected that a combined approach, with both permeated and focused elements is advocated, given that it ensures broad coverage across the PE curriculum, whilst also reinforcing the importance of health as a learning area within it (Cale and Harris, 2009a). In addition, Harris and Cale (2018) have proposed that a combined approach can support pupils to make links with other
curriculum subjects such as personal, social, health and economic education (PSHEE), science and food technology.

Cale (2000) explored how schools were delivering HRE and found that combined approaches were most commonly being used, involving integration within the various activity areas, teaching through discrete, distinct units of HRE within PE, as well as through delivery within other curriculum subjects. This arguably demonstrated a more explicit, comprehensive and structured approach to the teaching of health within PE. Following this, Ward (2010) recognised that, whilst combined approaches continued to be most commonly used to address HRE, there was much disparity between how these were employed and, consequently, children and young people’s experiences of HRE were variable. It was recognised by Harris (2000) that, in order to ensure effective learning in relation to health, guidance was required to support teachers in working towards the aims outlined within the NCPE, particularly given the limited guidance within the NCPE and its associated programmes of study. As such, Harris (2000) produced a publication providing detailed guidance on HRE within curricular PE, including health-related learning outcomes for each of the Key Stages. The outcomes encompassed cognitive, affective, psychomotor and behavioural components across four key learning areas, namely: safety issues, exercise issues, health benefits and activity promotion. The intention of the guidance produced by Harris (2000) was to support teachers in interpreting the health-related component of the NCPE and to ensure that health-related learning was broad and progressive. Further (and updated) guidance on health-related learning has since been produced by Harris and Cale (2018) with a focus on promoting active lifestyles within schools.

As previously noted, more recently, interest in the health-related component of PE has shifted from HRE to health-related learning, with increased focus on the pedagogies that support children and young people’s learning in this area (Cale, Harris and Hooper, forthcoming). This represents a response to concerns expressed by Armour and Harris (2013) regarding teachers’ lack of appropriate pedagogies for effectively addressing health-related learning. On this note, they claim that, despite there being much interest in the area, little attention has been afforded to the development of ‘PE-for-health’ pedagogies. Armour and Harris are not

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2 The National Curriculum (NC) is organised into ‘blocks’ which cover different age ranges and are referred to as Key Stages (KS).
the only researchers to express this concern, with many others calling for further research in this regard (e.g. Haerens et al., 2011; Armour and Harris, 2013; Hodges et al., 2016; Hastie, Chen and Guarino, 2017). These calls have largely resulted from some of the persistent challenges that PE has faced/faces in working towards effective health-related teaching, as discussed in the following sub-section.

2.4.1 Challenges within health-related learning in PE

Calls to consider the pedagogies utilised for health-related teaching have resulted from concerns being expressed with regard to the status of health within PE, and the approaches and practices that teachers are employing to address health-related learning (Cale and Harris, 2011b). The status afforded to health within PE has been questioned by several researchers (e.g. Cale, 2000; Alfrey, Cale and Webb, 2012; Cale, Harris and Duncombe, 2016). Despite PE teachers professing to consider health as an important learning area within the subject, and purporting to value it, their approaches and practices might not necessarily reflect this (Cale, 2000; Alfrey, Cale and Webb, 2012; Cale, Harris and Duncombe, 2016). Green (2009) posits that teachers’ practices are obscured by their dominant ardour for sport, which can result in sport being dominant within their approaches to health-related teaching (Alfrey, Cale and Webb, 2012). Allied to this, teachers’ preoccupation with sport can result in health-related learning being addressed with a ‘fitness for sports performance’ focus, resulting in fitness testing and training being common practices employed by teachers to facilitate health-related learning (Harris and Leggett, 2013, 2015). This would suggest that health-related learning within PE is often addressed through a narrow, sport performance-focused and fitness-orientated approach (Cale and Harris, 2009b; Puhse et al., 2011; Alfrey, Cale and Webb, 2012; Harris and Leggett, 2013, 2015).

Approaches and practices such as these have been criticised for several reasons. A focus on sport may result in a narrow and shallow curriculum, dominated by (competitive) games (Green, 2009), with limited attention being paid to lifestyle activities which have been recognised as important for health-related learning (Cale and Harris, 2005a; Cale and Harris, 2009a; Cale, Harris and Duncombe, 2016). In addition, such approaches and practices may not appeal to a significant proportion of children and young people and may well lead to their disaffection from PE (Green, 2002; Cale and Harris, 2005a; Cale and Harris, 2009a; Harris and Cale, 2018). Furthermore, it has been contested that such approaches and practices can result
in instrumental conceptions of health and the body (Alfrey and Gard, 2014). Consequently, health can be conceptualised narrowly, simplistically and superficially within PE and conveyed, for example, as an ‘energy in’ and ‘energy out’ process, thereby reducing a complex concept to a simple notion of balancing diet and exercise (Evans, Rich and Davies, 2004; Gard, 2004).

A potential reason for PE teachers’ adoption of such approaches and practices may well be their limited health-related knowledge. Over the past few decades, several researchers have reported PE teachers to have limited and even insufficient knowledge with regard to health (e.g. Miller and Housner, 1998; Cale, 2000; Cardon and De Bourdeaudhuij, 2002; Stewart and Mitchell, 2003; Fardy, Azzollini and Herman, 2004; Castelli and Williams, 2007; McKenzie, 2007; Kulagina et al., 2008; Keating et al., 2009; Puhse et al., 2011; Alfrey, Cale and Webb, 2012; Cale and Harris, 2013; Harris and Leggett, 2013, 2015; Hastie, Chen and Guarino, 2017). Castelli and Williams (2007) provide particularly concerning findings, highlighting that when PE teachers completed a test (designed for 14-15-year-old pupils in America), only 38% met the standard expected of the young people for which it was designed, despite teachers being confident in their abilities to successfully complete it. Accordingly, Stewart and Mitchell (2003) have questioned PE teachers’ ability to effectively contribute to children and young people’s health-related learning.

Despite the reported limitations with regard to PE teachers’ health-related knowledge, it has been suggested that teachers themselves do not necessarily recognise this (Cale and Harris, 2011b; Alfrey, Cale and Webb, 2012). In their work, Alfrey and colleagues (2012) identified that there was limited provision within PE teachers’ initial teacher training (ITT) programmes related to HRE. Yet, despite this, the majority felt confident in their abilities to effectively address health-related learning. In addition, they highlighted that teachers had not accessed any relevant continuing professional development (CPD) in the past three years (ibid.). Additionally, work by Armour and Harris (2008, cited in Cale and Harris, 2011b) identified that courses related to health within a national PE professional development programme were not accessed by a high proportion of teachers. Harris (2010) suggests that PE teachers may not perceive there to be a need to engage with health-related CPD on account of their backgrounds, which are predominantly sport science-based. On this note, she posits that PE teachers consider themselves to be knowledgeable about health on account of the
experiences that they are likely to have had prior to commencing ITT (ibid.). Tinning (2010) shares the opinion of Harris (2010) and blames the traditionally science-oriented programmes of study that PE teacher education (PETE) students access at university prior to their ITT programmes for their belief that they are well equipped for health-related teaching. However, such programmes are arguably unlikely to have sufficiently prepared PE teachers for health-related teaching, particularly on account of their (predominantly) physiological foci (Tinning, 2010).

It seems cogent to assume that if PE teachers themselves do not have sufficient health-related knowledge and are employing questionable approaches and practices for health-related teaching, the learning of their pupils is likely to be limited, with many researchers presenting evidence to this effect (see Harris et al. (2016) for an overview), as discussed further in the subsequent section.

2.5 Children and young people’s knowledge, understandings and conceptions of ‘health’

There is a growing body of literature expressing concerns over what children and young people know, understand and conceive about ‘health’ within the context of PE (e.g. Desmond et al., 1990; Harris, 1993; Merkle and Treagust, 1993; Harris, 1994; Dixey et al., 2001; Placek et al., 2001; Burrows, Wright and Jungersen-Smith, 2002; Stewart and Mitchell, 2003; Burrows and Wright, 2004; Kulinna, 2004; Wright and Burrows, 2004; Wright, O’Flynn and Macdonald, 2006; Beausoleil, 2009; Burrows, Wright and McCormack, 2009; Keating et al., 2009; Lee and Macdonald, 2009; Rail, 2009; Burrows, 2010; Lee and Macdonald, 2010; Brusseau, Kulinna and Cothran, 2011; O’Shea and Beausoleil, 2012; Burrows and McCormack, 2014; Powell and Fitzpatrick, 2015; Harris et al., 2016). This body of literature presents a relatively consistent picture with regard to children and young people’s conceptions of health, with this having been established over a considerable period of time and drawing on research emanating from many countries.

Early work by Harris (1994) explored children’s knowledge and understandings related to health via focus groups with children aged 11-14 within two English counties. She identified that children considered health almost exclusively in the physical sense and demonstrated a preoccupation with food and exercise as moderators of health. Further, she noted that
children are surrounded by conflicting messages which assumingly poses difficulties when they are attempting to make sense of such information in order to develop their conceptions of health. In light of this, Harris (1994) called for further research into children’s knowledge and understandings of health, stating that ‘if healthy practices have their roots in childhood, it is important for educators to increase their understanding of the ground in which they sow their seed, as well as the processes which might help or hinder germination and growth (p. 149). This call by Harris (1994) for further research has largely gone unanswered within England, though further research within the field has emanated from Australia, New Zealand, Canada and America (Placek et al., 2001; Burrows, Wright and Jungersen-Smith, 2002; Stewart and Mitchell, 2003; Burrows and Wright, 2004; Kulina, 2004; Wright and Burrows, 2004; Wright, O’Flynn and Macdonald, 2006; Beausoleil, 2009; Burrows, Wright and McCormack, 2009; Keating et al., 2009; Lee and Macdonald, 2009; Rail, 2009; Burrows, 2010; Lee and Macdonald, 2010; Brusseau, Kulina and Cothran, 2011; O’Shea and Beausoleil, 2012; Burrows and McCormack, 2014; Powell and Fitzpatrick, 2015).

Placek et al. (2001) conducted interviews with American children aged 11-12 exploring whether and why an individual might exercise and how they might go about getting ‘fit’. In addition, children were asked to define fitness and to identify different types of fitness training. The findings of this study corroborate those of Harris (1994), highlighting that children conceptualised health predominantly in the physical sense. In addition, Placek et al. (2001) also noted how children considered fitness as equating to looking good and being thin, believed that sweating ‘burns off’ fat, and thought that performing specific exercises could ‘burn off’ fat in a particular area. Further, they identified that, although children considered exercise to be ‘good for them’, they had difficulty in articulating why this was (ibid.). These findings demonstrate that the children’s health-related knowledge and understandings were limited and that they held a number of misconceptions. However, a limitation of this study was that it was concerned more with fitness than health which may have focused children’s attention on the physical dimensions of health, with fitness being a largely physical concept. For this reason, the findings related to the children’s conceptions of health in the physical sense may have been influenced by the design of the study itself.

Stewart and Mitchell (2003), incited by the findings of Placek et al. (2001), sought to conduct further research with high school-aged young people in American schools. Their study
involved young people sitting a test comprising a number of questions relating to health-related fitness, requiring them to apply their knowledge in order to make recommendations as to how to how a person might improve their fitness (ibid.). The findings highlighted that children had limited knowledge pertaining to health-related fitness and were only able to score on the more basic elements of the test. Further, Stewart and Mitchell (2003) noted how children had considerable difficulty in applying fitness concepts, particularly when this required them to make links between different concepts such as time and intensity. This led them to conclude that children’s knowledge of fitness concepts was ‘narrow, vague and often incorrect’ (ibid., p. 550). Indeed, the researchers questioned whether children are ‘incapable of learning this content’ (ibid., p. 551). Noteworthy within the study of Stewart and Mitchell (2003) was the finding that, though the children had considerable limitations with regard to their knowledge and understanding of health-related fitness, none failed their PE programme of study. This may reflect inadequacies in the teaching of health-related content in PE and/or the assessment of curricular PE. The concerns raised by Stewart and Mitchell (2003) are echoed by Keating et al. (2009) who, in examining children’s HRF in American programmes from kindergarten through to the 12th grade, identified two major issues, namely, an inadequate knowledge of HRF content, and misconceptions related to fitness (ibid.).

In the context of New Zealand, interest in children’s health-related knowledge and understandings has also been sparked. Burrows, Wright and Jungersen-Smith (2002) explored these, drawing upon data obtained from the National Education Monitoring Project (NEMP) with children aged 8-9 and 12-13. The children were presented with various interactive tasks (both individual and group-based) and also participated in interviews and/or focus groups. The aim of the tasks was to explore what children knew and understood in terms of both health and fitness (ibid.). Burrows, Wright and Jungersen-Smith (2002), in line with the findings of the aforementioned studies, identified that children predominantly viewed health physically (or, as they termed it, corporeally) noting that ‘according to the majority of the students [health] meant eating the right food, drinking lots of water, being active and keeping oneself clean’ (p. 44). That is not to say that other aspects of health were indiscernible though, and some children also referred to mental and social factors related to health. The researchers noted that, in their definitions of what it meant to be healthy, children made reference to exercise and diet as the key moderators in the process of maintaining health and
frequently conflated fitness with health (*ibid.*). Within their work, Burrows, Wright and Jungersen-Smith (2002) also highlighted that children often described fitness in relation to weight (which many assumed to be a measure of an individual’s fitness). Furthermore, appearance was intimately connected with both fitness and weight and often ‘looking good’ was a primary concern for many children. Findings such as these are corroborated by further studies in Australia (Lee and Macdonald, 2009, 2010) and Canada (Rail, 2009), with each identifying appearance as a significant feature within children and young people’s conceptions of health.

The findings of Burrows, Wright and Jungersen-Smith (2002) were later corroborated by further work that they conducted drawing on the NEMP data (Burrows and Wright, 2004; Wright and Burrows, 2004; Burrows, Wright and McCormack, 2009; Burrows, 2010). Within the extensive work conducted by researchers in New Zealand, there are two particularly interesting notions to highlight. Firstly, Burrows and Wright (2004) highlighted that children ‘talk’ about health with much certainty. On this note, they proposed that children ‘delineated a remarkably clear line between healthy and unhealthy practices’, with a healthy person being someone who ‘doesn’t smoke, drink, or take drugs, eat junk food, or too much food, stress out, watch too much TV, be lazy [or] think bad thoughts’ (*ibid.*, p. 201). Secondly, Wright and Burrows (2004) described how, when discussing health, children frequently used the word ‘don’t’ and outlined behaviours that should be avoided with much conviction. Burrows, Wright and Jungersen-Smith (2002) supposed that the responses elicited from the children within their study are indicative of ‘the effectivity of the health and fitness discourses which are circulating in ... society’ (p. 46). However, consistent with the findings of Stewart and Mitchell (2003), it would appear that whilst children are able to ‘recite’ such information, more complex relationships between concepts are less well understood. This is also supported by the American study of Brusseau, Kulinna and Cothran (2011) who, in exploring children’s understandings, found these to lack detail and to be superficial.

Powell and Fitzpatrick (2015) also conducted research in New Zealand and used photo elicitation interviews to explore the health-related knowledge and understandings of nine-year-old children. They identified that these children considered fitness to equal non-fatness and regarded fatness as something that was to be avoided (*ibid.*). Rail (2009) conducted research in Canada and used interviews and focus groups to explore the ways in which young
people (aged 13-16) conceptualised health. Within her work, she noted that young people were particularly concerned with ‘not being fat’, on account of the negative consequences associated with being labelled as such. Similar findings have also emanated from the work of Beausoleil (2009) and O’Shea and Beausoleil (2012) in Canada.

Whilst research in England following the work of Harris (1994) has been more limited than that in other countries (such as Australia, New Zealand and Canada), that is not to say there has been none. Dixey et al. (2001) conducted a study with children aged 9-11 to explore their understandings of fatness, thinness and health. Whilst others have proposed that children have relatively simplistic conceptions of health, Dixey et al. (2001) conversely highlighted how the children within their study had reasonably complex conceptions, for example, not necessarily believing that ‘thin is good and fat is bad’. When asked during focus groups what being healthy meant, the children were reported to recognise how maintaining a ‘healthy’ weight was important but equally that a fat person could be healthy too. The researchers posited that whilst children could recite what they had learnt in schools, they also drew on confounding information from other sources in their conceptualisations of health. Nonetheless, limitations in their knowledge and understandings were still noted as children failed, for example, to ‘make a firm link between exercise, or energy expenditure, and overweight’ (ibid., p. 212). In addition, Roth and Stamatakis (2010) drew on data from the HSE conducted in 2007 to explore the links between children’s knowledge of public health guidelines related to physical activity and their physical activity levels, finding that there was some correlation, though this was fairly weak for boys. However, relevant to the current study was the finding that only 10.8% of the sample knew the recommended guidelines for physical activity (ibid.). Arguably, this provides evidence in support of claims that children and young people’s health-related knowledge and understandings are limited.

Evidently, the health-related knowledge and understandings of children and young people have consistently been found to be limited, over a considerable period of time and across many counties. Allied to this, their conceptions of health have been found to be limiting and reductive. Therefore, it may be proposed that health-related learning within PE is not being addressed as effectively as it might.
2.6 Conclusion

This chapter has provided a critical review of the literature relevant to the study. It has highlighted that schools, and in particular PE, have been increasingly recognised for the role that they play in promoting healthy, active lifestyles amongst children and young people in light of the public health agenda. However, whilst schools have been recognised for the role that they can play in this regard, concerns have been expressed in relation to the status of health in PE and the approaches and practices used to address health-related learning. A particular concern is what children and young people know and understand about ‘health’, and how they come to conceive this within PE, with a growing body of literature suggesting that pupils’ conceptions are relatively superficial and simplistic.

Taking into consideration this literature, it is evident that children and young people’s health-related learning warrants further exploration, specifically within the context of England and in light of the current NCPE, given that this represents something of a ‘gap’ within the literature. However, given how influential the curriculum might be, it is also important to explore how health-related learning is currently being addressed within PE in England, as this will provide the context for interpreting children and young people’s conceptions of ‘health’. This also addresses another ‘gap’ within the literature, namely a current examination of health-related teaching practices within PE in England. Finally, given the aforementioned concerns related to teachers’ health-related knowledge and their practices and approaches with regard to health-related teaching, it seems pertinent to engage them within the research, to try and support the enhancement of health-related learning and teaching within the subject. These ‘gaps’, identified through the critical review of the literature, were used to inform the development and refinement of the research questions outlined in section 1.2.

The following two chapters outline (and reflect on) the research process that the study followed in order to address these research questions. Chapter 3 describes, somewhat procedurally, the research process and provides a detailed account of the various phases of it. Chapter 4 subsequently reflects on the research process and considers in detail how the participatory research design facilitated (or otherwise) pupils’ voices within the study. Whilst there is evidently some overlap between the two chapters, the thesis has been structured in such a way to ensure that the research process can be outlined in detail prior to being reflected upon critically.
Chapter 3: Methodology and methods

3.1 Introduction

This chapter provides an overview of the research process and outlines the methodology adopted and the methods employed within the study. Initially, research paradigms are considered, and the concepts of ontology and epistemology are explored. Subsequently, the research paradigm within which the study was located (and its underpinning assumptions) is discussed. Next, the study design and research strategy are considered, and the methodology adopted is explained and justified. Following this, the research process is described phase by phase, with the methods employed to generate data in each phase being discussed. The analytical technique employed to analyse these data is next outlined. Finally, ethical considerations relevant to the study are considered.

3.2 Research paradigm

The outlining of a researcher’s philosophical position is generally viewed as a prerequisite to undertaking (social) research (Coe, 2017). According to Kuhn (1962), philosophical positions are typically articulated through the expression of a commitment to a particular research paradigm and the assumptions that underpin it. There are several definitions of research paradigms (e.g. Patton, 1978; Sparkes, 1992; Guba and Lincoln, 1994; Bryman, 2012; Flick, 2014; Sparkes and Smith, 2014; Waring, 2017) though that of Guba and Lincoln (1994) is commonly referred to within the literature. They define a paradigm as ‘a world view that defines, for its holder, the nature of the ‘world’, the individual’s place in it, and the range of possible relationships to the world and its parts’ (ibid., p. 107). Whilst there are subtle differences between the various definitions of paradigms, a consistent feature within these is the significance attached to them. As Lincoln (2010, p. 7, emphasis as in original) outlines:

Paradigms... do matter. They matter because they tell us something important about researcher standpoint. They tell us something about the researcher’s proposed relationship to the other(s). They tell us something about what the researcher thinks counts as knowledge, and who can deliver the most valuable piece of this knowledge. They tell us how the researcher intends to take account of [the] multiple and contradictory values [they] will encounter.
Evidently, it is important for researchers to consider their paradigmatic positioning, with there being multiple positions that a researcher can adopt (Lincoln, Lynham and Guba, 2011; Hammersley, 2012). That said, within the literature, debates around paradigms typically tend to concern themselves with two contrasting positions, namely, positivism and interpretivism. There are three fundamental questions researchers need to consider in order to determine their own positioning (Guba and Lincoln, 1994; Denzin and Lincoln, 2005):

- What is the nature of reality, and what can be known about it?
- What is the relationship between the researcher and what (it is assumed) can be known?
- How can the researcher go about finding out that which can be known?

These questions each relate to a particular concept associated with research paradigms, namely: ontology, epistemology and methodology. The concepts are, as Smith and Sparkes (2016, p. 2) note, ‘interconnected in such a way that the answer given to any one question, taken in order, constrains how the others may be answered’. As may be expected, researchers of different paradigmatic ‘persuasions’ respond differently to these three questions.

The first question relates to ontology, which is concerned with existence itself, requiring consideration of the nature of the world and the existence of (social) phenomena within it (Jones, 2014; Sparkes and Smith, 2014; Smith and Sparkes, 2016; Waring, 2017). If ontology were to be viewed from a positivist perspective, it would be conceived that the world and (social) phenomena are ‘real’ and exist independently of perception (Coe, 2017). Contrastingly, from an interpretivist perspective, it would be considered that (social) phenomena are always perceived in a particular way and cannot exist without being perceived (ibid.). Building on this, the second question relates to epistemology. Epistemology is concerned more specifically with the nature of knowledge, in terms of what can be known and how this knowledge can be acquired (Jones, 2014; Sparkes and Smith, 2014; Smith and Sparkes, 2016; Waring, 2017). Positivists would propose that there is/are ‘truth(s)’ which can be objectively studied to generate knowledge (Cohen, Manion and Morrison, 2011). Interpretivists would argue that knowledge is subjective and socially constructed (ibid.).

The third question relates to methodology. Methodology refers to the study design and research strategy employed within the study and is the premise on which decisions such as
what methods to use to collect data, or which technique(s) is/are used to analyse the data are made (Payne and Payne, 2004; Bryman, 2012). Grix (2002) considers the concepts of ontology, epistemology and methodology as the ‘building blocks’ of research. However, he includes an additional concept in the form of methods, explicitly noting the distinctions between methodology and methods (ibid.). In line with this, methods are taken as the techniques and tools used to collect the data as part of the study (Payne and Payne, 2004; Jones, 2014), such as surveys, interviews and focus groups.

Smith and Sparkes (2016) assert that researchers should explicitly acknowledge the paradigm to which they are committing, on account of the influence it has on the study being conducted. In line with this, it is noteworthy that the present study was located within an interpretivist paradigm on account of the researcher’s philosophical position and the research questions that the study sought to address (as outlined in section 1.2). Given that the study was focused on exploring the ways in which pupils conceptualised ‘health’ within PE, and of which there were multiple, subjective interpretations, it necessitated a paradigmatic position that would facilitate the expression of these. As such, an interpretivist paradigm was deemed most suitable as it recognises that there are ‘multiple realties and that the mind plays a central role, via its determining categories, in shaping or constructing these’ (Sparkes, 1992, p. 27).

The subsequent section discusses the research methodology adopted within the study. Specifically, it considers the study design and the research strategy that was adopted, in line with the paradigmatic positioning outlined within this section.

### 3.3 Study design and research strategy

Savin-Baden and Howell Major (2013) propose that research methodologies have two components, namely, a study design and a research strategy. The methodology adopted is influenced by the paradigmatic positioning that a researcher aligns with and inherently influences the manner in which the research is conducted (discussed further in section 3.4). Within this study, a mixed methods study design was adopted along with a case study research strategy. These are discussed further within the following sub-sections.
3.3.1 Mixed methods research

A mixed methods study design was adopted as part of the research methodology, on account of different methods being best placed to address the different research questions of the study (as outlined in section 1.2). Mixed methods study designs are increasingly commonplace within pedagogical research, with Gibson (2016) suggesting that the use of mixed methods study design is ‘an intuitive and practical response to the varied demands of understanding the dynamic and multifaceted nature of human practices and the (social) world’ (p. 382). Similarly, Johnson and Onwuegbuzie (2004, p. 17) assert that researchers should ‘choose the combination or mixture of methods and procedures that works best for answering [their] research questions’.

At a most basic level, a mixed methods study design can be considered as one which draws upon both ‘qualitative’ and ‘quantitative’ approaches (Johnson, Onwuegbuzie and Turner, 2007). However, mixed methods study designs are far from straightforward and have been much debated within the literature (Biesta, 2017). In line with this, a number of researchers have attempted to characterise the different approaches that can be adopted based on the various design factors that comprise them (e.g. Greene, Caracelli and Graham, 1989; Tashakkori and Teddlie, 1998; Creswell et al., 2003; Teddlie and Tashakkori, 2003).

The sequencing of the qualitative/quantitative approaches that are employed within a mixed methods study design are an important factor. Specifically, the sequencing of these, concurrently or sequentially, designates the particular approach being taken (Creswell and Plano Clark, 2011). A specific coding system has been developed to categorise the different approaches using the codes of QUAL/qual and QUAN/quan, whereby a capitalised code designates the dominant status of a particular approach (ibid.). If a concurrent design is employed, both ‘qualitative’ and ‘quantitative’ approaches would be used simultaneously (QUAL + QUAN), whilst in a sequential design the approaches would follow one another (QUAL → QUAN) (Biesta, 2017). The design employed within this study was sequential, as ‘quantitative’ approaches were utilised during the initial phase of the study, with ‘qualitative’ approaches employed within the subsequent phases. Therefore, the design would be coded

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3 It is acknowledged that qualitative and quantitative are types of data, as opposed to approaches to research (Waring, 2017). However, the phrases qualitative/quantitative approaches are used to refer to methods that produce these forms of data.
as QUAN → QUAL. However, this would be better coded as quan → QUAL, to acknowledge
the dominant status that ‘qualitative’ approaches were afforded within the study design. On
account of this, the study design would be considered as exploratory (Creswell and Plano
Clark, 2011) in that it focused on generating interpretative understandings of a particular
(social) phenomenon, specifically, pupils’ conceptions of ‘health’ within PE.

Biesta (2010, 2017) argues that, in addition to considering the sequencing of mixed methods
study designs, attention must also be paid to the different ‘levels’ at which a researcher might
‘mix’ methods within their study. He suggests that there are seven ‘levels’ at which methods
might be mixed and, at each ‘level’, different questions must be considered to determine
how, if at all, ‘qualitative’ and ‘quantitative’ approaches might be drawn upon. These include:
data, methods, designs, epistemologies, ontologies, research purposes, and practical
orientations (ibid.). Within this study, the key ‘levels’ at which methods were mixed were the
first and second (data and methods) with both qualitative and quantitative data being
generated and a variety of methods (i.e. survey, interviews, focus groups) being employed.

Mixed methods study designs are considered to have developed from the concept of
triangulation, whereby it is proposed that the convergence of data from multiple methods
enhances the robustness and validity of the findings (Biesta, 2010). However, whilst this might
be the concept from which these developed, it has been proposed that there are five motives
for adopting a mixed methods study design, namely: triangulation, complementarity,
initiation, development and expansion (Greene, Caracelli and Graham, 1989). In relation to
this study, several of these motives applied. Mixed methods research enabled the findings
from one method to inform another method (development) and it enhanced the breadth of
the study, providing context for the (social) phenomenon that was to be the focus of it
(expansion). Furthermore, it enabled elaboration of the results due to the multiple sources of
data that were drawn upon (complementarity) and it facilitated corroboration of the results
from these sources (triangulation). A mixed methods study design was, therefore, deemed to
be most appropriate for the research methodology adopted, in combination with a case study
research strategy, as discussed in the following sub-section.
3.3.2 Case study research

A case study research strategy was adopted as part of the research methodology. It was assumed that such a strategy would complement the mixed methods study design as case study research strategies are ‘completely independent of methods of data collection and analysis’ (Gorard and Makopoulou, 2012, p. 113). As such, they are considered to be a relatively versatile research strategy that facilitate the use of a range of methods. However, that is not to say that case studies represent an ‘easy’ research strategy to employ, as there is a distinct lack of consensus as to what constitutes a case study (Savin-Baden and Howell Major, 2013).

Van Wynsberghe and Khan (2007) highlight that, as case study research strategies are not prescriptive in terms of structure, content or tools, it makes them somewhat difficult to define. Stake (1988, p. 258) offers a ‘pretty loose definition’ describing case studies as the ‘study of a bounded system, emphasising the unity and wholeness of that system, but confirming the attention to those aspects that are relevant to the research problem at the time’. Yin (2014) defines case study research strategies as an investigation of ‘a contemporary phenomenon in depth and within a real-world context, especially when the boundaries between phenomenon and context may not be clearly evident’ (p. 16). A case study research strategy was appropriate for this study, therefore, given that it enabled a (social) phenomenon, namely pupils’ conceptions of ‘health’ within PE, to be considered within the specific context in which it was being studied.

Punch (2014) elaborates on the definition provided by Stake (1988) identifying four key characteristics of case study research strategies. Firstly, a case study is bounded. In other words, there are boundaries applied to the research and there is a finite amount of research that can be conducted; if the research were boundless, a case study strategy would not be being applied. Secondly, it is particularistic, focusing on the specific rather than the general. Thirdly, and in contrast to the previous point, it is holistic. Whilst it focuses on the specific, it endeavours to take into account the case as a whole so as to preserve the unity and integrity of it. Finally, it is naturalistic, in that it occurs within the context that is being studied and typically draws on multiple methods/data collection points to explore this context.
There have been various categorisations of case study research strategies proposed (e.g. Merriam, 1988; Yin, 1993; Stake, 1995) though that of Yin (1993) is commonly referred to within the literature. He outlines three categories, namely: descriptive, exploratory, and explanatory (ibid.). The case study research strategy employed would be categorised as descriptive as it sought to provide a thick, rich and detailed account of a particular (social) phenomenon, namely pupils’ conceptions of ‘health’ within PE. The disciplinary perspective from which the study was approached is an amalgamation of educational and sociological disciplines, in line with the work of Stenhouse (1988) and Merriam (1988). This is due to the fact that the study was based in an educational context but drew upon sociological constructs.

It is necessary, when employing a case study research strategy, to outline what a ‘case’ is within the context of the study. Miles, Huberman and Saldana (2013, p. 28) define a ‘case’ as ‘a phenomenon of some sort occurring in a bounded context’. Cases are typically taken to be the unit of analysis within case study research strategies, and within any particular case there can be many sub-cases. Brewer and Hunter (2005) identify six different types of ‘case’: individuals; attributes of individuals; actions and interactions; residues and artefacts of behaviour; settings, incidents and events; and collectivities. In line with these categorisations, it is evident that the study utilised particular settings as a ‘case’. These settings were two schools and, on account of there being multiple cases, the research strategy would be considered a collective case study (Yin, 1994). Further, within each ‘case’, there were many sub-cases that were concerned with individuals, specifically, teachers and pupils.

The subsequent section outlines the research process and discusses the various phases of the study, in line with the research methodology detailed within this section.

3.4 The research process

The research process had four phases that took place between April 2015 and December 2016 (see figure 3.1). The first phase involved an online survey which was distributed to all secondary schools within the East Midlands region of England. The second phase involved semi-structured interviews conducted with PE teachers in two case study schools, along with pupil focus groups at the same schools. The third phase involved further focus groups with the same pupils at the two case study schools, while the fourth phase involved focus groups
with the PE teachers who participated in interviews during the second phase. These phases, and the methods employed within each, are discussed in detail within the following subsections.

Figure 3.1 Phases of the research process
3.4.1 Phase one

An online survey was distributed during the first phase of the research with the purpose being to explore the current landscape of health-related teaching and learning within secondary PE, in line with the current NCPE aim of ensuring that all pupils lead healthy, active lifestyles (DfE, 2013a). Specifically, the survey was employed to examine teachers’ views of, approaches to, and practices in, supporting pupils to lead healthy, active lifestyles. The employment of a survey within the first phase of the research was useful, as it enabled the context for the study, and the subsequent phases within it, to be established. The following sub-sections discuss the survey design, participants and administration and distribution in further detail.

3.4.1.1 Survey design

A recommendation when designing a survey is to initially consider drawing on pre-existing surveys, given that these have been used previously and, as such, ratified (Babbie, 2010; Neuman, 2010). Whilst similar survey-based research has been conducted with secondary PE teachers in England exploring health within the subject (e.g. Alfrey, Cale and Webb, 2012; Cale, Harris and Chen, 2014), it did not focus specifically on healthy, active lifestyles in line with the current NCPE (DfE, 2013a) which was the particular focus of this research. Therefore, whilst these surveys informed the design, construction and development of the survey, they could not be used in their entirety. Therefore, the survey was newly designed and constructed taking into account ‘best practice’ guidance (e.g. Babbie, 2010; Neuman, 2010; De Vaus, 2013; Jones, 2014).

The survey comprised four sections. The first section was concerned with demographic information about the teacher and their school. The questions within this section were all closed and required respondents to select an option from a multiple-choice list, using tick boxes. There was also an ‘other’ option included where relevant, so as to not restrict responses, as recommended by Jones (2014). It is advisable for surveys to begin with more straightforward questions, to ease respondents into the survey and to encourage them to complete it. As Brandl-Bredenback and Kämpfe (2012) note, many respondents will make a judgement as to whether or not to complete a survey during the early stages of it and their participation can be gained (or lost) relatively easily.
The second and third sections of the survey explored how pupils were supported to lead healthy, active lifestyles within PE and the wider school, respectively. These sections both contained a combination of open and closed questions; where closed questions were used, this was typically on a contingency basis with the respondent being required to follow-up and provide further information based on the prior response. This approach meant that any criticisms with regard to limiting responses could largely be overcome (Babbie, 2010). Questions for the survey were phrased in line with the guidance of Neuman (2010) and De Vaus (2013) to ensure that some of the common mistakes of survey question writing were avoided, such as: jargon language, leading/loaded questions, double-barrelled questions, questions making assumptions and prestige bias. The fourth and final section was more evaluative and sought to examine how effectively respondents felt pupils were supported to lead healthy, active lifestyles. This was organised in a similar way to sections two and three, though was notably shorter. The survey underwent a period of drafting and re-drafting and, as advocated by Brandl-Bredenback and Kämpfe (2012), colleagues within the University provided feedback as part of the refinement process, in order to work towards a version suitable for piloting (discussed further in sub-section 3.4.1.4).

3.4.1.2 Survey sample and participants

The sample for the survey comprised secondary PE teachers within the East Midlands region of England. In terms of inclusion criteria, it was decided that for respondents to be eligible, they must be working as a full-time PE teacher in a mainstream state secondary school and hold qualified teacher status (QTS). These criteria were established to ensure that those responding to the survey had familiarity with, and experience of delivering, the NCPE. The decision to exclude private schools (also known as ‘independent schools’) was made on account of such schools not being required to follow the NC, and because PE and sport provision in such schools can be considerably different to that provided within state schools (Tozer, 2012).

3.4.1.3 Survey administration and distribution

It has been suggested by Jones (2014) that online survey platforms are increasingly recognised as a convenient means by which surveys can be administered by researchers and completed by respondents. As such, the survey employed as part of the study was administered online via the Bristol Online Surveys (BOS) platform. It was distributed to schools as a link within an
email containing details regarding the survey and its purpose. The email was sent to all state secondary schools within the East Midlands region of England (n = 293) via generic email addresses that were available online from the respective city and county council websites within the region. A mailing list of these email addresses was developed in Microsoft Outlook and used for the purposes of contacting schools. At each school, the email was typically received by the reception staff, given that generic email addresses were used. On account of this, the email subject was marked as ‘FAO: Head of Physical Education’ and a short message was incorporated into the body of the email, requesting that it be forwarded on to the Head of PE (HoPE) at the school. It should be noted, however, that it was made explicit to the HoPE that it need not necessarily be them who completes the survey, and that they could pass it on to another member of staff within their department who met the inclusion criteria (as outlined in sub-section 3.4.1.2).

3.4.1.4 Piloting and conducting the survey

The survey was piloted in part of the West Midlands region of England between April and May 2015, prior to being launched in the East Midlands. It was distributed to 108 schools and was ‘live’ for a period of three weeks, with reminders sent routinely during this period (at weeks 2 and 3). A total of 14 schools responded, representing a 13% response rate. The piloting of the survey enabled it to be further developed/refined and allowed its practicability to be ‘tested’ to ensure that it was ‘fit for purpose’. Presser and Blair (1994) suggest that there are three key considerations when piloting a survey, namely: comprehensibility, consistency and completion time, and so particular attention was paid to these aspects during the pilot. In line with this, evaluative questions were incorporated at the end of the pilot survey to seek feedback from respondents. These questions focused on how easy the respondents had found the survey to complete, whether there were any particular questions they had difficulty in answering, and how long it took them to complete the survey. The pilot identified minor aspects of the survey that could be improved such as the removal of questions that resulted in similar/duplicated responses and the refinement of a small number of questions which were misinterpreted. The changes made to the survey as a result of the pilot were minimal, though did enable a finalised version of the survey to be confirmed (see appendix A).

The survey was subsequently launched in the East Midlands region of England between June and July 2015 and was distributed to 293 schools, being ‘live’ for a period of six weeks. As had
been the case with the pilot, schools were sent routine reminders (at weeks 2, 4 and 6) prompting completion of the survey. By the end of this period, a total of 52 schools had completed the survey, representing an 18% response rate. The response rate was lower than anticipated, though as Brandl-Bredenback and Kämpfe (2012) and Tymms (2012) note, a response rate of below 20% is not uncommon within survey-based studies, particularly those where the survey is administered online and distributed in a manner that permits anonymous completion.

In addition, the survey acted as the means by which potential case study schools were identified. At the end of the survey, respondents were made aware that there were further phases within the study and were asked to indicate whether they would be interested in being involved with these. It should be noted, however, that respondents were assured that this expression of interest was non-committal at that stage. Of the 52 PE teachers who completed the survey, 12 expressed an interest in being involved further, and it was from these that the two case study schools (and the pilot school) were selected for the subsequent phases.

3.4.2 Phase two

Semi-structured interviews (with teachers) and focus groups (with pupils) were conducted as part of the second phase of the study. The interviews were intended to act as a follow up to the survey that was employed during phase one (as discussed within sub-section 3.4.1) and, as such, sought to further explore the current landscape of health-related teaching and learning within secondary PE in England, but within the specific context of the two case study schools. Contrastingly, the purpose of the focus groups was to explore the ways in which pupils conceptualised ‘health’ within PE. The following sub-sections provide details regarding the case study schools and the recruitment of participants within these. In addition, they discuss the design and conduct of the interviews and focus groups that took place during this phase of the study.

3.4.2.1 Case study schools

The schools chosen as cases were selected on account of a combination of factors, based on demographic information about the schools available from the DfE website and the survey responses from the PE teachers at each school. With regard to the demographic information, the decision was made to select cases that were ‘typical’, given the exploratory case study
being employed as a research strategy (Hamel, Dufour and Fortin, 1993). In relation to the school settings, this meant that only mixed gender schools and those with pupils aged 11-16 or 11-18 were considered. In terms of the survey responses, it was decided to select schools at which the responding teacher had reported that at least some time was being spent addressing the NCPE aim of supporting pupils to lead healthy, active lifestyles within curricular PE. Further, it was decided to select a school at which the responding teacher felt that they needed further support to address this aim, and another that did not, in order to provide contrasting perspectives. An outline of the selection criteria for case study schools is provided in appendix B. Based on these criteria, three schools were identified as potential cases.

Following the identification of schools that would be suitable cases, their agreement to participate in the study was sought. In the first instance, the teacher who completed the survey was contacted and provided with further information about participating in the study. The teachers at all three schools remained interested and contact was made with the Head Teacher at each school. A letter was sent to each Head Teacher inviting them to participate in the study and detailing what would be involved (see appendix C). If the Head Teachers were willing to permit the study to be conducted in their school, it was requested that they respond and provide a letter to this effect. All Head Teachers responded positively and gave consent for their schools’ participation, meaning that two case study schools (and a pilot school) were secured as research sites. Demographic information about the participating schools is provided in table 3.1.
<table>
<thead>
<tr>
<th>School Demographic</th>
<th>Pilot School</th>
<th>Case Study School 1</th>
<th>Case Study School 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>Academy</td>
<td>Academy</td>
<td>State Comprehensive</td>
</tr>
<tr>
<td>Location (Urban/rural descriptor)</td>
<td>Nottinghamshire (Rural hamlet and isolated dwellings)</td>
<td>Nottinghamshire (Rural town and fringe)</td>
<td>Derby (Urban city and town)</td>
</tr>
<tr>
<td>Age Range</td>
<td>11-18</td>
<td>11-18</td>
<td>11-18</td>
</tr>
<tr>
<td>Gender</td>
<td>Mixed</td>
<td>Mixed</td>
<td>Mixed</td>
</tr>
<tr>
<td>Size</td>
<td>1001-1500 pupils</td>
<td>1501-2000 pupils</td>
<td>1001-1500 pupils</td>
</tr>
</tbody>
</table>

Table 3.1 Demographic information about participating schools (based on descriptors/figures for the 2015/2016 academic year)⁴.

### 3.4.2.1.1 Sampling and participant recruitment

The selection of (pupil) participants for the study was undertaken in conjunction with the participating school, on account of each having various stipulations about what they would/would not permit. Firstly, it was stipulated by all schools that the pupil focus groups be conducted during PE lesson time, given that the study was set within this context. Further, schools were not prepared to allow pupils in Years 9-11 to participate due to the focus groups being conducted during lesson time and these pupils undertaking their GCSE⁵ programmes of study. As such, Year 7 pupils (aged 11-12 years old) were selected to participate in the study. These pupils had more curriculum time allocated to PE than Years 8-11 at each school and it was felt that working with these pupils would cause the least disruption to their learning.

There were 30 pupils selected to be a part of the pilot study, whilst 60 pupils were selected at each of the case study schools. The characteristics of the pupil populations varied between the three schools, with case study school two differing considerably from the pilot school and case study school one (see Table 3.2). On account of this, a randomised stratified sampling

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⁴ Descriptors/figures were taken from the DfE managed EduBase portal (http://www.education.gov.uk/edubase/home.xhtml) at the beginning of the 2015/2016 academic year.

⁵ GCSEs are subject-specific qualifications typically studied by secondary school pupils in Years 9-11 (aged 14-16) in England (and other home nations) (DfE, 2017)
technique was utilised to ensure that the samples (of pupils) selected were representative of each individual school context, given that context is an important consideration when employing a case study research strategy (Emmel, 2013). The factors taken into consideration when generating the sample were the pupils’ gender, ethnicity, special educational needs and disability (SEND) status, English as an additional language (EAL) status and pupil premium (PP) status. PP status was taken as a measure of pupils’ socioeconomic status. The sampling grids used to determine pupil proportions for the two case study schools (and the pilot school) are included in appendix D.

<table>
<thead>
<tr>
<th>Pupil Characteristics (%)</th>
<th>Pilot School</th>
<th>Case Study School 1</th>
<th>Case Study School 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (M:F)</td>
<td>49.2%:50.8%</td>
<td>49.0%:51.0%</td>
<td>50.8%:49.2%</td>
</tr>
<tr>
<td>BME</td>
<td>6.4%</td>
<td>5.2%</td>
<td>77.0%</td>
</tr>
<tr>
<td>SEND</td>
<td>2.0%</td>
<td>2.5%</td>
<td>7.9%</td>
</tr>
<tr>
<td>EAL</td>
<td>1.0%</td>
<td>1.9%</td>
<td>21.5%</td>
</tr>
<tr>
<td>PP</td>
<td>6.1%</td>
<td>5.6%</td>
<td>25.4%</td>
</tr>
</tbody>
</table>

Table 3.2 Pupil characteristics at participating schools (based on descriptors/figures for the 2015/2016 academic year).

The pupils selected to participate were invited to an initial briefing led by myself and the contact teacher at each school. The briefing provided pupils with information about what participating in the study would involve and enabled the distribution of letters (and accompanying information sheets and opt-out forms) to the pupils, who were requested to take these to their parents/guardians (see appendix E). The pupils’ parents/guardians had a two-week period within which to complete and return the associated opt-out form, should they not consent to their child taking part in the study. If this was not returned within this period, it was assumed that the parents/guardians had provided consent for their child’s

6 Pupil premium is additional funding for publicly funded schools in England to raise the attainment of disadvantaged pupils (DfE, 2015).
7 Descriptors/figures were taken from the DfE managed EduBase portal (http://www.education.gov.uk/edubase/home.xhtml) at the beginning of the 2015/2016 academic year.
participation. This means of seeking consent was welcomed by the contact teachers at each school who, from the outset, expressed concerns over the administrative burden that might result from the study. As such, steps were taken throughout the research process to minimise/mitigate any burden on schools. At each school, few pupils, if any, were opted out of the study by their parents/guardians: four out of 30 at the pilot school; three out of 60 at case study school 1; and zero out of 60 at case study school 2. In addition to parental consent, pupils provided their assent prior to each focus group (discussed further in sub-section 3.4.2.5).

PE teachers at each school were also invited to a briefing with myself, at which they were provided with information about the study and how they might get involved should they choose to do so. It was considered important to inform all PE teachers about the study, regardless of whether or not they were directly involved, as some low-level disruption to their lessons may have resulted due to pupils’ participation in the focus groups and their consequential absence from PE lessons. Following the briefing, participant information sheets and consent forms (see appendix F) were handed out to the teachers and they were asked to complete and return these to the contact teacher at their school should they wish to participate. At each school, several teachers responded positively with three opting to participate at the pilot school, six at case study school one and seven at case study school two.

3.4.2.2 Interview design

A semi-structured format was adopted for the teacher interviews on account of its suitability for the study. Semi-structured interviews provide a structure for the researcher to work within which, on a practical level, can support them to ensure that the necessary questions are asked, and that the available time is used appropriately (King and Horrocks, 2010). In addition, whilst they provide a structure, this is flexible and permits reasonable freedom to the researcher, in terms of their lines of inquiry, and the participant, in terms of their responses (Wooffit and Widdicombe, 2006). As such, whilst questions are pre-determined, the researcher can follow up and seek to elaborate on the participants’ responses as and when necessary. This means that participants’ responses are not constrained, enabling them to shape the interview and share their experiences relevant to the study (Seidman, 2006).
A schedule was devised to guide the interviews which was largely based upon the questions within the survey employed during phase one of the study. This was on account of the interviews seeking to further explore the current landscape of health-related teaching and learning within secondary PE, within the specific context of the two case study schools. Accordingly, the interview schedule comprised four sections. The first was an introductory section which had the dual purpose of finding out demographic information about the teacher and easing them into the subsequent sections of the interview, as advocated by Jones (2014). The second and third sections, similar to the survey, explored how pupils were supported to lead healthy, active lifestyles within PE and the wider school respectively, and the fourth section explored the teachers’ perceptions of the effectiveness of this support. The questions used throughout the interviews were largely open, given that these facilitated more detailed responses from participants (Brinkmann and Kvale, 2015).

The interviews were planned to be approximately 45 minutes in duration and were intended to be organised at times suitable to the teachers at each of the schools, typically taking place during periods in which they were not timetabled to teach, during lunch breaks or after school.

3.4.2.3 Piloting and conducting the interviews

The interviews were piloted in October 2015 with the three teachers who volunteered to be involved in the study at the pilot school. The interviews typically took place in a classroom within the school. The location was considered important, not only to ensure that it was convenient for the participants, but also so that they were situated within the context within which they practised (Payne and Payne, 2004). The duration of the interviews ranged from approximately 30 to 60 minutes, and so an estimated duration of 45 minutes was confirmed through the pilot. Interviews were also audio-recorded using an Olympus WS-832 digital voice recorder for subsequent transcription.

Rubin and Rubin (2005) suggest that interviews are comprised of seven stages, namely: building rapport; reassuring participants; demonstrating understanding; gathering basic descriptions; asking difficult questions; asking controversial questions; and closing while maintaining contact. They propose that, during an interview, a researcher guides the participant through these stages as it progresses (ibid.). However, Ennis and Chen (2012, p.
note that whilst these stages ‘can deepen and enrich the interactions between the researcher and the [participant]’, they might not necessarily be sequential, and researchers may often have to demonstrate flexibility in progressing (or regressing) an interview. Nonetheless, both Rubin and Rubin (2005) and Ennis and Chen (2012) advocate developing a schedule to guide interviews.

In line with this, a schedule was devised, considering the various stages that it might need to progress through. It was ensured that, prior to the interview commencing, the participating teacher had completed the necessary consent form and had been given an opportunity to ask any questions they might have regarding the study. By doing so, rapport could be established with the teacher and any concerns they might have about participating, such as their comments being disclosed to their Head of Department (HoD), could be allayed. As discussed in sub-section 3.4.2.2, the questions that comprised the first section focused on demographic information, whilst those within the second and third sections encouraged participants to consider their practice further and as such were more challenging. The questions that comprised the fourth section were what Rubin and Rubin (2005) might refer to as ‘controversial’ in that they required the teacher to reflect on the effectiveness of their own practice and that of their department and school more broadly. At this stage in particular, attempts were made to demonstrate understanding/empathy with teachers, using both verbal and non-verbal cues appropriate to their responses. For example, smiling and nodding if they spoke positively about a particular element of their practice. At the close of the interview, the participating teacher was given another opportunity to ask questions and were reassured that the data generated from their interview would be treated confidentially and that their anonymity would be maintained.

The pilots were relatively successful in that the interviews flowed well, and teachers provided in-depth responses to the questions posed, suggesting that these were appropriate. Very few changes were made to the interview schedule following the pilot, the only notable one being the re-ordering of a small number of questions. The limited modification was likely due to the interview being based on the survey, which had already been ratified through its own pilot earlier in the study. Nonetheless, the pilot proved useful and provided an opportunity to further develop familiarity with the schedule and the questions being posed to teachers.
The interviews were conducted at each of the case study schools between November and December 2015. At case study school one, six teachers volunteered to be interviewed, whilst seven volunteered at case study school two. The interviews at both schools were conducted in a similar manner to the pilot, but with the revised schedule (see appendix G).

### 3.4.2.4 Focus group design

A participatory approach was employed for the pupil focus groups on account of the potential such approaches have been claimed to have in facilitating pupils’ involvement and engagement within research (Allard, 1996; Thomas and O’Kane, 1998; Waller and Bitou, 2011; O’Reilly and Dogra, 2017), discussed further within section 4.3. A schedule was devised to guide the pupil focus groups, as had been the case for the teacher interviews, and for similar reasons to those discussed within sub-section 3.4.2.2. However, given that a participatory approach was employed, the focus groups were activity-based with the schedule being constructed around four research tasks that the pupils participated in. These tasks were designed to stimulate discussion amongst the pupils, and questions were developed around these, to further explore the ways in which pupils conceptualised ‘health’.

The first task required pupils to draw what ‘health’ meant to them in order to broadly explore how they conceptualised it. Pupils were presented with a worksheet and allocated five minutes to draw (or as some did, write) about ‘health’. Following this, pupils were asked to share what they had drawn or written with the group and to explain how this depicted ‘health’ for them. Questions were subsequently posed to pupils to further explore their conceptions, in line with the drawings/explanations that they had produced. Whilst undertaking the task, particular attention was paid to the language being used with pupils, to try and avoid unduly influencing their conceptions. For example, dichotomous terms such as ‘healthy’ and ‘unhealthy’ were not used, unless questioning a pupil around their use of these terms. The use of drawings as participatory research method/technique is discussed further in sub-section 4.4.1.

The second task involved pupils being presented with ten cartoon images that represented a range of lifestyle contexts related to ‘health’. These were based on concept cartoons, which have been widely used within science and mathematics to explore pupils’ understandings and conceptions of specific topics (see, for example, Keogh and Naylor, 1999; Naylor, Keogh and
Mitchell, 2000; Naylor, Keogh and Mitchell, 2008). A brief was developed for the images (see appendix H) and a graphic designer at Loughborough University was engaged with to produce them. It was ensured that, in producing the images, care was taken to accurately capture a range of settings and contexts (related to ‘health’) and to appropriately represent individuals from diverse backgrounds. Within the focus groups, pupils were presented with the images and asked to ‘identify anything that related to health’ within them. Pupils worked in small groups (typically, of three) to discuss the images, before discussing these as a larger group, with some questioning around the discussion. The use of concept cartoons as participatory research method/technique is discussed further in sub-section 4.4.2.

The third task involved pupils completing a statement sheet. This consisted of ten statements that were either factual or opinion-based. On the first side of the sheet, pupils had to indicate whether they thought statements were true, false, or they did not know. On the second side, they had to indicate if they agreed with, disagreed with or were not sure about the statements presented. To identify their response, pupils were given green-coloured tick (✓), red-coloured cross (X) and orange-coloured question mark (?) stickers to place next to the various statements. The statements used for this task were developed from the current literature around what pupils know, understand, and conceive about ‘health’ (as discussed in section 2.5). Pupils completed the statement sheets individually before discussing these as a group, with further questioning as necessary.

The fourth task involved pupils producing a ‘mind map’ of the sources from which they acquired information about ‘health’. As with the third task, pupils completed this individually, before discussing their ‘mind maps’ as a group, with some questioning around the discussion. The focus group schedule and associated task resources are available in appendices I and J respectively.

3.4.2.5 Piloting and conducting the focus groups

The focus groups were trialled in the pilot school during October 2015, with five focus groups being conducted. There were between four and six pupils per group, and each was approximately 60 minutes in duration. The focus groups were typically held in a quiet classroom and were conducted during PE lessons on the request of schools (as discussed in
sub-section 3.4.2.1.1). The researcher was permitted to work unsupervised with pupils on account of having an enhanced Disclosure and Barring Service (DBS) check.

At the beginning of each focus group, pupils were given a participant information sheet and it was explained to them what participating in the study would involve. Pupils were then asked to confirm that they were willing to participate and, if they were, to complete the corresponding assent form (see appendix K). The focus group subsequently progressed in line with the schedule discussed in the previous sub-section. The focus groups were audio recorded using an Olympus WS-832 digital voice recorder, in order to permit transcription (discussed further in sub-section 3.5.1). As was the case with the teacher interviews, the pilot was useful in developing familiarity with the schedule and provided opportunities to practise conducting the tasks with pupils.

Following the pilot, the pupil focus groups were conducted in each of the case study schools between November and December 2015. The focus groups progressed similarly to those that had been conducted during the pilot. At each school, ten pupil focus groups were held, though the number of pupils within these varied from three to eight on account of factors such as pupil absences, field trips, and music examinations. The duration of the focus groups varied from approximately 45 to 75 minutes.

3.4.3 Phase three

Further focus groups (with pupils) were conducted as part of the third phase of the study. These were intended to act as a follow up to those conducted during the second phase of the study and were participated in by the same pupils. These focus groups had a similar purpose in that they sought to explore pupils’ conceptions of ‘health’ and adopted a similar participatory approach. However, as these were informed by the findings of the phase two focus groups, they enabled pupils’ conceptions to be explored further, with particular attention paid to the PE context and how this might have influenced the ways in which pupils conceptualised ‘health’. The following sub-sections discuss the design and conduct of the focus groups that took place during this phase of the study.

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8 DBS checks are background checks provided by the DBS to verify that a person is suitable for work within specific sectors, such as education. An enhanced DBS check provides details on any convictions, cautions, reprimands and/or warnings that a person has received and verifies that they are not on the DBS barred list as someone who should not work with children and/or young people (HM Government, n.d.).
3.4.3.1 Focus group design

A schedule was devised to guide the pupil focus groups, similar to that produced for those during the second phase of the study (as discussed within sub-section 3.4.2.4). This was similarly constructed around four research tasks that the pupils participated in. These were designed to stimulate discussion and questions were developed around these.

The first task required pupils to produce a poster about leading a healthy, active lifestyle. Pupils were presented with a worksheet and allocated ten minutes to produce their posters through which they were asked to portray what it meant to lead a healthy, active lifestyle, and how a person might go about leading one. Following this, pupils were asked to present their poster to the group and explain what they had drawn/written and how this related to leading a healthy, active lifestyle. Discussion subsequently took place around pupils’ explanations and questions were posed to explore these further.

The second task involved pupils compiling an information sheet about leading a healthy, active lifestyle. Pupils were asked to write down key pieces of information that they knew about leading a healthy, active lifestyle, and where possible, to indicate where they thought they had received this information from. As with the first task, pupils completed this individually before sharing their work with the group and discussing the information sheets that they had produced. Questions were posed to pupils about their information sheet, particularly in relation to the sources of health-related information identified on them.

The third task presented the pupils with four case studies which each outlined a health-related scenario. Pupils were asked to read through case studies and to consider how they might respond (if at all) if they found themselves in this situation, or what advice they might give to a peer in a similar situation. Similar to the statement sheets discussed in sub-section 3.4.2.4, the case studies were developed from the current literature around what pupils know, understand, and conceive about ‘health’ (as discussed in section 2.5). Pupils worked in small groups (typically, of three) to consider the images, before discussing these as a larger group, with some questioning around the discussion.

The fourth task involved pupils producing a ‘mind map’ that focused on: the different ways in which they could be physically active; the possible benefits of being physically active (if they considered there to be any); and the potential barriers to/challenges of being physically
active. As with the third task, pupils worked in small groups, before discussing their ‘mind maps’ as a larger group, with some questioning around the discussion. The focus group schedule and associated task resources are available in appendices L and M respectively.

3.4.3.2 Piloting and conducting the focus groups

The focus groups were trialled in the pilot school during May 2016 and were conducted similarly to the pilots during phase two of the study (as discussed in sub-section 3.4.2.5). Following this, the focus groups were conducted in each of the case study schools between June and July 2016. These progressed in a similar manner to those during phase two, the only notable difference being a small reduction in the number of pupils participating. There were a number of reasons for this, from pupils deciding that they no longer wanted to participate, to pupils having left or having been excluded from the school. However, this did not impact on the conduct of the focus groups.

3.4.4 Phase four

Semi-structured focus groups (with teachers) were conducted during the fourth and final phase of the study. Within these, teachers were presented with selected findings from the pupil focus groups during phases two and three of the study. The purpose of the focus groups was to encourage the teachers to consider the findings, which focused on pupils’ conceptions of ‘health’, and to reflect on what these might mean for their practice and their curricula (if anything). This phase was deemed to be particularly important in working towards a ‘youth voice’ agenda within the research. Indeed, as Long and Carless (2010) note, such an agenda involves hearing, listening and acting upon what children and young people say, with this phase intended to support the latter (discussed further within section 4.3). The following sub-sections discuss the design and conduct of the focus groups that took place during this phase of the study.

3.4.4.1 Focus group design

A schedule was developed to guide the teacher focus groups. This was constructed around a Microsoft PowerPoint presentation which comprised four slides, each of which contained three or four key findings from the study. Within the focus groups, the findings on each slide were presented to the teachers, with pupil quotations also provided, to exemplify the findings highlighted. Teachers discussed each of the slides, as they were presented to them, guided
by questions detailed on the schedule. Following the presentation, the discussion continued, and teachers were encouraged to reflect on the findings in the context of their own schools. It should be noted that, in line with the youth voice agenda that this study sought to work towards, it had been hoped that pupils would be able to present what they knew, understood and conceived about health to their teachers themselves. However, none of the participating schools were prepared to allow pupils to be involved in such a manner and as such the approach outlined had to be adopted.

The focus groups were planned to be approximately 45 minutes in duration and were intended to be organised at times suitable to the teachers at each of the schools, typically taking place during periods in which they were not timetabled to teach, during lunch breaks or after school. The focus group schedule and accompanying presentation are available in appendices N and O respectively.

3.4.4.2 Piloting and conducting the focus groups
A pilot focus group was conducted in October 2016. It was approximately 45 minutes in duration and three teachers participated. As had been the case for the teacher interviews conducted during phase two of the study, minimal changes were made to the schedule following this (as discussed within sub-section 3.4.2.3). Subsequently, two focus groups were conducted in each of the case study schools between November and December 2016. Unfortunately, particular difficulties were faced in trying to coordinate the teacher focus groups within the two case study schools, on account of the participating teachers’ contrasting timetables/schedules. As such, only four of the six teachers at case study school one, and six of the seven teachers at case study school two, participated.

The fourth phase marked the end of the research process and, accordingly, the subsequent section discusses how the data generated throughout the study were analysed.

3.5 Data analysis
3.5.1 Transcription
The data generated (in the form of audio files from interviews and focus groups) were transcribed prior to analysis taking place. Whilst there are varying levels of transcription that
can be employed, for the purposes of this study, clean verbatim transcription was utilised. As such, data were transcribed ‘word for word’ but text was ‘tidied up’ and contiguous utterances (for example) were removed from the speech in line with recommendations by Hepburn and Bolden (2017). Whilst it is acknowledged that such elements of speech are key for certain forms of analysis (particularly those with a focus on ‘talk’), these were not considered necessary within the study.

3.5.2 Discourse analysis

Discourse analysis was adopted as a technique to analyse the data generated through the research process (as discussed within section 3.4). Hall (2001) notes that there are many different forms of discourse analysis, and there has been much debate amongst researchers as to the similarities/differences between these (e.g. Burr, 1995; Potter and Wetherell, 1995; Parker, 1997). Generally though, it is accepted that most approaches are concerned with the role of language in the construction of social reality (Willig, 2015). Allied to this, discourse analysis typically proceeds on the basis of the researcher’s interaction with the text, making it an interpretive form of analysis.

It seems pertinent, in adopting discourse analysis as a means of data analysis, to first consider what is meant by the concept of discourse. Discourse has been variously defined with many of its definitions influenced by the work of the post-structural theorist Michel Foucault (1972, 1977, 1980). According to Foucault (1972, p. 49), discourses ‘systematically form the objects about which they speak’. Here, Foucault (1972) alludes to the notion that discourses constitute objects. Building on this, Ball (1990, p. 2) proposes that ‘discourses are about what can be said and thought, but also who can speak, when and with what authority’. In his definition, Ball (1990) alludes to the role that discourses play in constituting not only objects but also subjects. It is important to note though, that discourse is not only about that which is said, but also that which is not said (Willig, 2015).

In selecting an approach to discourse analysis, Foucauldian discourse analysis (FDA) was considered particularly appropriate for the study, as discussed within the following sub-section.
3.5.3 Foucauldian discourse analysis

The use of post-structuralist notions and Foucauldian thought to analyse data within research in PE (and health) is not new and numerous researchers have drawn on such frameworks (e.g. O’Flynn, 2004; Atencio, 2006; Knez, 2007; Rail, 2009; Burrows, 2010; Leahy, 2012). However, it should not be assumed that this was the reason why such an analytical technique was adopted. Rather, as Burrows (2010, p. 148) notes ‘drawing on Foucauldian concepts can help us to understand the complex ways in which power and knowledge operate to produce conditions of possibility for ‘being’ healthy and/or ‘doing’ health in any particular context’. Indeed, Wright (2004, p. 20) herself asserts that drawing on Foucault can be useful in order to ‘conceptualise and deconstruct relations both within and between physical and health education, the body, identity and health, as socially constructed domains’. Evidently, given that the study sought to explore pupils’ conceptions of ‘health’ within PE, FDA was deemed particularly appropriate.

Foucault’s work can be considered challenging to understand and difficult to apply. Over the course of his work, his ‘methods’ changed as the focus of his studies shifted (Kendall and Wickham, 1999; Arribas-Ayllon and Walkerdine, 2017). Therefore, in choosing to adopt such an analytic technique, a ‘disclaimer’ must be given. As Arribas-Ayllon and Walkerdine (2017, p. 110) suggest, it is ‘customary to warn that there are no set procedures for conducting Foucauldian-inspired analysis’. They explain that Foucault himself rebutted formalisation and advocated caution in prescribing a particular way of using Foucauldian thought (ibid.). Despite this, several researchers have attempted to delineate an approach to discourse analysis inspired by Foucault’s work.

An early interpretation of Foucault’s methods was provided by Parker (1992) who delineated a 20-step process for discourse analysis. These steps were centred on three main phases of analysis, namely: the selection of statements for analysis; the identification of subjects and objects as constructed through the text; and an exploration of the ways in which the discourses that form the text (re)produce power relations (ibid.). Subsequently, in 1999, Kendall and Wickham built on the work of Parker (1992) to produce a more refined analytical framework with fewer steps, and which arguably drew more on Foucault’s conceptual work. More recently, Willig (2015) outlined what could be considered the most structured framework for conducting FDA, describing a six-stage process. As Willig (2015, p. 156) states
‘these stages allow the researcher to map some of the discursive resources used in a text and the subject positions they contain, and explore their implications for subjectivity and practice’. However, as she explains, they do not necessarily ‘constitute a full analysis in the Foucauldian sense’ (ibid., p. 156). Arguably, this is on account of failing to adequately address Foucauldian concepts (for example, power-knowledge, technologies and subjectification). In contrast, Arribas-Ayllon and Walkerdine (2017) outlined an approach to FDA which was heavily influenced by Foucault’s theoretical concepts, however, it lacked structure compared with other approaches. Indeed, in their own words, it was a ‘light sketch of what a Foucauldian approach might look like’ (ibid, p.114). The following sub-section outlines the analytical framework used for the study.

3.5.3.1 Analytical framework

The analytical framework used within the study drew heavily on the work of Willig (2015) to provide structure and took theoretical insight from the work of Arribas-Ayllon and Walkerdine (2017). The six stages of the analytical framework are subsequently outlined:

**Stage One: Identifying discursive constructions**

The first stage of analysis involved identifying the (potentially) varying ways in which discursive objects, in particular ‘health’, were constructed within the texts. It was important to identify both explicit and implicit references to these objects - data were not to be overlooked simply because the text did not explicitly refer to the discursive objects of interest. Indeed, the lack of specific reference to a discursive object can also provide information as to how it is constructed. As Willig (2015) notes, in reading the data, the concern should principally be identifying meaning as opposed to ‘lexical comparability’ (p. 156). That is to say that, the analysis focused on identifying what was (or was not) being said by the text, not necessarily how it was said.

The statements identified were drawn together from the data in what Arribas-Ayllon and Walkerdine (2017, p. 115) refer to as a ‘corpus of statements’, in order to facilitate the subsequent stages of analysis. The various texts that were drawn upon for this included the transcripts produced from interviews and focus groups conducted with teachers, as well as the transcripts (and accompanying resources) from the focus groups conducted with pupils.
NVivo was used as a software package to facilitate the drawing together of texts as it enabled these to be easily stored and organised.

**Stage Two: Locating discourses**

Stage two involved locating the various discursive constructions of the object within wider discourses. Discourses do not exist in isolation, but rather interact and intersect with one another. Therefore, in reading the data, consideration must also be given to wider discourses. Burrows (2010) highlights the importance of considering these wider discourses, noting how they influence the resources (both material and immaterial) that children and young people have access to, and as such can draw upon, within their own discursive constructions (*ibid*.). For example, healthist discourses were particularly pertinent for the present study. In addition to locating discourses, within this stage of analysis, the differences between constructions should be explored, as a single discursive object can be constructed in many different ways (Arribas-Ayllon and Walkerdine, 2017).

**Stage Three: Considering action orientation**

The third stage of analysis required examination of the discursive contexts within which the different constructions of the object were deployed. Willig (2015, p. 158) outlines two key questions that must be asked of the data at this stage:

- What is gained from constructing the object in this particular way at this particular point in the text?
- What is its function and how does it relate to other constructions produced in the surrounding text?

By considering the action orientation of discursive constructions, the researcher is able to explore what becomes possible within a given context.

**Stage Four: Proposing positionings**

Stage four involved considering how the discursive object constructions and the wider contexts within which they are deployed made various subject positions available. As Willig (2015, p. 159) notes ‘discourses construct subjects as well as objects, and as a result make positions within networks of meaning available, which speakers can take up (as well as place
others within’). These subject positions offer individuals a discursive position from which they can speak the ‘truth’ (Arribas-Ayllon and Walkerdine, 2017).

**Stage Five: Possibilities for practice**

The fifth stage of analysis examined the ways in which the discursive constructions of objects, and the subject positions within them, enabled or constrained opportunities for action. By constructing particular versions of the world and by positioning subjects in particular ways, discourses shape what can be said and done (Willig, 2015). Consequently, certain practices are considered as constituting forms of behaviour within a particular discourse as legitimate or not (*ibid*.). These practices subsequently constitute the discourses that originally legitimate them.

**Stage Six: Subjectification**

Stage six involved considering the consequences of adopting various subject positions with regard to an individual’s subjective experience. Specifically, it focused on an individual’s thoughts, feelings and experiences from within particular subject positions. However, this stage of analysis is somewhat speculative as it can be questioned as to what extent subjectivity can be conceived upon the basis of discourse alone (Burr, 2003). Willig (2015, p. 161) expands upon this stating that:

> As there is not necessarily a direct relationship between language and [subjective experience], we can do no more than delineate what can be thought, felt and experienced from within various subject positions; whether or not, or to what extent, individual speakers actually do feel, think or experience in these ways on particular occasions is a different question (and one that probably cannot be answered on the basis of discourse analysis).

Despite this, it is possible to infer from the data the feelings, thoughts, and experiences that would be available to an individual within a particular subject position, regardless of whether or not they took these up.

Having outlined the analytical framework, it is important to acknowledge that it can be difficult to break this framework down into its constituent parts on account of the integrated
nature of the analytical process. This is particularly the case for stages three to five. To support the elucidation of the analytical framework, a worked example is provided in appendix P.

3.6 Ethical considerations

The study was designed and conducted in accordance with the guidelines of the Loughborough University Ethics Approvals (Human Participants) Sub-Committee. The Sub-Committee granted ethical approval for the study following completion of an ethical clearance application form which provided the University with a detailed overview of the proposed study (see appendix Q). Ethical approval for the study was granted in April 2015.

A number of minor revisions were made to the study after it had commenced, the most notable being the addition of a fourth phase. The teacher focus groups were initially due to be conducted during the third phase of the study but were moved from July 2016 to November/December 2016 to enable more information to be relayed to the teachers in the subsequent academic year, resulting in the addition of a fourth phase. The Secretary to the Sub-Committee was contacted in such instances and approval was sought (and granted) for the amendments/developments. The research was informed by the ‘Ethical Guidelines for Educational Research’ published by the British Educational Research Association (BERA) (BERA, 2018) and the researcher ensured that the study was conducted in line with the detailed guidance provided.

Further ethical considerations relevant to the study are discussed within the following chapter, particularly within section 4.5, and a reflexive account of ethical dilemmas experienced is presented within section 4.6.

3.7 Conclusion

Chapter 3 has outlined the methodology adopted and the methods employed within the study, providing an overview of the research process. Initially, research paradigms were explored and their significance to the research process was highlighted. It was noted that, the paradigm within which a study is located influences the methodology adopted and the methods employed and, as such, it must be duly considered. Accordingly, it was acknowledged that the present study was located within an interpretivist paradigm. Subsequently, the methodology adopted was explained and justified with the study design
and research strategy being outlined. The mixed methods study design adopted was described, and it was noted that the specific design of this was quan → QUAL given that ‘qualitative’ approaches were afforded dominant status within the study. In addition, the case study research strategy was described, with it being noted that this was descriptive and sought to provide a thick, rich and detailed account of pupils’ conceptions of ‘health’ within PE.

The chapter subsequently explored the four-phase research process of the study with the methods using during each being described. The phases of the research were considered in turn, and within each, the design of the methods and the conduct of the various research activities were outlined. For example, it was highlighted that within phase one of the study, a survey was employed with teachers and within the discussion around this, attention was paid to its design, administration and distribution, and conduct. Next, the analytical technique employed to analyse the data was outlined. Specifically, it was highlighted that a Foucauldian-inspired discourse analysis was employed, and the six-stage approach followed was described. Finally, ethical considerations relevant to the study were considered.

The next chapter critically reflects on the research process and explores the ways in which it facilitated pupils’ involvement in the study.
Chapter 4: Critical reflections on the research process

4.1 Introduction

This chapter critically reflects upon the research process outlined in chapter 3, focusing on the ways in which it facilitated pupils’ involvement within the study. Initially, it outlines the context of research with children and young people, with a particular focus on the perspectives of children and young people that can be adopted. Subsequently, the voices of children and young people within research are considered and the youth voice agenda is debated. Next, participatory approaches to research with children and young people are discussed and two methods/techniques employed within the study, namely drawings and concept cartoons, are examined. Following this, ethical considerations in research with children and young people are contemplated and the stances that can be assumed with regard to ethics are outlined. Next, the discussion highlights ethical sensitivities that can be evoked in research with children and young people, and the ethical considerations of consent, anonymity and confidentiality, and access are explored further. Finally, a reflexive account of ethical dilemmas encountered within the research process is provided.

4.2 Research with children and young people

The involvement of children and young people in research is, as O’Reilly and Dogra (2017, p. 1) state, a ‘fairly modern endeavour’. Fraser, Flewitt and Hammersley (2014) contend that, historically, research with children and young people was avoided on account of concerns over their perceived lack of competence in articulating their thoughts, feelings and experiences. Further, it has been proposed that because of the potential complexities of working with children and young people, researchers were previously hesitant to engage with this population (Thomas and O’Kane, 1998; Kellett et al., 2004; Delgado, 2006). However, since the 1990s, there has been growing recognition of children and young people as a distinctive population whose thoughts, feelings and experiences warrant consideration (James, Jenks and Prout, 1998; Mayall, 2008).

The growing recognition of children and young people as a distinctive population has led to a heightened interest in researching them. Initially, in the 1990s, this interest manifested in children and young people being objectified, with research being undertaken on them (Woodhead and Faulkner, 2008). However, more recently there has been increased emphasis
on research with children and young people, in which they are recognised as agentive subjects (Christensen and Prout, 2002; O’Reilly, Ronzoni and Dogra, 2013; Clark, 2017). The shifting focus of contemporary research involving children and young people is often considered to be due, at least in part, to the changing position and status of children and young people within society and in particular their rights (Alderson, 2008; Davidson, 2017; O’Reilly and Dogra, 2017).

4.2.1 Children and young people’s rights

The conceptualisation of children as having rights was first acknowledged, at least internationally, in 1924 by the Geneva Declaration on the Rights of the Child (DRC), adopted by the League of Nations. Subsequently, in 1989 the DRC was superseded by the Convention on the Rights of the Child (CRC), being ratified by all member states of the United Nations (UN). The CRC is comprised of 54 articles which outline the rights that all children should be entitled to, covering all aspects of their lives (UN, 1989). The UN (1989) explicitly state that the CRC should be taken as a whole - all of the articles, and the rights that they confer, are inextricably linked. Notwithstanding this, the status of ‘guiding principle’ is conferred to four of the articles which are considered to be vital for any and all rights within the CRC to be realised (ibid.).

Article 12 is one of the four articles to be conferred ‘guiding principle’ status and it is particularly pertinent to research involving children and young people. Specifically, it relates to their participation and their ‘right to be heard’ in matters that affect them. It states that any child:

> Who is capable of forming his or her own views [shall be assured] the right to express those views freely in all matters affecting [them]; the views of the child [shall be] given due weight in accordance with the age and maturity of the child (UN, 1989, p. 5).

Evidently, Article 12 emphasises the rights of children to express their thoughts, feelings and experiences and to have these considered and taken seriously. It stipulates that this is a fundamental right conferred to all children and young people, including within the research process (Freeman, Nairn and Sligo, 2003).

The CRC was a landmark step in recognising the rights of children and has foregrounded contemporary positionings of children and childhood (James, Jenks and Prout, 1998;
Matthews, Limb and Taylor, 1999; Shier, 2001; Grover, 2004; Sinclair, 2004; Lundy, 2007). The ways in which children and young people are positioned are significant from a research perspective as they inevitably influence the research process and in particular the relationship between the researcher and the participant(s) (Alderson and Morrow, 2004; Hendrick, 2008; Mayall, 2008; Freeman and Mathison, 2009).

4.2.2 Perspectives on children and childhood

It is no longer acceptable to consider childhood as a (solely) biological construct; it has been acknowledged as being more than just a point within the life course (Christensen and James, 2008; O’Reilly and Dogra, 2017). Childhood is also a sociological construct - it is historically, culturally and politically positioned (Christensen and James, 2008; Hendrick, 2008; Rossi and Baraldi, 2009; O’Reilly and Dogra, 2017). As such, it should be considered as dynamic, and the ways in which children are viewed should be regarded as changeable, in line with the shifting perspectives of contemporary society. Traditionally, and in Piagetian terms, children were considered as ‘human becomings’, on account of their perceived lack of competence (Roberts, 2008). However, the development of new conceptions of childhood worked to oppose such perspectives, instead proposing that children (like adults) are ‘human beings’ whose thoughts, feelings and experiences deserve to be duly considered (Uprichard, 2008; Qvortrup, 2009).

There have been several attempts to conceptualise the ways in which children and their capacities can be considered within research (e.g. Alderson, 2000; Christensen and Prout, 2002; Punch, 2002a). In line with changing perspectives of children and childhood, these have typically focused on the extent to which children and young people can be/are involved with the research to be/being conducted. Christensen and Prout (2002) provide a particularly useful conceptualisation, suggesting that within contemporary research with children and young people, there are four perspectives that can be assumed, namely: the child as an object; the child as a subject; the child as a social actor; and the child as a participant/co-researcher.

The first of these, the perspective of the child as an object, regards the child as acted upon by others, rather than being a subject in their own right (Christensen and James, 2008). A perspective such as this evidently subordinates children, doubting their capacity and
competence and assuming their dependency on the others who act upon them. Evidently, the perspective of the child as an object underpins much of the research that has been/is conducted on children (as discussed in section 4.2). The second perspective challenges the first by recognising the child as a subject (Christensen and James, 2008). However, whilst the subjectivity of the child is acknowledged, their involvement in the research remains mediated by their perceived capacity and competence. As such, their developmental stage (often taken as their age) is used to judge the extent to which they can/could be involved. Solberg (1996) is particularly critical of using developmental stages as a factor in making judgements about research with children and young people, advocating instead for consideration of wider, contextual factors that will have influenced their needs and capacities.

The third perspective, the child as a social actor, similarly involves recognising the child as a subject; however, it places emphasis on their agency. Within this perspective, children are considered to ‘act, take part in, change and become changed by’ the social context within which they reside (Christensen and Prout, 2002, p. 481). As such, children are recognised for having thoughts, feelings and experiences that they themselves can articulate, independent of the structures that they are usually considered as being dependent on (such as families and schools). A key feature of this perspective is ‘ethical symmetry’ in that it does not take for granted any distinction between children and adults; rather, it assumes capacity on the part of the child (Christensen and Prout, 2002; Christensen and James, 2008). That is to say that, the starting point for making decisions about the involvement of a child within research is the same as if the research were being conducted with an adult. The fourth perspective aligns with the third but constitutes children as more active participants (and even co-researchers) within the research process (Thomas and O’Kane, 1998; Alderson, 2000). As a more nascent perspective, it proposes that children have both the capacity and competence to be actively involved in the research process (Woodhead and Faulkner, 2008).

Christensen and Prout (2002) propose that the different perspectives on research with children coexist. Therefore, within any study, aspects of different perspectives may be combined, typically on account of pragmatic factors. Evidently, the perspective of children that a researcher orientates his- or herself from has significant implications for, and impact on, their practice. Within this study, children were positioned as social actors, in line with the third perspective, though aspects of the fourth perspective were drawn upon to encourage
their active participation throughout the research process (discussed further in section 4.3). 

At times, the approaches adopted within the study also aligned with the second perspective, typically on account of necessity rather than choice on the part of the researcher. For example, meeting institutional obligations for seeking and obtaining consent (discussed further in sub-section 4.5.2.1).

The changing perspectives of children and young people have led to increased interest in representing their ‘voices’ within and through research (Grover, 2004; Hill, 2006). Indeed, as Sandford, Armour and Duncombe (2010, p. 66) note, ‘there is a growing shift towards acceptance of, and support for, viewing [children and] young people as competent and skilled social agents who are capable of reflecting upon, understanding and articulating their experiences’. The articulation of these experiences typically occurs through youth voice, but the concept has been problematised and as such is considered further within the following section.

4.3 Children and young people’s voices within the research process

The increased interest in representing the voices of children and young people within research has led to a focus on youth voice (Heath et al., 2009). However, the concept of youth voice, despite being frequently referred to within the literature, is not well defined. Arguably, it can be considered as an agenda within contemporary research that is concerned with including the voices of children and young people more authentically within the research process (Halsey et al., 2006). It recognises that children and young people are uniquely positioned to provide an insight into their own lives (Delgado, 2006) and seeks to realise the right for children and young people’s thoughts, feelings and experiences to be shared, acknowledged and acted upon (Serido, Borden and Perkins, 2011).

The youth voice agenda emerged not only as a result of changing perspectives of children and young people (as discussed in section 4.2) but also due to concerns that children and young people’s voices were somewhat muted within much research centred on youth (Prout and Hallett, 2003; Alderson and Morrow, 2004). Cook-Sather (2002, p. 5) expressed particular concern about this, contesting that children and young people represented the ‘missing voices’ of educational research. Certainly, the youth voice agenda has enabled progress to be
made in this regard and, increasingly, researchers are considering how they might best enable children and young people to ‘speak’ within and through their research. However, despite these efforts, children and young people’s voices continue to be, at least to some extent, distorted by the adults conducting the research. As such, working towards a youth voice agenda is not without its challenges, and it necessitates consideration of the key concerns and criticisms related to this agenda.

A concern in working towards a youth voice agenda within research relates to whose voices are being represented and how representative these voices are. It might be assumed that if a group of children and young people were specifically selected to participate in a study, and did so actively, that the thoughts, feelings and experiences they discussed would be representative of all children and young people. However, it has rightly been questioned as to the extent to which a specific group of children and young people (such as a sample within a research study) can be taken to be representative of the population more broadly. As Harden et al. (2000) note, children are by no means a homogenous group, and factors such as gender, ethnicity and social class all mediate their diverse identities, and concomitantly their thoughts, feelings and experiences. Further, whilst attempts may be made within research to ensure that a variety of voices are heard, those children who are most likely to be excluded from society at large are typically the most likely to be excluded by research also (Matthews, 2001; Brownlie, Anderson and Ormston, 2006). France (2000) suggests that researchers should endeavour to ensure that their samples are representative, so that a range of voices can be ‘heard’. Within the present study, I endeavoured to do so by employing a randomised stratified sample (as discussed in sub-section 3.4.2.1.1). However, it is important to acknowledge that the resulting samples were only representative of the particular school populations researched within the study.

The youth voice agenda has also been criticised for being tokenistic in nature, and concerns have been raised that children and young people are being ‘used’ by researchers (Heath et al., 2009). Hart (1992, cited in Heath et al., 2009) describes tokenism as seeking children and young people’s views but providing them with ‘little or no choice about the subject or the style of communicating it, and little or no opportunity to formulate their own opinions’ (p. 9). Stafford, Laybourn and Hill (2003) note that whilst the voices of children and young people are increasingly being sought by researchers, not all are attempting to do so admirably. They
argue that children and young people can become highly attuned to the possibility that researchers are not as interested as they might be led to believe, and this can result in them being cynical towards the research process, inhibiting their engagement with it (ibid.). In order to avoid tokenism within the research process, Kirby et al. (2003) propose a number of measures that can be put in place, including: ensuring that children and young people are fully aware of what their involvement entails; providing them with opportunities to participate in relevant ways; and endeavouring to ensure that their participation in the research has influence/impact for them. Indeed, as Sandford, Armour and Duncombe (2010, p. 69) assert, researchers must ‘work hard to ensure that [children and young people] are given legitimate opportunities to speak and be heard’. By implementing measures such as those proposed by Kirby et al. (2003) within the present study, and by having a genuine interest in children and young people’s voices, I endeavoured to ensure that my engagement with them was meaningful.

Power relations within the research process are also a key concern related to youth voice. A particular criticism of the youth voice agenda is the notion of ‘giving voice’ to children and young people and the implications this has for power relations within the research process. As Bucknall (2014, p. 72) notes:

The oft-heard phrase ‘giving children [and young people] a voice’, for example, suggests that voice is a gift attainable only through the generosity of adult others. The assumption that ‘giving children a voice’ in research will address inequalities in child-adult power relationships thus presents something of a paradox since participative opportunities for children and young people are, indeed, in the gift of the adults leading the projects, who control not only what can be talked about but also the methods employed [to talk about it].

Evidently, the notion of ‘giving voice’ wrongly implies that children do not have a voice without an adult enabling them to ‘speak’. As such, it subordinates children and young people to adults, patently contradicting perspectives that position children and young people as agentive subjects within the research process. This is incompatible with a youth voice agenda and as such, I consider it more appropriate to refer to facilitating voice rather than giving it. All children and young people have voices and, as researchers working with this distinct
population, it is our responsibility to ensure that these can be heard through the research process.

Working towards a youth voice agenda is a challenging endeavour and as Sandford, Armour and Duncombe (2010, p. 68) note, ‘while many researchers acknowledge the importance of [youth] voice, it is clear that the process of actually hearing voices, and acting upon them, is far from straightforward’. That said, whilst facilitating children and young people’s voices is difficult, one means of working towards this is the use of participatory approaches to research (O’Kane, 2000; Gallagher, 2009), as discussed within the subsequent section.

4.4 Participatory approaches to research with children and young people

Participatory research methods have increasingly been turned to as a means of engaging with the voices of children and young people (Freeman and Mathison, 2009; Heath et al., 2009). However, what it means for research to be participatory has been much debated and warrants consideration. Participatory research has been variously described as technique(s), method(s) and approach(es). In considering what it means for research to be participatory, Pain and Francis (2003, p. 46) explicate that ‘the defining characteristic of participatory research is not so much the methods and techniques employed, but the degree of engagement of participants within and beyond the research’. Evidently, participatory approaches should not be considered as techniques or methods, nor should they be considered as a methodology per se. Rather, they should be recognised as an approach to research, in which the researcher makes a commitment to privileging the voices of their participants. Within this study, participatory research has been viewed as an approach, recognising it in the broadest sense.

There are a number of different methods/techniques that have been employed within participatory research with children and young people. Examples include: drawing, photography, timelines, story-telling, role-playing, tours and/or mapping (Greig, Taylor and MacKay, 2013; Groundwater-Smith, Dockett and Bottrell, 2015). As Graue and Walsh (1998) highlight, research with children and young people is a creative endeavour and generating data with children and young people challenges researchers to be creative. Accordingly, researchers have turned to such participatory methods/techniques in attempts to engage
children and young people within the research process in a more meaningful way (Coad and Lewis, 2004).

The supposed benefits of employing participatory approaches to research with children and young people have been variously acknowledged. It has been proposed that participatory approaches provide children and young people with the opportunity to ‘shape’ the research agenda (Thomas and O’Kane, 1998) and, in doing so, it is claimed that children and young people are empowered to participate (Allard, 1996; Waller and Bitou, 2011). Further, participatory approaches have been suggested as being particularly useful in researching more complex and/or abstract social phenomena (Thomas and O’Kane, 1998; Kesby, 2000), with McWhirter (2014) noting how useful such approaches can be for researching ‘health’. Finally, participatory approaches are also considered to be ethically appropriate for research with children and young people, as they facilitate ‘voice’ within the research process (Gallagher, 2008).

However, concerns have been expressed over the potentially uncritical application of participatory approaches. Indeed, as Horstman et al. (2008) note, the mere use of participatory approaches does not in itself guarantee that the children or young people can express their views freely. It is important to consider whether the children or young people participating will enjoy and engage with the methods/techniques to be employed. In addition, the need for creative participatory methods/techniques needs to be questioned as some children and young people may be able and willing to participate fully and communicate freely without the need for the imposition of additional techniques (ibid.). As such, Punch (2002a) states that researchers must engage in critical reflection with regard to their application of participatory approaches to consider how they could, can and do use them appropriately within practice. O’Reilly and Dogra (2017, p. 105) reiterate this, exclaiming that ‘no use of participatory [approaches] is going to replace the skills of the researcher in building rapport with the child, and realising when that child might need some reassurance or encouragement’.

Whilst participatory approaches have been widely used within educational research and have also been used increasingly within the physical education field specifically, there continues to be a lack of critical discussion around the application of the specific methods and/or techniques drawn upon to generate data. Enright and O’Sullivan (2012) provide perhaps the
most detailed interrogation of participatory methods in PE, exploring the application of two specific methods/techniques, namely timelines and photography. Within their work, they reflect on their application of these methods/techniques, considering: the opportunities afforded by these; the challenges faced in their application; and what this meant in terms of meaningfully engaging children and young people as participants. Following the work of Enright and O’Sullivan (2012), I now critically reflect upon the methods/techniques that I applied within this study and explore pupils’ responses to these.

A number of different methods/techniques were utilised within the present study (as discussed in sub-sections 3.4.2.4 and 3.4.3.1) in an attempt to facilitate participatory research. Each of the different methods/techniques employed engaged the pupils, albeit to varying extents, and there were benefits and challenges associated with each. Two key methods/techniques are discussed in further detail within the following sub-sections, namely drawings and concept cartoons.

4.4.1 Drawings

Drawings are a widely used participatory method/technique and have been utilised extensively within educational research to support researchers exploring a range of topics with children and young people (Einarsdottir, Dockett and Perry, 2009; Freeman and Mathison, 2009). Typically, drawings require participants to respond to a particular stimulus and to produce an image or images to visually depict their response, though a variety of adaptations of drawing-based methods/techniques exist (Groundwater-Smith, Dockett and Bottrell, 2015). Drawings tend not to be used in isolation and when utilised as a research activity, participants are often requested to also include text to support their image(s), referred to as the ‘draw and write’ technique (Sewell, 2011).

The ‘draw and write’ technique, specifically, has been adopted by many educational researchers since the 1980s, but there has been some critique of the technique, particularly in recent decades (Horstman et al., 2008; Angell, Alexander and Hunt, 2015). Specifically, concerns have been raised over the potential for misinterpretation on the part of the researcher. That is to say that, the researcher may not interpret images in the ways in which they were intended by the participants (Angell, Alexander and Hunt, 2015). Indeed, as Fargas Malet et al. (2010) note, researchers have had a tendency to focus on what they understand
drawings to mean and have perhaps failed to sufficiently attend to the meanings that their participants would have attributed to them. Further, Backett-Milburn and McKie (1999) argue that there is potential for researchers to over-interpret the data generated from activities based on the ‘draw and write’ technique. In response to such concerns, a more progressive form of the technique has come to be developed, in an attempt to overcome such limitations (Angell, Alexander and Hunt, 2015). The ‘draw, write and tell’ technique adds a further stage which seeks to expand on the former iteration of the technique by attending to how pupils interpret their images/text. As Dreissnack (2005, p. 420) notes, there has been a shift in focus ‘from what the children draw to what the children say about what they draw’. Angell, Alexander and Hunt (2015) highlight the need for this, explicating that there can be significant dissonance between participants’ visual/textual contributions and their verbal interpretations of these.

The use of drawings as a participatory method/technique is not new within physical (and health) education research and various studies have utilised these as a means of exploring children and young people’s knowledge, understandings and conceptions, particularly in relation to concepts such as health, physical activity, and sport (e.g. Williams, Wetton and Moon, 1989; Pridmore and Bendelow, 1995; MacPhail, Kinchin and Kirk, 2003; Burrows, Wright and Jungersen-Smith, 2002; Knowles et al., 2013; Parker et al., 2017). The work of Williams, Wetton and Moon (1989) provides an early example of drawings being applied as a research tool, using a ‘draw and write’ technique, whilst the work of Parker et al. (2017) provides a useful example of how the technique has been developed, adopting (something akin to) a ‘draw, write and tell’ technique.

The present study utilised a ‘draw, write and tell’ approach within the pupil focus groups (as discussed in sub-section 3.4.2.4). Pupils were presented with a task sheet (see appendix I) and were asked to draw (and write, if they wished) about ‘health’. Pupils were only provided with standard pencils (as opposed to colouring pencils, for example) in an attempt to ensure that pupils focused more on the meaning conveyed by the drawing, rather than stylistic features. This was partly due to the fact that the act of drawing/writing was only scheduled to take between five and ten minutes (though in reality, often took longer). After the allotted time, pupils were asked to present their drawings to their peers (and myself) and to outline the meaning of these. Drawings proved to be a beneficial method/technique to employ for a
number of reasons, though there were also challenges in utilising them, as subsequently discussed.

The drawing task was the first activity that pupils participated in and it was intended to help establish a relaxed environment within which to conduct the focus group, given its relative informality. It was also intended to support me in building rapport with the pupils. As Greig, Taylor and MacKay (2013, p. 117) note, drawings can be a ‘good form of initial engagement for getting to know [children] or [young people]’. Arguably, this may be due to the freedom it permits the researcher to interact with pupils, as they are acting in a facilitative role. Pupils were evidently familiar with the activity of drawing and were generally keen to engage with it. O’Reilly and Dogra (2017) suggest that creative activities (such as drawing) are something that children and young people regularly engage in, both at home and at school, and as such they are likely to have a certain propensity towards these.

Horstman et al. (2008) suggest that drawing-based activities, if employed appropriately, can enhance communication between researchers and participants, specifically children and young people. The drawing task was incorporated as part of the focus groups as a means of generating discussion amongst pupils. It provided them with space and time to consider their response to the task of articulating what ‘health’ meant to them. As Miles (2000) notes, drawings can be particularly useful in this respect as they enable pupils to structure their narratives which can subsequently facilitate more productive discussions. This was particularly beneficial for pupils who were perhaps less capable of expressing themselves verbally, which can be a limiting factor within research with children and young people (Moss et al., 2007). For example, at CS2, a significant number of pupils spoke English as an additional language and a few of these had limited proficiency in speaking English. As Punch (2002b) notes, drawings can be particularly useful for engaging with and ensuring the inclusion of such pupils.

Whilst the vast majority of pupils readily engaged with the drawing task, there were some whose feelings towards it were somewhat indifferent, and a few pupils who evidently disliked it. Pupils who felt indifferent towards the activity generally participated, but those who disliked it were more reluctant to do so. These pupils typically expressed a dislike of the activity of drawing, often on account of their (perceived) inability to draw, which they felt would inhibit them in participating in the activity. In such instances, pupils were encouraged
to ‘have a go’ at drawing, but also advised that it was more than acceptable to write instead. It was also the case that, for pupils who were less interested or engaged, the drawings produced represented an ‘easy’ or ‘quick’ way to complete the task. In such instances, the focus of the task was perhaps discounted by pupils (at least, to some extent) in order to complete it with as little effort as possible. However, this is arguably a benefit of using drawings in that it allowed the pupils to ‘speak’ as much or as little as they wanted (Miles, 2000).

A further concern related to the use of the drawing activity was the potential for pupils to be influenced by their peers. Whilst I endeavoured to minimise this, for example, by ensuring that pupils were spaced out around the table within the focus group, there were instances where pupils were evidently trying to copy one another. Arguably, therefore, some of the images/text generated by some pupils may represent social rather than individual processes (Groundwater-Smith, Dockett and Bottrell, 2015). It has been suggested that this can be on account of prompts/guidance being too open or vague, meaning that participants are uncertain as to what is expected of them (ibid.). However, within the present study, pupils were intentionally given limited information as I was conscious that I did not want to influence the resulting images/text produced. That said, the information provided was considered sufficient to ensure that they understood what was required of them.

4.4.2 Concept cartoons

Concept cartoons, in contrast to drawings, are a novel participatory method/technique developed for use within the study. To date, there is no reported evidence of these having been used for the purposes of educational research. However, concept cartoons have been used within education for pedagogical purposes, specifically within the subjects of science and mathematics (see, for example, Keogh and Naylor, 1999; Naylor, Keogh and Mitchell, 2000; Naylor, Keogh and Mitchell, 2008). Concept cartoons were initially developed in the 1990s with the purpose of engaging children and young people in learning about complex and/or abstract concepts (for example, photosynthesis, buoyancy, and combustion) (Keogh and Naylor, 1999; Naylor and Keogh, 2013). The term ‘cartoon’ is perhaps a little misleading as, whilst the images are graphically designed, they are educative rather than satirical. Within research on the application of concept cartoons as a pedagogical tool, it has been found that these can be particularly useful in stimulating discussion and eliciting pupils’ knowledge,
understandings and conceptions on a range of topics (Keogh and Naylor, 1999). As such, it seemed logical that these could be applied as a research method/technique within the study.

As discussed within sub-section 3.4.2.4, the cartoon images were produced by a graphic designer at Loughborough University. The images were research-derived as they were based on findings from the current literature around what pupils know, understand, and conceive about ‘health’ (as discussed in section 2.5). For example, Harris (1993, 1994) found that many children did not consider household chores to be a form of physical activity, whilst Burrows and Wright (2004) found that children considered watching TV to be ‘unhealthy’. These findings were subsequently used to inform the design of concept cartoon 5 (see figure 4.2). The research findings taken from the current literature were used to produce a brief (see appendix I) that guided the designer and supported the development of draft images. These images underwent a significant period of drafting and re-drafting in order to work towards final versions. In particular, during this period, care was taken to ensure that the images accurately captured a range of settings and contexts (related to ‘health’) and that they appropriately represented individuals from diverse backgrounds. Ten images were developed and utilised within the study (see appendix J) and examples of these images (numbers 3, 5, 7 and 9) are provided in figures 4.1-4.4. Pupils were presented with the images and asked to ‘identify anything that related to health’ within them. Pupils worked in small groups to discuss the images, before discussing these as a larger group, with some questioning around the discussion. Similar to drawings, concept cartoons proved to be a useful method/technique to employ, but whilst there were benefits, there were also challenges related to their use, as subsequently discussed.
Figure 4.1 Concept cartoon 3
Figure 4.2 Concept cartoon 5
Figure 4.3 Concept cartoon 7
Figure 4.4 Concept cartoon 9
The concept cartoon task was the third activity that pupils participated in and, as had been the case with the drawing task, it supported me in maintaining a relaxed environment and facilitating discussions in the focus group. Holm (2008) highlights how useful visual material can be for stimulating discussion with children and young people in research and this was evidently the case for the concept cartoons. Pupils were most engaged by the images and many seemed excited that they would have the opportunity to discuss cartoons. Positively, this meant that much discussion was generated amongst the pupils, with little prompting required. In addition, given that the images presented to the pupils depicted a range of settings and contexts, they were all able to find at least one image that resonated with them. This is important as Groundwater-Smith, Dockett and Bottrell (2015) note that pupils engage far more readily when they are able to relate to stimulus material. The concept cartoons used were researcher-generated, in that they were designed specifically for the task at hand. A particular benefit of researcher-generated visual material is that it enables researchers to present specific examples which may not be possible if using found material (Banks and Zeitlyn, 2015). Further, pupils attended less to the personal characteristics of the children and young people portrayed within the concept cartoons, in comparison to those within ‘real life’ images, as had been trialled during the initial pilots. This was beneficial as it meant that students did not get preoccupied with the ‘characters’ in the images and remained focused on the task.

Whilst concept cartoons were well received by the vast majority of participants, there were some challenges in employing them as a participatory method/technique. A potential limitation of using any visual material is that only a certain number of examples can be provided (Banks and Zeitlyn, 2015). As such, it could be argued that by using visual materials, boundaries are applied to the possibilities of the discussions. However, this was seemingly not a particular problem within the study, as pupils readily discussed topics beyond those portrayed within the concept cartoons. A further challenge was that, occasionally, pupils would become distracted by particularly small features of an image (for example, an item of food on a plate). This meant that it was difficult to move discussions on at times. However, given the participatory focus of the research, it could be suggested that this is not necessarily problematic, as children and young people should be given the scope to discuss the aspects that they consider to be most pertinent (Waller and Bitou, 2011).
As has been made evident within this section, there were both benefits and challenges in endeavouring to use participatory methods/techniques within the research process. Nonetheless, employing these evidently enhanced the process of generating data with the pupils who participated in the study. The use of participatory methods/techniques does, however, draw attention to ethical considerations in research with children and young people, and these are discussed within the subsequent section.

4.5 Ethical considerations in research with children and young people

Participatory approaches are considered as an ethically appropriate means of conducting research with children and young people (as discussed in section 4.3), but there are many factors to consider in order to ensure that research practice is ethical. Despite adopting a perspective of children and young people based on ‘ethical symmetry’ (as discussed in sub-section 4.2.2), it would be remiss to not acknowledge that research with this population typically evokes ‘different’ ethical sensitivities in comparison to research with adults (Duncan et al., 2009). The way in which a researcher responds to such ethical sensitivities depends on their ethical stance and this is discussed within the following sub-section, before consideration is given to some ethical sensitivities evoked within the study, with a particular focus on consent, anonymity and confidentiality, and access.

4.5.1 Ethical stances in research with children and young people

There are three major ethical stances, each of which emerges from philosophical thought. The first and second of these, consequentialism and principlism, are considered as ‘traditional’ approaches to ethics (Brinkmann and Kvale, 2005). Consequentialism, based on a belief in universal ethical principles, derives from utilitarian thought and asserts that ethics should be based on the actual and potential consequences of actions, as opposed to their intent (Edwards and Mauthner, 2012). Principlism derives from Kantian thought and, whilst also based on a belief in universal ethical principles, differs from consequentialism in that actions are judged to be ethical or not, on account of their intent, as opposed to their consequences (be they actual or potential) (ibid.). With regard to the universal ethical principles that underpin these approaches, Beauchamp and Childress (2008) are credited with seminal work in this regard. The most recent iteration of this work outlines four common principles of ethical research practice, namely: autonomy, non-maleficence, beneficence and
justice (*ibid*.). Lahman *et al.* (2011) note that these ‘traditional approaches’ typically align with what has been termed procedural ethics, with principism being the basis of much institutional guidance around ethical practice within research.

Procedural ethics can be considered as the requirements put in place by institutional ethics committees that researchers must meet in order to be granted ethical clearance to conduct research (as discussed in section 3.6). They act as a means of institutions regulating research practice and ensuring that (at some level) common guidelines are adhered to across what can be rather divergent studies within any institution (Alderson, 2007). Whilst institutional ethics committees can be considered as having an important role to play in ensuring that research practice is regulated, they have been criticised for a number of reasons (Hammersley, 2009). A key criticism is the (potential) failure of institutional ethics committees to acknowledge/appreciate the iterative nature of certain forms of research and the emergent nature of ethical considerations in practice (*ibid*.). Evidently, at the time of submitting an application for ethical approval, not of all potential actions or consequences can be anticipated. As such, there needs to be recognition of this within the ethical approval seeking procedure. Consequently, Lahman *et al.*, (2011) contend that research ethics need to move beyond procedural ethics, due to the ‘irrepressible nature of all human research and to the in-depth, long-term relationships that may develop between participants and researchers in some forms of human research’ (*ibid.*, p. 1399). They propose that, by doing so, there will be enhanced recognition of the need to consider ethics throughout the research process.

In contrast to more ‘traditional’ approaches to ethics, a number of alternative approaches have been proposed. These alternative approaches, or rather ‘aspirational ethics’ as they have been collectively termed by Lahman *et al.* (2011), represent the third major ethical stance. Aspirational ethics can be defined as ‘the highest stance the researcher tries to attain in ethics above and beyond minimum requirements. Researchers’ aspirational ethical stances may differ depending on culture, values and morals, and are judged and processed internally with no mandated checks’ (*ibid.*, p. 1400). Of the various approaches that aspirational ethics encompass, virtue ethics offer a particularly useful stance, and as such have guided my research. Virtue ethics place emphasis on the moral character of the researcher and align with Aristotelian thought (Brinkmann and Kvale, 2005). They also focus on the notion of phronesis, taken to be cultivated practical wisdom (Blee and Currier, 2011). Evidently, within virtue
ethics, the concern is with the agent (otherwise, the researcher) as opposed to the act of research itself and, as Blee and Currier (2011) note, this means that for research to be ethical, it is crucial that it is conducted by researchers ‘with integrity who have such characteristics as courage, honesty, resoluteness and humility’ (p. 403). It is, therefore, in the practice of the researcher that ethical research is realised, with reflexivity being a key component of this.

Guillemin and Gillam (2004) outlined two key dimensions of ethics. The first of these was procedural ethics, as discussed, whilst the second was ‘ethics in practice’. Ethics in practice refers to the ‘ethical issues that arise in the doing of the research’ (ibid., p. 263). It is within ‘ethics in practice’ that ethical sensitivities are evoked, that ethical dilemmas are faced, and in which virtue ethics may be practised, as discussed within the following sub-section and section 4.6.

4.5.2 Ethical sensitivities in research with children and young people

It has been acknowledged that research with children and young people typically evokes ‘different’ ethical sensitivities in comparison to research with adults. However, before considering these, it seems pertinent to consider the ethical sensitivities that are particularly prominent in ‘qualitative’ approaches to research more broadly. O’Reilly and Kiyimba (2015) propose that there are five key ways in which research within the qualitative domain warrants particular consideration, namely: depth, researcher involvement, iterativity, visibility, and data management (see table 4.1).
<table>
<thead>
<tr>
<th>Ethical sensitivity</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Depth</td>
<td>Research is in depth by nature and elicits personal (and potentially sensitive) information from participants</td>
</tr>
<tr>
<td>Researcher involvement</td>
<td>The researcher is part of the research process and typically the means by which data are generated</td>
</tr>
<tr>
<td>Iterativity</td>
<td>The research process is non-linear and unpredictable; it can change considerably over the course of a study</td>
</tr>
<tr>
<td>Visibility</td>
<td>Data generated can put participants at risk of identification and so anonymity is key</td>
</tr>
<tr>
<td>Data management</td>
<td>Researchers typically generate large amounts of data; they must ensure that they manage this appropriately and not gather more than is necessary</td>
</tr>
</tbody>
</table>

**Table 4.1** Ethical sensitivities with qualitative research (adapted from O’Reilly and Kiyimba, 2015)

Duncan *et al.* (2009) highlight that ethical sensitivities such as these can be amplified in research with children and young people on account of the potential complexities of conducting research with this particular population. On this note, O’Reilly and Dogra (2017) suggest that researchers should examine these sensitivities alongside key ethical considerations within the research process, namely: consent, anonymity and confidentiality, and access. They propose that, in doing so, researchers can highlight how they have acted ethically within and through the research process and potentially highlight ethical dilemmas that they have faced in conducting the research (*ibid*.). As such, these three key ethical considerations are next discussed within sub-sections 4.5.2.1-4.5.2.3.

**4.5.2.1 Consent**

Consent is an important ethical consideration in research with children and young people. It requires participants to be provided with information about what their involvement entails, and they should have the opportunity to weigh up this information so that they are able to
make an informed decision about their participation. Consent must be freely given, and it should be sought in a manner that enables a participant to behave autonomously as, by providing their consent, they give explicit agreement to participate (Alderson and Morrow, 2004). It should be noted that, within research involving children and young people, it is typically the parents or guardians who have the right and responsibility to provide consent for their child to participate, as opposed to the child or young person themselves, though ethical researchers will also seek their assent (France, 2004). Assent can be considered as approval by a child or young person of the consent provided by their parents or guardians (ibid.). Consent is related to two of the ethical sensitivities proposed by O’Reilly and Kiyimba (2015), namely: iterativity and data management. The research process is non-linear and unpredictable, it can change over the course of a study (iterativity). As such, providing participants with information about what their participation will involve can be challenging. Further, large quantities of data are typically generated through the research (data management) and participants must be informed of how this will be managed and reported. Therefore, it is important to consider how consent is sought and obtained within the research process.

The assumption that children are not able to provide consent results from an age-based approach to competence which assumes that children below a certain chronological age are not capable of making informed decisions about their participation (Morrow and Richards, 1996). However, Groundwater-Smith, Dockett and Bottrell (2015) question the assumption that the process of seeking and obtaining consent can be based on an age-related criterion. Such an approach is limited in that it fails to recognise the diversity of ability/experience amongst children and young people. The experience-based approach provides an alternative to the age-based approach and recognises that children and young people can have varying abilities/experiences and that the context of the research warrants consideration (Mason and Urquhart, 2001). It is necessary to acknowledge the differences between children and young people’s abilities/experiences within the process of seeking and obtaining consent as it can affect the manner in which this is undertaken. For example, whilst one child might be able to make an informed decision having been briefed about the research and provided with a participant information sheet as part of a group, another might require a one-to-one briefing in order to feel capable of asking questions to clarify. An experience-based approach to
consent seeking would have been desirable for the present study, given that it emphasises the agency of the child or young person. However, it was not possible to adopt such an approach on account of institutional requirements which stipulated that for research involving children and/or young people under the age of 16, consent must be sought from parents or guardians. Evidently, this highlights the compromises that can be necessary to comply with the expectations of institutions when conducting research with children and young people.

Consent was sought from parents and guardians by means of an opt-out process. Letters (and accompanying information sheets and opt-out forms) were distributed to parents/guardians and they were given a two-week period within which to complete and return the associated opt-out form, should they not consent to their child taking part in the study (as discussed in sub-section 3.4.2.1.1). If this was not returned within this period, it was assumed that the parents/guardians had provided consent for their child’s participation. By adopting such a process, it meant that parents/guardians were rightly informed of their child’s (potential) participation within the study and had the opportunity to withdraw their child should they have a reason to do so. However, it also ensured that pupils’ agency was recognised, and they were empowered to take ownership for their participation within the study, as their assent (or dissent) was central (Heath et al., 2009).

Pupils had the purpose of the study and what participating would involve explained to them at the beginning of each of the focus groups conducted during phase two (as discussed in sub-section 3.4.2.5) and participant information sheets were used to facilitate the assent seeking process (see appendix J). It was ensured that the participant information sheets were appropriate for the pupils and that they provided sufficient information, without providing too little or too much. The former could have misled the pupils, whilst the latter could have been off-putting. Following this, pupils were given the opportunity to ask any questions they might have about participating and any concerns that they might have had were addressed. Subsequently, if were they willing to participate, they were asked to complete the accompanying assent form. It is important to seek pupil assent as, just because a parent or guardian has provided their consent (albeit, assumed), it does not mean that their child necessarily agrees to participating (Dockett, Perry and Kearney, 2012). As such, the assent seeking process provides pupils with the necessary opportunity to indicate their dissent.
Mahon et al. (1990) note that seeking assent and/or consent should not be regarded as a ‘one-off’ process, particularly in research with children and young people. Rather, it should be conceived as a negotiated and ongoing process (Groundwater-Smith, Dockett and Bottrell, 2015; O’Reilly and Kiyimba, 2015). Over the course of a study, children or young people may decide that they no longer wish to take part or are only willing to participate with certain stipulations about how they might do so. As such, opportunities should be taken throughout the research process to clarify that children or young people remain willing to participate. Therefore, during each interaction that I had with pupils, I checked that their willingness to participate had not changed. For example, on conducting the second pupil focus group during phase three of the research (as discussed in sub-section 3.4.3), I confirmed with each pupil that the assent they provided during phase two remained.

Voluntary participation is an important notion within assent and consent, but it can be somewhat problematic in research with children and young people and care must be taken to ensure that it is not undermined (Groundwater-Smith, Dockett and Bottrell, 2015). Within institutions (such as schools), children and young people can perceive that they are obligated to participate, and they can be concerned about how adults might react to their decision to withdraw and the potential ramifications of doing so (David, Edwards and Alldred, 2001). On account of this, at the time of seeking their assent, I assured pupils that they were under no obligation to participate and that they would not face any consequences, should they choose not to do so. Whilst this does not necessarily guarantee that pupils did not feel obligated to take part (at least, to some extent), the fact that a few pupils chose not to participate did indicate that they felt able to exercise this right.

4.5.2.2 Anonymity and confidentiality

Anonymity and confidentiality are also key ethical considerations in research with children and young people. Anonymity is concerned with the protection of a person’s identity, whilst confidentiality relates to the management of their personal and private information (Heath et al., 2009). They are related to three of the ethical sensitivities proposed by O’Reilly and Kiyimba (2015), namely: depth, visibility and data management. Evidently, personal information is elicited through the research process (depth) and the data generated can put participants at risk of identification (visibility). This is compounded by the fact that large quantities of data are typically generated through the research and handled by the researcher
(data management). As such, consideration must be given to how anonymity and confidentiality are ensured (as far as is practicable) within the research process.

Anonymity can be safeguarded by not disclosing participants’ real names within the managing and reporting of the data. Typically, this is achieved by assigning codes or pseudonyms to participants, with the former being adopted within the present study, due to the considerable number of pupils involved. In addition, Hadjistravropoulos and Smythe (2001) note that, with data commonly being reported through the use of verbatim quotations, it must also be ensured that any ‘identifiers’ be appropriately anonymised, or where this is not possible, removed. Otherwise, participants’ identities may be discernible through deductive disclosure, whereby details relating to their identity lead to this being determined by others (Tilley and Woodthorpe, 2011). As such, care was taken to remove any such ‘identifiers’ during the transcription process (as discussed in sub-section 3.5.1).

Whilst anonymity is typically the default position assumed within research, in order to protect participants’ identities, there are some who have argued that assuming such a position can disempower participants (e.g. Kelly, 2009; O’Reilly et al., 2012). Indeed, O’Reilly et al. (2012) contest that some children and young people want their thoughts, feelings and experiences attributed to them, though they acknowledge that many are cautious about this. As such, it is the responsibility of the researcher to ensure that they sufficiently attend to the potential consequences of allowing their participants to forego their anonymity. Morse (2007, cited in O’Reilly et al., 2012) suggests that children and young people might not fully appreciate the implications of their identities being disclosed and as such advises researchers to ‘proceed with caution’. A particular concern in foregoing anonymity is the potential for repercussions within the research site (DiCicco-Bloom and Crabtree, 2006). For example, if a pupil made negative remarks about the practice of a particular teacher, this could adversely affect the relationship between them. As Stein (2010) notes, participants who make remarks that are not well received can face prejudice, sanctions and reprisals. On this note, it has been proposed that anonymity can make it easier for participants to share their thoughts, feelings and experiences openly and honestly, as they are less likely to be concerned about the potential consequences of doing so (Heath et al., 2009). Within this study, data generated by the pupils (in the form of direct quotations) were reported to teachers at the two case study schools during the fourth phase of the study (as discussed in sub-section 3.4.4) and pupils
were made aware that this would be the case. As such, I deemed it to be in the pupils’ best interests not to permit them to forego their anonymity, given that some of the remarks that they made may not have been well received by the teachers. In addition, I felt that this would also ensure that pupils did not ‘censor’ what they were saying within the focus group discussions.

Confidentiality can be enhanced by anonymising participants within the reporting of the data but can also be aided by ensuring that research sites are appropriately anonymised. Whilst it is important to ensure that these are described in sufficient detail as to appropriately contextualise the research, care should be taken to not inadvertently make the research site (otherwise, the school) identifiable (Tilley and Woodthorpe, 2011). Whilst demographic information about the schools was provided in sub-section 3.4.2.1, it was ensured that this would not be sufficient to enable the identification of the schools. Confidentiality can also be protected by ensuring that discussions about the participants do not take place outside of the research context. However, Leonard (2007) notes that this can be challenging in focus group-based research with children and young people. Whilst a researcher would not intentionally breach confidentiality themselves, they cannot control what the participants of the focus group might disclose to others (ibid.). The focus groups conducted during the study did not involve discussion of any particularly ‘sensitive’ topics, though at the beginning and end of each focus group, I made pupils aware that what was to be/had been discussed within it was not to be shared outside of it, in an attempt to ensure that they respected one another’s privacy.

Confidentiality can be somewhat problematic in research with children and young people, particularly in relation to the assurances that can be made by the researcher (Heath et al., 2009). Researchers assume a ‘duty of care’ when working with children and young people, in line with the Children Act (1989) and, as such, have an obligation to report instances where a child or young person discloses that they are at risk of harm or are in danger, or that they could pose a risk or be a danger to others. If a child or young person did make such a disclosure, a researcher would be required to breach confidentiality and to notify the appropriate authorities of their concerns in order to ensure that the child did not come to (or cause) harm. As such, it is important for researchers to make children and young people aware of instances where they might need to breach confidentiality, and this should be done
during the consent seeking process (O’Reilly and Kiyimba, 2015), discussed within the previous sub-section. Whilst no such disclosures were made during the present study, it is something that researchers must be prepared for, as these can and do occur within the research process.

4.5.2.3 Access

Access is an important ethical consideration in research with children and young people. It relates to gaining approval to conduct research at/within a particular site, typically through negotiation with gatekeepers – those in positions of power within an institution (such as Head Teachers within schools) (Heath et al., 2009). Access is related to two of the ethical sensitivities proposed by O’Reilly and Kiyimba (2015), namely, researcher involvement and iterativity. The researcher is part of the research process and evidently influences how this is conducted (researcher involvement) but there may be stipulations or restrictions put in place by the research site. Further, given that the research process is non-linear and unpredictable, it can change over the course of a study (iterativity) and re-negotiation with gatekeepers (in relation to access) can be necessary. Therefore, it is important to consider how access is gained within the research process.

Gatekeepers have a legitimate role in ensuring that, within their respective institutions, they protect their charges from unnecessary or inappropriate research. However, this can be problematic as it means that gatekeepers are responsible for making judgements as to whether or not research is worthwhile (Heath et al., 2009). Therefore, access can be difficult to negotiate if the focus of the research is not deemed by the gatekeeper(s) to be important. In addition, their judgements are often influenced by factors such as workload pressures, safeguarding concerns, and fears over public scrutiny (ibid.). Whilst gaining access to research sites was not particularly challenging within this study, it did require negotiation. Schools were willing to grant access, but restrictions were put in place around this and compromises had to be made. For example, I was only permitted to conduct focus groups with pupils during PE lesson time (as discussed within sub-section 3.4.2.1.1). Whilst I wanted pupils to be able to participate in the research (if they were willing), I would have preferred for this to have not been during their PE lesson time, given the evident value that I attach to the subject. On this note, France (2004) asserts that researchers can often be required to make compromises in
negotiating access to research sites, and he suggests they can often be hesitant to challenge gatekeepers on account of not wanting to jeopardise the access that they have been granted.

Whilst it is possible to anticipate some of the ethical sensitivities that may be evoked within the research process, such as those discussed with sub-sections 4.5.2.1-4.5.2.3, ethical dilemmas that arise over the course of a study typically cannot be foreseen. As such, it is important for researchers to highlight ethical dilemmas that arise within their practice and to consider how they managed these, as discussed within the subsequent section.

4.6 Reflexivity and ethical dilemmas within the research process

Birbeck and Drummond (2007) have suggested that despite researchers encountering ethical dilemmas within the field, these are not frequently discussed within the literature. However, it is increasingly being acknowledged that such dilemmas warrant discussion, with Warin (2011, p.813) asserting that researchers ‘need to make very deliberate and explicit attempts to incorporate the [discussion] of ethics in practice’ within their work. Further, it is increasingly being recognised that reflexivity is an important aspect of research practice that contributes to both rigour and ethical soundness (Guillemin and Gillam, 2004; Gewirtz and Cribb, 2006; Etherington, 2007; Warin, 2011; Phelan and Kinsella, 2013). Indeed, Etherington (2007) highlights the need for researchers to be reflexive, so that they can elucidate not only what data they have generated, but also how the data were generated and the role that they have played within this process. To facilitate reflexive practice, Rolfe (2006) proposes that researchers should maintain reflexive diaries, within which they record their reflections on their experiences in the field. He suggests that these can be particularly useful for noting down thoughts ‘in the moment’ within the field, and that they can subsequently stimulate reflexivity ‘out of the moment’ (ibid.). Therefore, I ensured that throughout the study I maintained a reflexive diary, in which I recorded my reflections on the research process. Whilst the entries within this varied in length, complexity and frequency, I endeavoured to write an entry following each of my school-based visits, as a minimum. These entries were intentionally written as soon as practicable following the visit, so as to ensure that key information was not forgotten. Further, I attempted to write ‘freely’ within the diary. That is to say that, I did not filter my thoughts as I was writing them, rather, I wrote as I thought.
McEvoy, Enright and MacPhail (2015) provide perhaps the most detailed account of ethical reflexivity in PE. Within their work, McEvoy and colleagues reflect on McEvoy’s experiences of conducting focus group-based research with young people, drawing on portions of text from transcripts. They highlight four key ethical dilemmas faced over the course of the research process and discuss these in relation to situated judgement (ibid.). Situated judgement has been defined by Kvale and Brinkmann (2009, p. 61) as ‘the intellectual virtue of recognising and responding to what is most important in a situation’. It is regarded as the translation of procedural ethics and ethical guidelines into ‘ethics in practice’. McEvoy, Enright and MacPhail (2015) proposed that the ethical dilemmas they discussed may have seemed somewhat ‘mundane’, though Warin (2011) contests that such dilemmas are those which researchers should be attending to within their practice. She proposes that, by doing so, they can elucidate how they have enacted situated judgement, be that ethical, or not (ibid.). Following the work of McEvoy and colleagues (2015), I now critically reflect upon two ethical dilemmas that I encountered during the research process, drawing on excerpts from my reflexive diary.

**Ethical Dilemma 1: Do you want to talk to me?**

The first diary extract relates to a focus group that was conducted at CS1, during phase two of the study. The ethical dilemma encountered concerned a pupil and his willingness to participate (or not) in the focus group:

> I escorted the pupils with me to the room where we were due to conduct the focus group. We sat down, and I explained what would be happening in it. I handed out the assent forms, and as I did one pupil said that they didn’t want to take part. He was due to be swimming in his PE lesson and said that he would rather do that than speak with me. Of course, I said that that wasn’t a problem, and I asked him to return to his lesson. The remaining pupils were all happy to participate and after completing their assent forms, we commenced the first activity. About five minutes or so passed, and the pupils were busy with the drawing activity, but there was a knock at the door. The teacher was stood there with the pupil who I had asked to return to his lesson. The teacher ushered him into the room and told me that he now wanted to take part.

(Research diary excerpt - Entry 12)
The pupil had evidently exercised his right to dissent participating, which was perfectly acceptable. I had asked him to return to his class, as had been agreed with my contact teacher at the school, should any pupils not wish to participate. Therefore, I was concerned that the teacher may have coerced the pupil into participating, likely on account of being worried about the pupil giving a bad impression of the school by not being willing to participate. I did not want to have the pupil participating against his will but, equally, did not want to offend the teacher by saying that they should not have returned the pupil to the focus group. I was conscious that in negotiating this ethical dilemma, I would need to be respectful of the agency of the pupil and the authority of the teacher.

I did not want to cause any further disruption to the pupils who were actively participating in the focus group as, by this point, they were ready to show/tell what they had drawn. Given that the teacher had already left, I asked the pupil who had been returned if he would be happy to sit, watch and listen whilst his peers presented what they had drawn. Subsequently, I intended to speak with him privately, once the other pupils had started the next task. After the other pupils had presented their drawings and started the next activity, I went to speak with the pupil. He explained that he had wanted to go swimming as this was his favourite activity within PE. However, having seen the activities that his peers were participating in, he was now keen to participate in the focus group. Therefore, I was rather fortunate in that the pupil had changed his mind and did now want to participate.

The ethical dilemma encountered relates to both consent (or rather, assent) and access. With regard to consent, it highlighted how influential the school context can be, and how teachers might inadvertently coerce pupils to participate in research. Evidently, there was an assumption that, given that the research was based within the school and being conducted during lesson time, pupils would be obligated to participate (as discussed in sub-section 4.5.2.1). Therefore, this made me aware that voluntary participation can be easily undermined, and care must be taken to safeguard pupils’ right to consent (or otherwise). Allied to this, there was evidently a need to reiterate to teachers that pupils were under no obligation to participate. However, in relation to access, I was concerned that if I challenged the teacher’s actions, I could undermine their authority and/or offend them. I was conscious that, by doing so, I could put my position within the school ‘at risk’. As discussed within sub-section 4.5.2.3, access can be difficult to negotiate, and so researchers can be hesitant to
challenge gatekeepers on account of not wanting to jeopardise the access that they have been granted. Despite this, I knew that I had a responsibility to ensure that pupils’ autonomy was respected and so I discussed the matter with my contact teacher at the school and requested that he reiterate to his colleagues that pupils were under no obligation to participate. I felt that, by having the contact teacher liaise with his colleagues regarding this, the message would be better received and, as it was conveyed to all teachers, it meant that the teacher involved was not ‘singled out’ for their actions.

**Ethical Dilemma 2: Why will you not talk to me?**

The second diary extract relates to a focus group that was conducted at CS2, during phase two of the study. Similar to the previous ethical dilemma, it concerned a pupil and her willingness to participate (or not) in the focus group:

The pupils had finished the drawing activity and I had asked them to share their drawings with myself and their peers. We went around the group and, one by one, each pupil showed and told us what they had drawn. One of the pupils was very reluctant to do so and seemed unwilling to join in with the discussions. At this stage, I thought she might just be a little nervous (or not be confident in her drawing abilities) and so moved on to the next pupil. As we progressed through the focus group, however, she continued to remain quiet. Despite having some questions directed towards her, she was seemed disinterested and unwilling to engage with me or her peers. On a couple of occasions, this made the atmosphere within the focus group rather awkward, particularly at one point when another pupil expressed their frustration that they were contributing whilst this pupil wasn’t.

(Research diary excerpt - Entry 26)

The pupil had given her assent freely, though she seemed hesitant to participate, particularly with regard to the discussions taking place within the focus group. Initially, I thought that she may be nervous and so tried to give her time to ‘settle in’, though I did direct a few questions towards her, to give her the opportunity to engage in the discussions, should she wish. However, as the focus group progressed, it became evident that the pupil did not want to contribute to the discussions taking place. I was somewhat concerned as, whilst directing questions towards her was well intentioned, I did not want her to feel obliged to participate,
should she not wish to do so. Given the pupil’s hesitancy, I took the opportunity to check with her that she remained willing to participate in the focus group and she nodded to confirm.

Whilst the pupil evidently did not want to contribute to the discussions, I did notice that she was completing each of the tasks. For example, on the third task, whilst she was not prepared to discuss it, she had completed the statement sheet. Therefore, with consideration of a youth voice agenda (as discussed in section 4.3), it could be argued that this pupil was simply choosing to speak as much (or perhaps, as little) as she wished. Whilst I did not necessarily realise this immediately, it became apparent that the pupil was contributing to the focus group, albeit in her own way. However, though I appreciated this, some of the other pupils in the focus group did not and felt that it was unfair that they were sharing their thoughts, feelings and experiences whilst she was not. It was somewhat challenging to manage this, as the other pupils’ frustrations were understandable. That said, I could not make the pupil engage in the discussions, nor did I want to, given her hesitance. As such, I endeavoured to allay the other pupils’ concerns and acknowledged that whilst she was not engaging in the discussions, she was contributing by completing the tasks. The other pupils were mostly content with this, though one was quite aggrieved by this. As such, he too decided to engage less in the discussions, which he was obviously also entitled to do.

The ethical dilemma encountered relates to both consent (or rather, assent) and anonymity and confidentiality. In relation to consent, it made evident that whilst a pupil might be willing to participate in a study, the extent to which they engage during research activities (such as a focus group) can vary. However, it is important to respect pupils’ autonomy and to ensure that they are supported to engage as much or as little as they wish. Otherwise, a researcher could unduly influence a participant, effectively ‘forcing’ their voice (as discussed in section 4.3). In addition, it highlighted that consent and/or assent cannot be regarded as ‘one-off’ processes (as discussed in sub-section 4.5.2.1). Rather, they require ongoing negotiation between the participant and the researcher, as evidenced within this focus group. With regard to anonymity and confidentiality, it was evident that pupils were frustrated by what they perceived to be an unequal contribution from one of their peers. They were concerned that whilst they were sharing their thoughts, feelings and experiences, their peer was not. As discussed within sub-section 4.5.2.2, confidentiality in focus group-based research with children and young people can be challenging, as a researcher cannot control what the
participants might disclose to others. Evidently, the pupil who participated less than her peers was privy to their discussions but contributed little to these. However, she was entitled to participate as little as she liked, as were the other pupils, with one of these deciding to exercise their right to do so.

4.7 Conclusion

This chapter has critically reflected upon the research process and the ways in which it facilitated pupils’ involvement within the study, in line with the participatory approach adopted. Initially, the context of research with children and young people was explored and it was highlighted that, emphasis is increasingly being placed on conducting research with children and young people as opposed to on them. Allied to this, it was suggested that this shifting focus may be due, at least in part, to the changing position and status of children and young people within society and in particular their rights. It was acknowledged that the rights conferred to children and young people by the CRC extend to research and as such, it should be ensured that all are able to express their thoughts, feelings and experiences, and to have these taken seriously within the research process. Subsequently, perspectives on children and young people were outlined and consideration was given to the perspective adopted within the study. It was explained that pupils were regarded as social actors, recognising that they are agentive subjects who actively participate in the social context within which they reside. Next, children and young people’s voices within the research process were considered and the youth voice agenda within research was debated. It was recognised that working towards such an agenda, whilst worthwhile, can be challenging and the concerns and criticisms associated with this were examined. The ways in which a youth voice agenda can be worked towards were highlighted, and it was noted that participatory approaches can be particularly useful in this regard.

The chapter subsequently considered participatory approaches to research with children and young people, highlighting their potential for engaging with and facilitating children and young people’s voices. Accordingly, the benefits and challenges of using participatory approaches were duly considered. For example, it was noted that such approaches can provide children and young people with ownership over the research process and can empower them to participate within it. However, it was acknowledged that the mere use of
participatory approaches does not in itself guarantee that children or young people can (or will want to) participate. As such, the use of a participatory approach was subsequently examined within the context of the present study. Specifically, the use of drawings and concept cartoons as participatory methods/techniques was discussed. It was highlighted that, whilst these methods/techniques were useful in engaging the pupils within the focus groups conducted as part of the study, there were challenges in employing them. For example, with consideration of drawings, it was suggested that whilst the vast majority of pupils readily engaged with and enjoyed the task, there were some who did not. Further, whilst it provided pupils with the space to structure their narrative in response to the complex task of articulating what ‘health’ meant, there was potential for pupils to be influenced by their peers.

Following this, the chapter explored ethical considerations in research with children and young people. Initially, the ethical stances that a researcher can assume were discussed and comparisons were made between traditional and alternative approaches, referred to as ‘aspirational ethics’. It was highlighted that, aspirational ethics offer a particularly useful stance for conducting research with children and young people, given that they encourage researchers to consider not only procedural ethics, but also ‘ethics in practice’. Accordingly, the ethical sensitivities evoked in research with children and young people were outlined and the ethical considerations of consent, anonymity and confidentiality, and access were discussed in relation to the study. With regard to consent, the process of seeking and obtaining this was described, but consideration was also given to the complexities surrounding this. For example, the notion that children and young people under a certain age do not have capacity to provide consent was debated. Finally, ethical dilemmas encountered over the course of the research process were reflected upon and discussed.

Chapters 5, 6 and 7 subsequently report on and discuss the data generated within the study, through the research process outlined within this and the preceding chapter. Chapter 5 focuses on the data generated from the survey conducted during phase 1 of the study, and the teacher interviews that were a part of phase 2. Accordingly, this chapter provides the necessary context for the following chapter. Chapter 6 is the focal chapter of the thesis and is concerned with the data generated through focus groups with pupils during phases 2 and 3 of the study related to pupils’ conceptions of ‘health’. Chapter 7 focuses on the teacher
focus groups that took place during phase 4 of the study and in which pupil data (discussed in chapter 6) were presented to the teachers. Whilst only one of the three data chapters focuses explicitly on the pupil data generated within the study, the thesis has been structured in such a way to ensure that the data is reported and discussed in a coherent manner, which aligns with the sequential design of the study (as each phase built on data generated through the previous one). Further, direct links are made to the pupil data throughout chapters 5 and 7, where relevant.
Chapter 5: A picture of health? The context of health-related teaching within physical education

5.1 Introduction

Within this chapter, the data generated through phases one and two are analysed and discussed in order to address one of the study’s secondary research questions (SRQ-1):

How is pupils’ health-related learning addressed within PE?

This chapter provides an overview of the current context of health-related teaching within PE in secondary schools in England. Evidently, the ways in which health-related learning are addressed within PE will influence pupils’ conceptions of ‘health’ in the subject, which is the main focus of the study. Therefore, the chapter will provide the necessary context for addressing the primary research question (as outlined in section 1.2) within the subsequent chapter.

Initially, demographic information pertaining to the participants and their settings is outlined. This includes the teachers who responded to the survey during phase one, and their respective schools, and those who participated in interviews during phase two at the two case study schools (CS1 and CS2). Subsequently, the policies and practices associated with health-related teaching within PE are explored, and teachers’ philosophies are also considered in relation to this. Next, the specific teaching approaches/strategies used by teachers to address pupils’ health-related learning are outlined, along with the activities and resources/facilities that they drew upon. This section also discusses the notion of performativity and how this manifested within teachers’ health-related teaching practices. Further within the chapter, the messages that teachers convey to pupils are examined, with particular attention paid to the healthist discourses that surround these messages and the influences these might exert on pupils’ conceptions. Next, teachers’ health-related knowledge and their perceptions/experiences of CPD are discussed, before pupils’ conceptions of ‘health’ in PE are explored from teachers’ perspectives. Finally, the chapter considers the ‘bigger picture’ of health and examines the role of extra-curricular PE in supporting pupils to lead healthy, active lifestyles, as well as the influence of whole-school approaches. The chapter concludes by reflecting on teachers’ perceptions of who is responsible for pupils’ health and the extent to which they feel they could/should contribute to this.
5.2 Participants and settings

A total of 52 schools completed the survey conducted during phase one of the study (as discussed in sub-section 3.4.1). Demographic information pertaining to these schools is provided in figures 5.1-5.4.

**Figure 5.1 Type of school**

<table>
<thead>
<tr>
<th>Type of School</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Academy</td>
<td>25</td>
<td>48.1%</td>
</tr>
<tr>
<td>State Comprehensive</td>
<td>23</td>
<td>44.2%</td>
</tr>
<tr>
<td>State Faith</td>
<td>4</td>
<td>7.7%</td>
</tr>
<tr>
<td>Free School</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>

**Figure 5.2 Age range of school population**

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>11-18</td>
<td>32</td>
<td>61.5%</td>
</tr>
<tr>
<td>11-16</td>
<td>12</td>
<td>23.1%</td>
</tr>
<tr>
<td>Other</td>
<td>8</td>
<td>15.4%</td>
</tr>
</tbody>
</table>

**Figure 5.3 Gender of school population**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mixed (Throughout)</td>
<td>41</td>
<td>78.8%</td>
</tr>
<tr>
<td>Boys only</td>
<td>2</td>
<td>3.8%</td>
</tr>
<tr>
<td>Girls only</td>
<td>6</td>
<td>11.5%</td>
</tr>
<tr>
<td>Other</td>
<td>3</td>
<td>5.8%</td>
</tr>
</tbody>
</table>

**Figure 5.4 Size of school population**

<table>
<thead>
<tr>
<th>Size Range</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;500</td>
<td>5</td>
<td>9.6%</td>
</tr>
<tr>
<td>500-1000</td>
<td>21</td>
<td>40.4%</td>
</tr>
<tr>
<td>1001-1500</td>
<td>16</td>
<td>30.8%</td>
</tr>
<tr>
<td>1501-2000</td>
<td>10</td>
<td>19.2%</td>
</tr>
<tr>
<td>&gt;2000</td>
<td>0</td>
<td>0%</td>
</tr>
</tbody>
</table>
As figure 5.1 demonstrates, almost all of the schools (92.3%) were either an academy or a state comprehensive and the vast majority (84.6%) had an age range of 11-18 years (as demonstrated by figure 5.2). Of those schools that reported ‘other’, four provided only for KS3 pupils, covering the 11-14 age range, and four provided only for KS4 and KS5 pupils, covering the 14-18 age range. The vast majority of schools were also mixed gender throughout (78.8%), as figure 5.3 demonstrates. The schools that reported ‘other’ were boys’ or girls’ only at KS3 and KS4 but were mixed at KS5. With regard to size, taken as the number of pupils, schools varied but the most common size was between 500-1000 pupils (representing 40.4% of schools), as demonstrated by figure 5.4.

Demographic information for the two case study schools was outlined in sub-section 3.4.2.1, though it is pertinent to outline key demographic information relating to the teachers at these schools, including details such as their gender, training (including both undergraduate and postgraduate studies), and their teaching experience, taken as the number of years that they have been teaching (see table 5.1). The teachers at the two case study schools have each been assigned a code to identify them and their respective school within the reporting and discussion of the data. For example, the code CS1-T1 designates teacher number 1 from case study school 1.
<table>
<thead>
<tr>
<th>Teacher</th>
<th>Gender</th>
<th>Training</th>
<th>Experience</th>
<th>Specific Role (if applicable)</th>
</tr>
</thead>
<tbody>
<tr>
<td>CS1-T1</td>
<td>Male</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>5</td>
<td></td>
</tr>
<tr>
<td>CS1-T2</td>
<td>Female</td>
<td>BSc - PE and Youth Sport, PGCE - PE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CS1-T3</td>
<td>Male</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>CS1-T4</td>
<td>Female</td>
<td>BSc - PE and Youth Sport, PGCE - PE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CS1-T5</td>
<td>Female</td>
<td>BEd - PE</td>
<td>10</td>
<td>Head of Department (HoD)</td>
</tr>
<tr>
<td>CS1-T6</td>
<td>Male</td>
<td>BA - Sports Development, PGCE - PE</td>
<td>11</td>
<td>Assistant Head Teacher (aHT)</td>
</tr>
<tr>
<td>CS2-T1</td>
<td>Female</td>
<td>BSc - PE and Youth Sport, PGCE - PE</td>
<td>11</td>
<td>Deputy Head of Department (dHoD)</td>
</tr>
<tr>
<td>CS2-T2</td>
<td>Male</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>CS2-T3</td>
<td>Female</td>
<td>BEd – HPE, PGDE - PE</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>CS2-T4</td>
<td>Female</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>CS2-T5</td>
<td>Male</td>
<td>BEd - PE</td>
<td>30</td>
<td>Head of Department (HoD)</td>
</tr>
<tr>
<td>CS2-T6</td>
<td>Male</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>30</td>
<td>Head of Department (HoD)</td>
</tr>
<tr>
<td>CS2-T7</td>
<td>Male</td>
<td>BSc - Sports Science, PGCE - PE</td>
<td>9</td>
<td>Deputy Head of Department (dHoD)</td>
</tr>
</tbody>
</table>

Table 5.1 Demographic information relating to participating teachers
The demographic information provided in table 5.1 highlights that the gender representation across the sample of teachers was relatively even, with 7 male and 6 female participants. It demonstrates that the training routes that teachers took were varied, though the most common was an undergraduate degree (typically in sports science), followed by a postgraduate degree specialising in education. It should be noted that one of the teachers, CS2-T3, completed her training in her home country of New Zealand. The teachers within the sample had a range of experience, from two to 30 years. However, excluding the one teacher who had been teaching for 30 years, the average number of years’ experience was approximately 5.5. Within the sample, there were some participants who held a specific role within the department or the wider school, including the Head of Department (HoD) at each school and two Deputy Heads of Department (dHoD) at CS2.

5.3 Mind the gap: Policy, philosophy and practice in relation to health-related teaching

The survey data highlighted that 46 of the 52 schools (88.5%) had a policy outlining a departmental approach to teaching PE and, of these, 32 (69.6%) stated that their policy made explicit reference to the NC aim of ensuring that all pupils lead healthy, active lifestyles. This is evident progress when compared with early work by Harris (1994) and later work by Ward (2010), both of whom found that few schools had a formal, written commitment to health-related teaching and learning. Interestingly, the interview data did not corroborate that of the survey. Indeed, despite there being a policy at both case study schools, awareness of this within the department was limited. Aside from the HoD at each school, no other teacher (including the two dHoD at CS2) was aware of its existence. The difference between the findings of the survey and the interviews may be due to the fact that the survey was typically completed by the HoD at each school (as discussed in sub-section 3.4.1.3). Therefore, this may explain why the vast majority within the survey reported that their school had a policy that outlined a departmental approach and this figure may have been lower had other members of the department completed it. Evidently, whilst such policies may exist, awareness of them seems to be limited. As such, it could be questioned as to whether or not these are being put into practice within schools.

With consideration of support for health-related teaching at policy level within schools, teachers were asked (within both the survey and the interviews) about the status that the key
curriculum aim of promoting healthy, active lifestyles held within their respective PE curricula. The survey data highlighted that whilst some teachers (12.4%) reported that the aim had a limited status, the vast majority (73.2%) felt that it had a very high status. Indeed, many teachers considered it to be a central focus within their curriculum:

*The focus of our whole PE curriculum is about leading healthy, active lifestyles – it’s the key aim* (Survey respondent 1)

*[It has] high status. The aim of healthy, active lifestyles underpins, and is embedded across, the whole PE curriculum* (Survey respondent 6)

However, despite the vast majority of teachers suggesting that promoting healthy, active lifestyles had a very high status within their respective PE curricula, this was not necessarily reflected in the time allocated to addressing the aim within curricular PE. Whilst 36.5% of survey respondents considered it to be afforded sufficient time or better, 63.5% expressed that it was afforded limited or little to no time. Evidently, this indicates a contradiction between teachers’ talk around the status they feel health holds within the PE curriculum and the amount of time afforded to it. Findings such as these support the work of several researchers (*e.g.* Harris, 1994; Cale, 2000; Ward, 2010) who similarly identified that whilst PE teachers purport to valuing health within the PE curriculum, such a philosophy is not necessarily reflected within their practices. As Cale (2000, p. 85) states, if teachers are to be successful in working towards the aim of promoting healthy, active lifestyles, they will need ‘more than an enthusiasm for and belief in its value’. Indeed, working towards this aim will require teachers’ philosophies to align closely with their practices. However, as discussed with the subsequent section, there are ‘issues’ with current health-related teaching practices within PE.

**5.4 Fit for purpose? Teachers’ approaches to health-related teaching in the PE curriculum**

The teachers within the survey typically outlined a combined approach to teaching health within PE, which comprised permeated and focused elements. Cale and Harris (2009a) suggest that such an approach is perhaps the most appropriate for addressing health-related
learning within PE, given that the individual strengths of each approach can be drawn upon and, as learning is being reinforced through multiple means, it implies to pupils that the area is important (Cale, 2000; Harris, 2000; Cale and Harris, 2009a; Harris and Cale, 2018).

With consideration of the permeated element, teachers typically discussed covering health-related learning through different activity areas within the PE curriculum (e.g. games, athletics and gymnastics). The vast majority of examples provided made reference to what might be termed more traditional sports/activities (e.g. football or cross-country), with a particular emphasis on (competitive) team games, though a few references were made to less traditional sports/activities (e.g. boxing or Zumba). It is perhaps unsurprising that many teachers chose to deliver the area through (competitive) team games, given PE teachers’ reputed preoccupation with sport, and in particular games, within the PE curriculum (Green, 2003; Kirk, 2010).

In terms of the focused element, almost all teachers expressed how health-related learning was addressed through particular units within their PE curricula. Whilst the units were variously described in the survey data, for example, as a HRE unit, a HRF unit or a fitness unit, the core focus was predominantly fitness (typically, in the interests of sports performance). Despite outlining a combined approach, the vast majority of the teachers expressed that health-related learning was addressed predominantly through the focused element, namely the fitness-focused unit. The activities most commonly reported as being included within this were running, circuit training, weight lifting, aerobics and fitness testing. The majority of teachers also indicated (in one way or another) using a reproductive teaching style to deliver the focused element. The most frequently reported were command and practice, and teachers seemingly considered these effective means of delivering health-related content, as exemplified by the following quotations:

*It’s teacher-led. We set up the activities and instruct students through them* (Survey respondent 14)

*We use a direct style when teaching (the fitness unit), to explain what they (students) need to do and to get them active; it’s what’s needed for that content* (Survey respondent 46)
Lessons are quite teacher-centred, and we use command style teaching for the fitness unit as it’s just circuits and fitness testing (Survey respondent 43)

As Cale and Harris (2011, p. 23) note, the PE profession has ‘a responsibility to ... ensure that the experiences offered [within the subject] are meaningful, relevant and positive’. However, if pupils’ experiences of health-related teaching are associated with repetitive activities delivered using direct teaching styles, they may not necessarily be meaningful, relevant or positive. Indeed, Curtner-Smith et al. (2001) describe how pupils can find such styles repetitive and tedious and as such, this might not be facilitating as positive a PE experience as it might.

Whilst the majority of teachers indicated that they adopted reproductive styles (albeit it in varying ways), there were some who indicated that they used productive styles within the fitness-focused unit with guided discovery being the most frequently reported. Teachers adopting such styles suggested that their use contributed to the development of independent learning, which they considered to be important in terms of leading a healthy, active lifestyle:

*The fitness lessons are mostly delivered in a student-centred way. We encourage them to take the lead on health* (Survey respondent 39)

*We tend to use styles like guided discovery an awful lot – it encourages the students to take responsibility for their own learning* (Survey respondent 37)

The interview data highlighted similar findings, with a combined approach to health-related learning being adopted within the PE curriculum at both schools. However, the data generated through the interviews provided further detail with regard to how this area was addressed. It was evident that for many of the teachers interviewed, a permeated approach represented an ‘easy’ way to address health-related learning within the PE curriculum. Allied to this, and implicit within the talk of the teachers, was an assumption that health-related learning happened ‘naturally’ through the permeated element. That is to say that, teachers assumed that by making sure that pupils were active during lessons and actively participating
in sports, they would be working towards the NC aim of ensuring that all pupils lead healthy, active lifestyles. For example, two teachers stated:

*It comes through in every lesson, in one way or another – you just touch on it, sometimes without even planning on it* (CS1-T6)

*It’s brought all the way through the PE curriculum at the school, health is very easy to cover in whatever unit is being taught. The pupils take away health messages even when the lesson has been on football* (CS2-T1)

Of course, if teachers are providing positive (and active) learning experiences for pupils, as Cale and Harris (2011a) advocate, this will encourage them to participate in physical activity and sport for life. However, this is evidently not sufficient in working towards attainment of this key curricular aim (Harris and Cale, 2018). Further, teachers’ talk around how health-related learning was addressed through a permeated approach often inferred limited and superficial coverage of the area. For example, many teachers implied that simply by referring to warming up and cooling down in lessons (making links to exercising safely), they would effectively be working towards addressing this aim. One teacher stated:

*You know, when we’re teaching, we’re meeting that aim without much effort. So, I’ll talk about warming up for the lesson and I’ll let them know that that’s so that we can exercise safely – and there’s a health link right there!* (CS1-T2)

Whilst the NCPE does not explicitly state what should be covered in order to address this aim, if teachers are covering health-related learning in a limited and superficial manner, pupils’ learning in this area is unlikely to be as effective as it might, or needs to, be. It would seem that for many teachers, there was a lack of educative expectation associated with the aim of ensuring that all pupils lead healthy, active lifestyles. Indeed, their talk inferred that this aim was more about providing opportunities for pupils to be active as opposed to equipping them with the knowledge, skills, behaviours and experiences to do so. However, as Harris (2000, p.
2) notes, education within this particular area requires pupils to be equipped with the ‘knowledge, understanding, physical competence and behavioural skills’ to engage in physical activity and to be supported to develop ‘positive attitudes and confidence’ towards it. As such, health-related teaching is about more than just providing opportunities to be physically active. On this note, two of the teachers interviewed expressed that learning in this area (when being delivered through a permeated approach) could be far more explicit and themselves questioned how effectively both they and their colleagues were addressing this aim, with one stating:

*It could be a lot more explicit. Unless the students are on the fitness unit, what we teach really isn’t that focused on it (health)* (CS2-T5)

Harris (2010) found that health-related teaching within PE was often unstructured and characterised by variations within practice. She also expressed concern over teachers’ superficiality in their approach and expressed that effective learning is the key priority for any curriculum subject (*ibid.*). Whilst the NCPE provides limited guidance on what should be covered in relation to healthy, active lifestyles, information from other sources is available and this is discussed further in sub-section 5.6.3.

In terms of the focused element, similarly to the survey respondents, the teachers at both case study schools reported a fitness-focused unit to be the key means by which health-related learning was addressed within their PE curricula. On exploring this further, it became apparent that whilst teachers considered these units to work towards health-related learning outcomes (which they did, to an extent), the content covered was almost exclusively fitness-related, typically including components of fitness, principles of training, and fitness training activities. Furthermore, in much of the teachers’ talk around teaching health through these fitness units, health was taken to be synonymous with fitness, as found by Garrett and Wrench (2008) and Green (2008).

The data generated from both the survey and the interviews highlighted that teachers regarded gyms (or fitness suites, as they were sometimes referred to) to be an important context for learning about health. Within the interviews, teachers reported that they
considered gyms to be the most likely context in which pupils would exercise post-compulsory education and as such, they felt that they had to familiarise pupils with the gym environment. There were gym facilities at both case study schools and some teachers expressed how they would ‘struggle’ to teach about health without these, particularly at KS4. In line with this, it was unsurprising that most survey respondents, based at schools without gym facilities, reported this to be a significant barrier to effectively teaching about health within PE.

Concerns have been expressed with regard to an over-emphasis on fitness within PE (Cale and Harris, 2013; Cale, Harris and Duncombe, 2016) as it can lead to wider aspects of learning being paid limited attention or neglected (Cale and Harris, 2006; Garrett and Wrench, 2008) which can consequentially limit pupils’ learning. Underlying this fitness focus within PE teaching, were performative discourses and as such, fitness testing was often considered as a key activity for learning about health (or perhaps rather, fitness). Further, this fitness orientation was also frequently associated with examination-based PE, with teachers considering it important to align their teaching practices around health with examination specifications, as discussed in the following sub-section.

5.4.1 Testing times: Performative notions in health-related teaching

Within the fitness-focused units, considered by teachers to be a key means of addressing health-related learning within the PE curriculum, fitness testing was identified as the main activity through which content was delivered. Indeed, 46 of the 52 survey respondents (88.5%) and 12 of the 13 interview participants (92.3%) reported this to be the main activity used to address health-related learning. A focus on fitness testing is not new, and Cale and Harris (2009b) noted the widespread use of fitness testing as a means of educating about health within PE curricula. Within the present study, teachers justified the use of fitness testing as an activity for learning on the grounds that it contextualised pupils’ learning, suggesting that it enabled pupils to identify their current fitness levels, and work out what they could improve on (if necessary). The talk surrounding this practice was evidently ‘well intended’ and some teachers were cognisant of the potential limitations of using fitness testing. However, for many, it was seemingly deployed unproblematically:
Fitness testing makes it real for them, they know why they’re learning it then, otherwise they just don’t see the point in health (CS1-T6)

You know, it shows them where they’re at... when they see they’re not up to scratch in terms of endurance, you can make it relevant by showing them how to improve on that (CS2-T2)

Of particular concern in teachers’ use of fitness testing, were some of the associated practices they reported around assessing, monitoring and comparing pupils’ fitness levels. Gard and Wright (2001) note how such practices have become a standard feature within PE, though they warn of the potential dangers of this, or at least of some of the messages associated with these (discussed further in sub-section 5.5.1). Arguably, fitness testing practices are driven by obesity discourses which have been strongly criticised by many (e.g. Evans, 2003, 2007; Gard and Wright, 2001; Wright and Dean, 2007; Rich, 2010; Cale, Harris and Chen, 2014). As Evans (2007, p.13) states, they can encourage ‘unprecedented levels of surveillance of young people’. However, this surveillance is not just of young people as Evans (ibid.) suggests, but also by young people, as these practices can promote self-surveillance (discussed further in sub-section 6.4.1). In a sense, this seemed to be what some of the teachers in the study were trying to encourage, as they felt it important for pupils to take responsibility for their own health (discussed further in section 5.8), reflecting broader, healthist discourses. With consideration of what this means for teaching practices and pupil learning, Cale, Harris and Chen (2007) suggest how, if employed inappropriately, fitness testing can actually be counterproductive to the agenda of promoting healthy, active lifestyles. Indeed, Cale and Harris (2009b, p. 103) note how fitness testing ‘may well represent a misdirected effort in the promotion of healthy lifestyles’ suggesting that PE time could perhaps be ‘better spent’. Nonetheless, they maintain that if employed appropriately, it could be a valuable feature of a PE curriculum working towards promoting healthy, active lifestyles but it should not define it (ibid.).

In addition to fitness testing, examination-based PE was cited by the vast majority of teachers, in both the survey and the interviews, as a driver behind much of their health-related teaching. Indeed, teachers often discussed drawing on KS4 content (typically that taken from
GCSE syllabi), when delivering to KS3 pupils. Whilst some teachers described how they ‘watered down’ this content, to make it ‘comprehensible’ to KS3 pupils, it seemed that they were not only motivated to support pupils’ health-related learning, but also to enhance academic achievement. Indeed, underlying teachers’ talk were strong notions of performativity allied to examination-based PE performance. For many teachers, this appeared to be a key motive for covering health-related learning within PE, as it was assessed at KS4 and enabled them to prepare pupils for examinations, with two teachers stating:

*We use the GCSE specification as a guide... whatever content is on there, it makes sense to cover in years 7, 8 and 9. You obviously don’t use the same terminology, well, not at first, but that’s the content you cover (CS1-T3)*

*It’s on the specification at GCSE - leading healthy, active lifestyles - so you need to cover it to prepare them (the pupils) in case they take it as an option, which a lot of our students do (CS2-T4)*

Teachers’ preoccupation with examination-based PE and the preparation of pupils for this is somewhat concerning, as this does mediate the health-related messages that pupils receive, as discussed below. Indeed, performative orientations have been criticised by many within PE (e.g. O’Connor, Alfrey and Payne, 2012; Evans, 2013) for their potential to align with healthist agendas. Such performative orientations have been proposed by Macdonald (2011) as being reflective of a broader, prevailing neoliberal agenda within education.

5.5 Getting the message: Teachers’ perceptions of health-related learning

Within the survey, teachers identified a number of messages that they expected pupils to be conversant with by the end of KS4. One key message that was that sport, physical activity and PE should be enjoyable. Allied to this, was an assumption that, if teachers could convey this message, this would encourage pupils to be active (in the interests of being healthy), as exemplified by the following quotations:
Enjoyment is key – that is the main message that we try to put across to all students within PE (Survey respondent 10)

We try and make sure that they know that being active is enjoyable, because not every student thinks that. If you can get them enjoying it, they’re far more likely to keep doing it and be healthy for life (Survey respondent 23)

Whilst enjoyment of sport, physical activity and PE was key for the majority of teachers, it was not the most frequently reported message. Rather, the most frequently reported message(s) that teachers sought to convey related to ensuring that pupils knew how to lead a healthy, active lifestyle (and the benefits of doing so). In relation to this, teachers typically described what they would expect pupils to know in terms of how to be healthy (or perhaps rather how not to be unhealthy). Interestingly, this was almost exclusively in relation to two lifestyle factors, namely: exercise and diet. For example, two teachers stated:

We try to make sure that they know what they need to do to be healthy... we try and equip them with what they need to know in terms of their diet and exercise (Survey respondent 48)

They learn all about exercise and diet and they should know that certain things are better for their health than others. They should know that they shouldn’t eat foods that are high in sugar or fat and that they shouldn’t watch too much TV or play too many computer games and so on (Survey respondent 42)

Evidently, whilst teachers were intending to support pupils in leading a healthy, active lifestyle, the focus was predominately on physical aspects of health (specifically exercise and diet) resulting in a corporeal focus. Indeed, conspicuous in its relative absence was reference to any dimension of health beyond the physical (such as mental, social and emotional dimensions). As discussed within section 2.2, health is a broad concept, though it would seem
that its breadth in PE is limited, which may be detrimental to pupils’ learning (discussed further in section 6.2).

In addition to a corporeal focus, the positioning of health within teachers’ talk was noteworthy. Whilst teachers explicated that they sought to ensure that pupils knew how to lead a healthy, active lifestyle, in the talk that surrounded this, they generally described what *not to do* to be healthy, rather than what *to do* to be healthy. The notion of ‘negative talk’ evident within this needs to be duly considered. Indeed, it is questionable as to how effective such practice might be in supporting pupils to lead healthy, active lifestyles. For example, a teacher could advise pupils not to be sedentary for long periods of time or they could advise them that (in line with current recommendations) they should try to be active for at least 60 minutes per day at moderate to vigorous intensity. Arguably, positive messages may make them more likely to engage in health-enhancing behaviours.

The interview data highlighted that these teachers were seeking to convey similar messages to pupils within and through PE lessons. However, it enabled these to be explored further and revealed some interesting (and concerning) findings. As had been the case for the survey data, the key focus of teachers’ messages was ensuring that pupils knew how to lead a healthy, active lifestyle and these messages were predominantly focused on the physical dimension of health. However, it became apparent that for many of the teachers, the messages that pupils received were mediated by the teachers’ perceptions of their ability:

*I think what we teach them (about health) depends on the ability of the student. The messages will differ depending on whether they’re high or low ability* (CS1-T3)

*If you take two students in the same year group, one high ability and one low ability, the difference between what one would take away compared to the other would be vast – they get different messages* (CS2-T6)

*The low ability students really need the health messages bringing through, you know that they’re likely to not be the fittest of students and so it’s going to be harder to get things across* (CS1-T1)
Whilst it is reasonable to assume that there may be differentiation between what is taught to lower ability pupils and what is taught to higher ability pupils, it would seem that ability is being conceptualised (exclusively) in the physical sense. Further, implicit within the talk of many teachers was an assumption that lower ability pupils were more likely to be unhealthy. This led to some concerning talk in this regard, as discussed within the following sub-section.

5.5.1 Troubling talk: Healthist discourses in health-related teaching

Underlying some of the teachers’ talk around health-related teaching were some concerning discourses. For example, a few teachers described somewhat worrying practices such as: promoting exercise (predominantly) for weight management, encouraging dietary restriction and normalising pain. Six teachers stated on the survey that they promoted exercise for weight management and two discussed this within the interviews, with two stating:

*We make sure that they know about how exercise is important for managing their weight. It’s something they need to learn to keep on top of* (Survey respondent 13)

*I mean, with the girls, you have a really obvious way to promote health; you talk about how, if they exercise it will help them be thin enough to get in their prom dress. Even with the boys, you talk about looking good in their suits* (CS1-T1)

It should be noted that exercise has a legitimate role in weight management, and that is not necessarily the concern in this regard. Rather, the concern surrounds teachers’ articulation of this, the emphasis that is placed on it, and the tracking/surveillance practices being promoted through it. There were also a few teachers who felt it important to normalise pain in relation to exercise. For example, two teachers stated:

*They need to understand [that] exercise should be hard, and it should make you sweat, it can hurt but that shouldn’t mean that you give up* (Survey respondent 42)
You’ve got to make them realise that if you run, your heart will beat faster, and you will breathe quicker. It will hurt, but that’s what happens when you exercise, and you need to work through it, rather than just stopping (CS2-T2)

Whilst it is acknowledged that exercise may cause some (mild) discomfort, particularly if it is not a type/intensity of exercise that a pupil is accustomed to, it is just to argue that this should not be to the point that it is considered painful. Though these practices were only articulated by a minority of teachers, they are nonetheless concerning and work within the field points to the potentially detrimental effects that such practices can have on pupils’ health and wellbeing (Cale and Harris, 2009b; Rich and Evans, 2009).

5.6 In the know? Health knowledge and continuing professional development in health-related teaching

It is increasingly being recognised that the health-related knowledge of pupils and teachers warrants consideration in relation to health-related teaching and learning (see Cale, Harris and Hooper (forthcoming) for an overview). In line with this, it was deemed important to explore teachers’ health-related knowledge, the sources of information they drew upon for health-related teaching and in turn their perspectives on the (potential) need for CPD. Further, given the focus of the study, teachers’ perceptions of their pupils’ health-related knowledge and understandings were also sought, as discussed within the following sub-section.

5.6.1 They have a lot to learn: Teachers’ perceptions of pupils’ health-related knowledge, understandings and conceptions

The interviews provided an opportunity to discuss with teachers their perceptions of pupils’ health-related knowledge and understandings. This was of particular interest, as pupils’ knowledge and understandings evidently influence the discursive resources that they have available to them and consequently their conceptions of ‘health’ (discussed further in section 6.2). Teachers at both case study schools generally reported pupils’ health-related knowledge and understandings to be limited and superficial:
They (the pupils) struggle with health... they don’t always know a lot about it (CS1-T1)

They have a real lack of knowledge in terms of health and what they do know is superficial. They can tell you some things about how to be healthy, but if you asked them about why something is healthy, most wouldn’t know why (CS2-T7)

In addition, most of the teachers readily provided examples of specific misinformation that pupils espoused. These examples related almost exclusively to the physical dimension of health, which is perhaps unsurprising given the strong focus on this dimension within the teachers’ practices (as discussed in sub-section 5.3.3). Specifically, examples related to either exercise (e.g. not being aware of what constitutes physical activity, how active they need to be or at what intensity they should be exercising) or diet (e.g. not knowing what foods are healthy and unhealthy or what it means to have a balanced diet). For example, two teachers stated:

There’s a lack of knowledge about how active they need to be, and what they should be doing to be healthy. They think walking around is enough and they don’t understand that it’s got to be more [intense] than that (CS2-T2)

It’s diet that they really struggle with. They don’t understand what they’re eating and whether it’s healthy or not... they need to better understand what a balanced diet is (CS1-T3)

One of the teachers (CS2-T3) provided an interesting perspective by contrasting the knowledge, understandings and conceptions of her current pupils in England, with her former pupils in New Zealand, where she had previously trained and taught (as discussed in section 5.2). Indeed, this teacher felt that pupils in England were not as well informed as their peers in New Zealand and that, in particular, pupils lacked (and were in need of) a more critical perspective on health:
“The pupils just aren’t as critical... they ask me questions like “What does a healthy body look like?” and for their age, I’d expect them to be able to consider that for themselves, at least to a certain extent’ (CS2-T3)

The teachers’ talk around pupils’ health-related knowledge, understandings and conceptions positioned them in two rather contrasting ways. One perspective positioned pupils as ‘disinterested’ whereas the other positioned them as ‘challenged’ in relation to their health. The former inferred that, whilst pupils had limited understandings of health, they knew enough to be healthy but chose not to be:

They’ll tell you that it’s healthy to eat something, but they (the pupils) know it’s not. They try and tell you that chicken nuggets are healthy because they’re chicken, but they know it’s not really that healthy. They’re just trying to kid themselves or make themselves feel better about being unhealthy (CS2-T2)

Meanwhile, the latter suggested that pupils did not have sufficient knowledge to be able to make healthy choices and recognised the broader factors at play within this:

They’re often really confused by food, but I think that’s because of the mixed messages they (the pupils) receive about what is and isn’t healthy to eat. You need to recognise though that most adults are confused about it too, it isn’t just because they’re [children] (CS2-T1)

The way in which teachers position pupils in this respect is significant. The former contributes to a ‘blame’ perspective and aligns with healthist perspectives that position individuals as being at ‘fault’ (as discussed in sub-section 2.2.3.1). The latter recognises that pupils do require support (some, at least) to lead healthy, active lifestyles and acknowledges that the wider context within which they live their lives requires consideration.
Given that teachers reported pupils espousing misinformation related to health, it seemed pertinent to consider the ways in which they attempted to address these (if they did) within PE. Within the interviews, teachers often had difficulty articulating how they would support pupils’ health-related learning should there be any misinformation and some even expressed how they did not intervene in this regard as they felt that pupils were not receptive to such messages. Amongst those teachers who did attempt to address misinformation, the most commonly reported strategy used was questioning, with the intent being to encourage pupils to consider alternative perspectives. Some teachers also suggested that they would present pupils with contrasting information, though as discussed further in section 6.7, this may not be a helpful approach from the pupils’ perspectives. Additionally, some teachers simply stated that they would explain to pupils that they were ‘wrong’ and provide the ‘right’ information to them, though this might not necessarily result in their knowledge being enhanced. A further strategy discussed by two teachers (CS2-T2 and CS2-T6) was somewhat concerning, in that they suggested that if pupils presented misinformation to them, they would make fun of the situation and perhaps ‘take the mick’ out of the pupil in question:

They get it better if you make light of the situation – you just joke about it with them and have a bit of fun about it (CS2-T4)

You just take the mick, I mean, just a little bit, but you make like fun of them being wrong, and you make a joke out of it. You do just need to call them out when they’re kidding themselves (CS2-T2)

There are evident links between how these teachers attempted to address misinformation and how they positioned pupils. Indeed, these two teachers both positioned pupils as ‘disinterested’ and this influenced how they approached their teaching. Whilst well-intended, there are potential dangers to such practices, as identified by Evans, Rich and Holroyd (2004) who provide concerning examples as to how such practices can adversely affect pupils’ relationships with food, their bodies and their conceptualisations of self (discussed further in sub-section 6.3.1).
5.6.2 Keeping it current? Sources of information for health-related teaching

With regard to the sources of information that teachers drew upon in relation to health-related teaching, three key sources were outlined within the interviews, namely: their personal experiences, their studies, and current news/media articles related to health. In relation to their personal experiences, most teachers explained that they regarded themselves as being healthy (or perhaps rather, fit) individuals who knew how to lead (and had experience of leading) a healthy, active lifestyle. They noted how they had amassed this knowledge through experience over the course of their lives and generally felt that this positioned them well to convey such information to pupils, with two teachers stating:

Well, I’m a healthy person myself. I play sports and I go to the gym too, and I eat the right things. I’d like to think that my own experiences help inform my teaching (CS2-T1)

I’m actually really into my fitness, I train at the gym every day; it’s quite a big thing for me. I make sure I eat clean. It’s what I enjoy myself, so I know a lot about it (CS2-T2)

For many of the teachers, the knowledge that they had acquired through ‘life experiences’ was positioned as equally (if not, more) important that than acquired through their studies. O’Sullivan (2005) notes how teachers can often attach more significance to these informal, lived experiences as opposed to formal taught ones such as training or CPD. Interestingly, in discussing their studies and how these had equipped them with relevant knowledge for health-related teaching, most teachers reported that their undergraduate degrees had been more influential than their postgraduate degrees (the point at which most had completed their ITT). This was particularly the case for teachers whose undergraduate degree was sports science-related, as exemplified by the following quotations:

I’ve got quite a decent knowledge of health... I [studied] sports science as an undergraduate, so you know, I know what I’m talking about in that sense (CS2-T2)
It’s generally what I know from my degree... I studied sports science, so I’ve got quite a good knowledge of diet, exercise and those sorts of things (CS2-T6)

As discussed in sub-section 5.3.3, teachers’ focus within health-related teaching was predominantly on the physical dimension of health, which is perhaps to be expected given the perceived significance of their (largely sports science-related) undergraduate degrees as a source of information for health-related teaching.

As noted, current news/media articles were reported by many teachers to be important sources of information to support health-related teaching. These were used by teachers not only as sources of information for themselves (to keep their knowledge ‘current’), but also as resources for pupils. Within the interviews, teachers described how they felt that articles provided easily accessible information for both themselves and pupils and that, by using current news/media articles, they would better engage pupils as it would likely be about a topic that they would be conversant with. Indeed, the topic that teachers most frequently referred to was obesity, with one teacher stating:

I try to use news articles and things... obviously, obesity is a massive issue at the moment so that’s something useful to talk about. The topics that are current are best as it’s relevant to them, they’re going to know about it and hopefully have an opinion on it too (CS1-T2)

On the whole, teachers within the interviews seemed to engage with current news/media articles fairly unproblematically, perhaps not recognising the implicit bias that may be evident within them. That is, with the exception of one teacher (CS2-T3), who despite drawing upon such content with her teaching, acknowledged (and ensured that she conveyed to pupils) that it was constructed in a certain manner:

I’ll use social media content with the students, you know, because it’s what they know and use, but I make sure they know that it’s written from a certain perspective, like
there’s intent behind it. You need to make sure that if they’re accessing that content, they’re looking at it critically (CS2-T3)

5.6.3 Knowing it all? Teachers’ perspectives on the need for continuing professional development

The survey data highlighted that none of the 52 respondents had accessed any form of continuing professional development (CPD) specifically to enhance their health-related teaching. Further, when asked if they would be interested in accessing such CPD, only two of the 52 teachers expressed an interest. A further four teachers stated that they would be interested in accessing health-related teaching resources/materials, but they did not feel that there would be any need for CPD associated with using these.

Similarly, within the interviews, none of the teachers had accessed any form of CPD relevant to health-related teaching specifically and, with the exception of one teacher, none were interested in accessing CPD related to it. The need for such CPD was questioned by teachers, with most suggesting that it would be unnecessary, as they were already well informed in this regard. In doing so, teachers seemed to position themselves as ‘experts’ in relation to health. Teachers legitimated such a position based on their own personal experiences and their training which they felt had equipped them with the necessary knowledge and skills required for health-related teaching. This was particularly the case for those teachers who had completed sports science-related degrees as part of their undergraduate studies (as discussed in sub-section 5.6.2). There are evident links between the findings of this study and those of Alfrey, Cale and Webb (2012). Within their work, Alfrey and colleagues outlined the HRE conundrum as pictured in figure 5.5.
The HRE conundrum is a four-stage model which considers teachers’ engagement with HRE and HRE-CPD, or rather the lack of it. The model identifies that teachers’ philosophies are often imbued with sport/fitness-related ideologies and that these can lead to narrow conceptualisations of health and limiting approaches when teaching about it (Alfrey, Cale and Webb, 2012). The model also identifies that teachers have largely misguided confidence in their ability to teach health and, as such, a lack of willingness to engage in HRE-CPD (ibid.). Evidently, and as the model demonstrates, this leads to a perpetuating cycle, within which
narrow conceptualisations of health are taught through fitness-focused practices with no ‘breaks’ in the cycle.

For a few of the teachers within the study, there was an assumption that, as they taught examination-based PE, they must have sufficient knowledge and skills for health-related teaching. Allied to this, one teacher expressed how, in his opinion, it would be far more beneficial to access examination-related CPD as opposed to health-related CPD. He justified this on the grounds that this would be more relevant to his practice, given the significance of examination-based PE and the outcomes of this:

>You just wouldn’t choose to attend health-related CPD... if you had a choice between that and a course to support teachers preparing pupils for GCSE exam[inations], you’d send them on that one (the examination-related CPD). You have to think about the impact it would have on the department and GCSE results are what we’re judged on (CS1-T3)

This teacher’s opinion is perhaps to be expected given the focus on examination-based PE (as discussed in sub-section 5.4.1) and as Quennerstedt and Webb (2010) note, the performance driven environment which serves to regulate teachers’ practice and foci. The one teacher (CS2-T3) who did express an interest in accessing health-related CPD was trained in HPE, having studied a combined undergraduate degree in New Zealand. Of all the teachers interviewed, she was perhaps the most well placed to deliver health-related teaching, given that she had received more extensive training in the area. Nonetheless, she was also the most keen to further develop her knowledge and skills in this regard. This teacher’s interest may reflect her origins from a more critically-oriented ITT culture, within which health has a more prominent focus (Tinning, 2000). If so, this does raise questions as to what changes to ITT in England might achieve in terms of enhancing health-related teaching.
5.7 The bigger picture: Health-related learning beyond PE and across the whole school

The survey data highlighted that extra-curricular provision was perceived by teachers as making a significant contribution to health-related learning. Indeed, 20 of the respondents (38.5%) stated that it contributed extensively, whilst the remaining 32 (61.5%) considered it as contributing to a reasonable extent. These findings were corroborated in the interviews, within which all of the teachers similarly expressed that extra-curricular provision made a significant contribution. A further finding was that teachers perceived extra-curricular provision to be an important context within which to address the curricular aim of promoting healthy, active lifestyles. Indeed, for some of the teachers, it was reported to be a more important context than curricular PE, as exemplified by the following quotations:

*I think it (extra-curricular provision) is really important for teaching pupils about being healthy and active – it’s like giving them chance to practice going to a sports club or something (CS2-T5)*

*I think we actually meet the aim of promoting healthy, [active] lifestyles through it, to be honest. I mean it’s all about giving them opportunities to be active, so what better than a club at lunchtime or after school (CS1-T2)*

The proposition by teachers that this statutory curricular aim could be met by means of extra-curricular provision could be considered somewhat contradictory. Whilst there are evident links between the aim and extra-curricular provision (or rather, pupils attending this), it should perhaps not be considered as the most significant context within which teachers emphasise learning about healthy, active lifestyles. This is particularly the case as teachers within both the survey and the interviews noted that, whilst extra-curricular provision was ‘open to all’, opportunity did not necessarily equate to access. Indeed, the majority of the survey respondents (55.8%) expressed how they did not feel that extra-curricular provision provided opportunities that all pupils could access and engage in. Similarly, within the interviews, teachers variously described how extra-curricular provision (whilst often well attended) was accessed by the same pupils each time:
The [extra-curricular provision] we have is extensive, but not all access it. It’s the same ones, you know, that actually engage in lessons, and they’re the ones that come along every week, and often multiple times (CS2-T2)

It’s open to all – but that doesn’t mean that they all attend it. You tend to find as well, that the ones that would benefit the most from it, are the ones that don’t attend at all (CS1-T1)

It would seem that, in this regard, little has changed since early work by Penney and Harris (1997, p. 41) who proposed that extra-curricular provision provides ‘more of the same, for the more able’. However, this could be somewhat problematic with consideration of the present study. Evidently, whilst extra-curricular provision might be able to support pupils in leading healthy, active lifestyles through the provision of opportunities to be active, and whilst there may well be opportunities for health-related learning to take place, health-related content is unlikely to be taught explicitly within it. As such, though it may be able to contribute to pupils’ health-related learning, this should be in addition to curriculum PE. In addition, if some teachers are using extra-curricular provision as the key context to work towards the aim of ensuring that all pupils lead healthy, active lifestyles, some pupils may be ‘missed’ as not all access it. Indeed, as discussed in sub-section 2.3.1.1, PE has long legitimated its potential to educate pupils about health based on the ‘reach’ that it has (Cale, 2000). Evidently though, if this aim is not being worked towards sufficiently within curricular PE, this ‘reach’ may not be being used to its full potential. It could also be argued that these findings further support the proposition discussed in section 5.4, that teachers perhaps have a lack of educative expectation with regard to the aim of promoting healthy, active lifestyles. It would seem that for many, meeting this aim is more concerned with providing opportunities for pupils to be active, than equipping them with the necessary knowledge, skills, behaviours and experiences to do so.

In considering health-related learning beyond PE and extra-curricular PE, it seemed pertinent to explore how the area was addressed more broadly across schools. The survey highlighted that there was significant variance, in terms of whether schools had a coordinated (or rather, whole-school) approach to health or not. Of the 52 respondents, 15 (28.8%) reported that they had a whole-school approach to health, 14 (26.9%) reported that they did not, and the
remaining 23 (44.2%) reported that they were unsure/did not know. At both case study schools, teachers reported that there was not a whole-school approach to health. For most of these teachers, it was felt that, consequentially, responsibility for delivering health-related learning fell to PE (discussed further in section 5.8). Of these teachers, many felt that a whole-school approach to health would be useful in order to ensure that health-related learning was well coordinated, particularly in relation to cross-curricula coverage.

With regard to cross-curricula coverage, teachers (on both the survey and within the interviews) were also asked how much they knew about health-related learning in other curriculum subjects. The survey data highlighted that, again, there was some variance. Whilst 23 respondents (44.2%) stated they were aware, 27 (51.9%) were unsure/did not know, and the remaining two (3.8%) were not aware. Of those respondents who were aware, the most frequently reported subjects that they recognised as contributing to pupils’ learning in this area were PSHE, science and food technology. Similar findings were evident from the interviews with all teachers expressing at least some uncertainty as to what content was covered and within which curriculum subjects. Indeed, during several of the discussions, teachers expressed concern and/or guilt regarding their lack of awareness. For example, two teachers stated:

I have to be honest, I don’t really know what is covered and where... I mean, I can guess, like, they’ll probably cover the body in science, the skeleton and the muscles. But that’s all guess work on my part. I probably should know more about it than I do really (CS2-T3)

I’m not at all aware. I could maybe guess, but I don’t know for sure. That’s pretty bad isn’t it? But I just don’t know (CS2-T5)

Whilst whole-school approaches to health, or even awareness of health coverage at a cross-curricula level are not necessarily indicative of an effective approach to health-related teaching within schools, it could be argued that their presence does imply broader coverage of the topic and more ‘joined up’ working, which may better support pupils’ health-related learning (Harris and Cale, 2018).
5.8 Whose job is it? Responsibilities for health-related teaching and learning

It became evident within the teacher interviews that whilst all teachers felt responsible for pupils’ health, this was to varying extents, with some considering it to be the most important part of a PE teacher’s role:

*I think PE teachers have the biggest role to play when it comes to promoting healthy, active lifestyles* (CS1-T1)

*It’s key… if you’re a PE teacher, there has to be an expectation that you’ll encourage pupils to be healthy* (CS1-T4)

In expanding on this, one teacher (CS2-T4) justified this for three key reasons, namely: the need to educate pupils about health, their knowledge in relation to this, and the opportunity to do so, stating:

*Well… firstly, it’s something they need to be taught, you know, they need to get those messages. Secondly, we’re PE teachers, we have that knowledge. Thirdly, we have the opportunity to teach them about health within lessons. So, really, we’re well placed to deliver those messages* (CS1-T4)

Underlying teachers’ talk around being responsible for ensuring that pupils lead healthy, active lifestyles were notions of role-modelling. Indeed, when discussing their responsibilities, almost all teachers within the interviews articulated (in one way or another) how it was important for PE teachers to lead healthy, active lifestyles as pupils looked to them as healthy, active role models who ‘led by example’. For example, two teachers stated:

*I think they look up to us; we’re considered role models for them in that regard. You know, they expect us to healthy* (CS1-T1)

*I mean, if you’re a PE teacher, there’s an expectation that you’re going to be healthy. You lead by example in that respect* (CS2-T2)
There were evident links between teachers’ talk around being a role model and the ‘expert’ position that many of them assumed in discussing their health-related knowledge (as discussed in sub-section 5.6.3). However, despite many teachers considering themselves to be role models, some contested the extent of the responsibility they should assume with regard to ensuring that pupils lead healthy, active lifestyles. Indeed, whilst some felt it reasonable to assume considerable responsibility, others typically described parents as being largely responsible for their children’s health and in doing so positioned them as ‘caregivers’ with responsibility for raising a ‘healthy’ child.

_We do our best, but we can only do so much... their parents have to take responsibility for them. At the end of the day, it’s the parent that puts the plate in front of them at dinner time, and it’s them that decides what’s on it (CS2-T2)_

_I think we have some responsibility but not all. They (the pupils) spend most of their time with their parents; they’re with us for about two hours a week... we can’t be expected to fill gaps of poor parenting (CS2-T1)_

Whilst it is not surprising that teachers positioned parents in this way, it does somewhat contradict their own positionings in terms of ‘expert’ and ‘role model’ and has implications for their opportunities for action. Indeed, by conceptualising themselves as somewhat passive within the process of educating children about health, they may well be downplaying the positive influence that they could well have, within the PE context.

**5.9 Conclusion**

This chapter has sought to provide an overview of the current context of health-related teaching within PE in secondary schools in England and in doing so has addressed one of the study’s secondary research questions (SRQ-1). Initially, it was highlighted that whilst the majority of schools that participated in the study had departmental policies linked to health-related teaching, these were not necessarily implemented, potentially on account of the limited awareness of them within PE departments. Further, it was identified that whilst the
vast majority of teachers purported to value health, this was not necessarily reflected in terms of the time allocated to it within curricular PE.

This chapter has described the ways in which teachers approach health-related teaching within the PE curriculum. It outlined that a combined approach, comprised of permeated and focused elements, was the most commonly used and that reproductive teaching styles characterised much of teachers’ delivery within health-related learning. It has also highlighted that there seemed to be a lack of educative expectation in relation to the NC aim of ensuring that all pupils lead healthy, active lifestyles. Indeed, teachers described a rather superficial coverage of the area that seemed more concerned with providing opportunities to be active than educating and equipping pupils with the relevant knowledge, skills, behaviours and experiences to do so. Teachers’ approaches were also heavily fitness-focused leading to a lack of breadth in coverage. In line with this, performative notions were evident in much of teachers’ talk and they placed much emphasis on both fitness testing and examination-based PE with regard to teaching about health.

Following this, it was explained that most teachers sought to convey messages to pupils about how to be healthy (or rather, how not to be unhealthy). An interesting notion emerged from within this, namely ‘negative talk’. This notion relates to the way in which teachers conveyed health-related messages to pupils and tendency of these to be from a negative/deficit perspective. Indeed, rather than informing pupils what to do to be healthy, teachers generally reported how they informed pupils what not to do to be healthy. However, it was highlighted that some worrying notions were evident within teachers’ talk, relating to weight management, tracking/surveillance and normalising pain and these were duly considered.

Teachers’ perspectives on pupils’ health-related knowledge were explored and it was explained that all teachers considered their pupils’ knowledge to be superficial/limited, with many noting specific examples of misinformation that pupils had espoused. It was outlined that teachers largely drew upon three key sources of information for health-related teaching, namely: personal experiences, training and the media. A notable finding was teachers’ lack of engagement with health-related CPD, and the perceived lack of need for it. The reasons for this were explored and it was suggested that this was likely due to teachers’ perceived ability in teaching within the area, based on their personal experiences and training (particularly at undergraduate level).
The broader landscape of health within schools was explored and particular attention was paid to the role that extra-curricular provision was perceived to play in meeting the NC aim of ensuring that all pupils lead healthy, active lifestyles. Subsequently, whole-school approaches and cross-curricula subject coverage were examined, highlighting considerable variance between contexts. Finally, consideration was given to who teachers perceived to be responsible for ensuring that pupils led healthy, active lifestyles. Whilst all teachers felt that they had some responsibility (at least), much emphasis was placed on the responsibility of children’s parents in this regard.

The subsequent chapter explores pupils’ conceptions of ‘health’ in PE, making links between these and the context of health-related learning, as discussed within this chapter.
Chapter 6: Talking the talk? Pupils’ conceptions of ‘health’ and being ‘healthy’

6.1 Introduction

This chapter analyses and discusses the data from phases two and three of the study and addresses the study’s primary research question (PRQ):

What are pupils’ conceptions of ‘health’ within PE?

Initially, pupils’ conceptions of ‘health’ in PE are explored broadly, before the most prevalent features of their conceptions are considered in more detail. Specifically, the corporeal focus and aesthetic orientations of these are examined. With regard to the former, the role of diet and exercise within pupils’ conceptions is described. In relation to the latter, the notion of weight and its position within pupils’ conceptions is debated. The discourses that have influenced pupils’ conceptions are subsequently explored and, accordingly, the sources of information that pupils draw upon in formulating their conceptions of ‘health’ are outlined. Finally, the chapter concludes by considering the potential for pupils to develop more holistic conceptions of ‘health’.

In reporting the data within this chapter, it was deemed important to give some indication as to the scale of the findings relative to the sample in line with the work of other researchers (e.g. Burrows, Wright and McCormack, 2009; Harris et al., 2016). As such, the findings are reported in relation to the proportion represented by the responses. An approach akin to that used by Harris et al. (2016) is employed, whereby specific terms relate to a specific proportion, namely: almost all (> 90%), the vast majority (≥ 76%, ≤ 90%), most (≥ 51%, ≤ 75%), many (≥ 31%, ≤ 50%), some (≥ 10%, ≤ 30%) and few (< 10%).

The pupils have each been assigned a code that indicates their respective school, in order to ensure that these can be identified within the reporting and discussion of the data (as was the case for teachers within chapter 5). For example, the code CS1-P1 designates pupil number 1 from case study school 1.

6.2 Putting it simply: Pupils’ conceptions of ‘health’ and being ‘healthy’

The data highlighted remarkably consistent findings in relation to pupils’ conceptions of ‘health’. Indeed, pupils at both schools, regardless of gender, ethnicity and/or social class,
conceptualised ‘health’ remarkably similarly. Evidently, pupils were drawing upon similar discursive resources in forming their conceptions of ‘health’. However, that is not to say that the consistency between pupils’ conceptions was a positive finding, as these were generally found to be reductive, limited and limiting, in line with the work of many researchers (e.g. Desmond et al., 1990; Harris, 1993; Merkle and Treagust, 1993; Harris, 1994; Dixey et al., 2001; Placek et al., 2001; Burrows, Wright and Jungersen-Smith, 2002; Burrows and Wright, 2004; Kulmina, 2004; Wright and Burrows, 2004; Wright, O’Flynn and Macdonald, 2006; Beausoleil, 2009; Burrows, Wright and McCormack, 2009; Keating et al., 2009; Lee and Macdonald, 2009; Rail, 2009; Burrows, 2010; Lee and Macdonald, 2010; Brusseau, Kulmina and Cothran, 2011; O’Shea and Beausoleil, 2012; Burrows and McCormack, 2014; Powell and Fitzpatrick, 2015; Harris et al., 2016).

The physical dimension of health was predominant in pupils’ conceptions, with most conceptualising ‘health’ exclusively within the physical domain, highlighting the reductive ways in which ‘health’ was conceptualised. Similar findings were noted by Burrows, Wright and Jungersen-Smith (2002) who suggested that children and young people have a tendency to conceive health as a corporeal concept. That is to say, they constitute ‘health’ in bodily terms, or as Rail (2009, p. 145) describes ‘things that are done to the body… or that are associated with the body’. Evidently, ‘health’ was something that a person did, it was not so much a state of being, but a state of doing (Rail, 2009). Given the predominance of the physical domain within pupils’ conceptions, and their propensity to articulate ‘health’ as something that a person did, it is perhaps to be expected that diet and exercise featured strongly within pupils’ talk. Accordingly, almost all pupils referred to diet and/or exercise in outlining what ‘health’ meant (albeit it in various ways), as exemplified by the following quotations and figures 6.1-6.3:

*You need to do lots of exercise to be healthy, and you need to not eat bad foods* (CS2-P15)

*A healthy person eats the right foods, and drinks enough water… they’ll do exercise as well, like, they’ll play sports* (CS1-P32)
You can’t eat bad foods, like fatty foods, if you want to be healthy... and you have to exercise a lot, you can’t be lazy (CS1-P5)

If you’re going to be healthy, you need to make sure that you’re getting enough exercise and that you’re not eating the wrong foods (CS2-P45)
Figure 6.1 Health drawing (CS1-P12)
Figure 6.2 Health drawing (CS2-P25)
Figure 6.3 Health drawing (CS2-P42)

- Exercising such as running, jogging.
- Eating healthy meals.
- Eating fruit & a day getting vitamins.
- Heart beating when you run.
Pupils’ tendency to refer to diet and exercise indicated that they regarded these as key moderators of ‘health’. Findings such as these support the work of several researchers (e.g. Burrows, Wright and Jungersen-Smith, 2002; Burrows and Wright, 2004; Burrows, Wright and McCormack, 2009; Rail, 2009; Burrows, 2010) who similarly identified the prevalence of diet and exercise within pupils’ conceptions of ‘health’. Whilst it is positive that pupils recognised the contribution that these factors can make to a person’s ‘health’, there were some concerning notions underlying pupils’ talk (discussed further in sub-sections 6.3.1 and 6.3.2) and it was disappointing to note how few pupils referred to factors related to wider dimensions of health such as the mental, social and emotional domains (discussed further in section 6.5), given their similar potential to contribute to a person’s ‘health’ (Corbin et al., 2010).

Conceptual confusion was also evident, at least to some extent, for most pupils, indicating their reductive, limited and limiting conceptions. For example, many pupils demonstrated confusion around the role that diet and/or exercise played in their health and/or fitness, in line with the work of Placek et al. (2001) and Harris et al. (2016). For example, some pupils described how eating healthily would make them fitter:

- *If you eat fruits and vegetables, they’ll make you fitter* (CS1-P54)

- *You need to make sure that you eat healthily to get fit, so having enough of each food is important* (CS2-P11)

Allied to this, most pupils had difficulty in distinguishing between the concepts of health and fitness and, in trying to do so, often conflated the two:

- *I think being healthy is about keeping fit, like if you’re fit, you’re going to be healthy* (CS1-P12)

- *If you’re healthy, I think it means you’re fit, you’ll be active and be able to do sports and things* (CS2-P13)
Whilst some pupils were able to distinguish between the concepts of health and fitness, where this was the case, they typically considered health to be associated with diet, and fitness to be associated with exercise. However, for most pupils, health and fitness were taken to be synonymous, with one constituting the other. That is to say that, a ‘healthy’ person was fit, and a fit person was ‘healthy’. Burrows, Wright and Jungersen-Smith (2002) express concern about notions such as health equating to fitness, suggesting that children and young people can unproblematically accept such notions, assimilating these within their conceptions of ‘health’. Notions such as these are likely to have resulted from what Foucault (1969) termed discursive formations. Discursive formations result from the assimilation of discourse whereby relations of similarity are emphasised over relations of differences (ibid.). That is to say that, the similarities between these discourses are unduly recognised, with limited attention paid to the differences that exist between them. Pupils’ assimilation of two distinct discourses (namely, health and fitness) served to produce a discursive formation that applied boundaries to their conceptions of ‘health’. As such, the number of ways in which pupils could know and/or practice ‘health’ became limited. Burrows (2010) asserts that discursive formations such as these can limit the number of opportunities that pupils recognise to engage with (and in) ‘health’, and consequentially, certain behaviours can be rendered as preferential. For example, it could mean that pupils consider exercise that is more physically exertive to be ‘better’ than incidental exercise (discussed further in sub-section 6.3.2). Evidently, such discursive formations are likely to have contributed to the pupils’ limited and limiting conceptions of ‘health’.

Dichotomous views were also demonstrated by many pupils in relation to ‘health’ which further highlights their reductive conceptions. Pupils seemingly positioned a person as being either ‘healthy’ or ‘unhealthy’ dependent on their health-related behaviours (typically associated with their diet and exercise), as exemplified by the following quotations and figures 6.4-6.6:

*I think if you’re doing enough exercise and making sure you eat the right foods, you’ll be healthy* (CS1-P5)
If you aren’t doing any exercise or if you eat like, lots of bad foods, you’re going to be unhealthy (CS2-P45)
Health

Figure 6.4 Health drawing (CS1-P3)
Figure 6.5 Health drawing (CS1-P43)
Figure 6.6 Health drawing (CS2-P12)
Pupils’ conceptions of ‘health’ in line with a ‘healthy/unhealthy’ dichotomy is somewhat troubling, particularly given the perspicuity with which these were constituted. Rail (2009) proposes that pupils adopt subject positions relative to such states of being, with a ‘healthy’ positioning evidently being preferential. However, such conceptions are inherently limited, given that very few, if any, pupils will attain a ‘perfect’ state of health (ibid.). Further, those pupils who are positioned as ‘unhealthy’ could be marginalised as a result of their health status, given the assumptions made about those who are ‘unhealthy’ (discussed further in sub-section 6.4.2).

Allied to this, pupils were relatively prescriptive in terms of how a person does ‘health’. Generally, they were able to provide extensive lists of what a person should and should not do to be ‘healthy’ (discussed further in sub-sections 6.3.1-6.3.3). Interestingly though, many pupils were able to describe more behaviours that should be avoided than behaviours that should be engaged in. That is to say, they spoke more of the things that they should not do, to be ‘healthy’, than the things that they should. For example, pupils stated:

- You shouldn’t eat junk food if you want to stay healthy. You shouldn’t have fatty foods and things, they’re really bad for you (CS1-P22)
- It’s not good for you to sit down on the sofa and not do anything but like play on your PlayStation or your Xbox, you shouldn’t do that (CS2-P4)
- You can’t have sugary drinks... they’ll make you all unhealthy (CS1-P17)
- You shouldn’t smoke or drink, or do drugs, they’re all really bad for you, like, really bad (CS2-P28)

Pupils described the behaviours required to be ‘healthy’ with much certainty and clearly distinguished between behaviours that they considered to be ‘healthy’ or ‘unhealthy’. Burrows and Wright (2004) noted similar findings within their work, suggesting that children and young people delineate ‘a remarkably clear line between healthy and unhealthy [behaviours]’ (p. 201). Whilst it is positive that pupils are able to distinguish between what might be considered ‘healthy’ or ‘unhealthy’ behaviours, the certainty with which they do so
may be problematic. Indeed, it would seem that most pupils assumed that engaging in, or avoiding, certain behaviours will make them ‘healthy’. However, as Burrows, Wright and Jungersen-Smith (2002) assert, there can be much uncertainty in the pursuit of ‘health’ and children and young people need to be cognisant of this (discussed further in section 6.6).

The tendency of pupils to outline behaviours that should be avoided, as opposed to engaged in, suggests that they are orientating their conceptions of ‘health’ from a negative perspective. Wright and Burrows (2004) noted similar orientations in pupils’ conceptions of ‘health’, highlighting the prevalence of the word ‘don’t’ in pupils’ talk around health-related behaviours. Whilst this might not seem to be particularly concerning, when considered in relation to the relative lack of reference to pleasure within pupils’ conceptions of ‘health’ (discussed further in sub-section 6.5.1), it is rather disconcerting. In addition, it further evidences that pupils’ conceptions of ‘health’ were not only limited but limiting.

Evidently, pupils’ conceptions of ‘health’ were found to be reductive, limited and limiting and concerns have been expressed with regard to these. The subsequent section explores pupils’ conceptions of ‘health’ in further detail, focusing specifically on the physical dimension of ‘health’ which featured strongly within their conceptions.

6.3 Getting physical: Corporeal notions and the practice of doing ‘health’

Pupils constituted ‘health’ as something that a person did, not something that a person was and, as discussed in section 6.2, they provided extensive lists of what a person should and should not do for their health. With pupils’ conceptions of ‘health’ being predominantly corporeal, the vast majority of the behaviours that pupils outlined related to the physical dimension of health and specifically, diet, exercise and hygiene/habits. Accordingly, these are each discussed in detail within sub-sections 6.3.1 – 6.3.3.

6.3.1 Making a meal of it: Diet and health(iness)

Diet featured strongly within pupils’ talk around ‘health’ and pupils variously referred to what a ‘healthy’ person should/should not eat and/or drink. Whilst a few pupils simply stated that to be ‘healthy’, a person should ‘eat healthy foods’, most were able to elaborate and provide specific examples of foods and/or drinks that they considered to be ‘healthy’ or ‘unhealthy’. ‘Healthy’ foods and drinks typically reported by pupils included: fish, poultry and lean meats;
wholemeal breads, cereals and pastas; fruit and vegetables; and water. Contrastingly, ‘unhealthy’ foods and drinks included: non-lean meats; dairy products; chocolate and sweets; and carbonated drinks. ‘Junk food’ was a popular phrase used by pupils to describe ‘unhealthy’ foods and drinks, as were the terms ‘fatty’ and ‘sugary’ (referring to foods and drinks high in these particular nutrients), as exemplified by the following quotations:

Fatty foods are really unhealthy... like, burgers and pizzas and chips and things (CS1-P8)

Sugary foods, like chocolate and sweets, they’re unhealthy... and fizzy drinks too, they’ve got a lot of sugar in! (CS2-P6)

In addition to stating what foods and drinks should/should not be eaten or drunk, many pupils also placed emphasis on the types and amounts of food and drink that should be consumed stating, for example:

You need to eat lots of fruit and veg[etables], especially dark green ones, they’re the best ones for you (CS1-P16)

You should drink lots of water, that’s really important for your body, at least eight glasses a day (CS2-P52)

The concept of a ‘balanced diet’ featured within many pupils’ talk around the consumption of food and drink, and there were two ways in which this manifested. Firstly, many pupils made explicit reference to needing to have a ‘balanced diet’ in order to be a ‘healthy’ person, with public health resources such as the Eatwell Guide (NHS, 2016) being frequently cited by pupils. Secondly, a few pupils referred to limiting the consumption of certain foods or drinks (on account of their perceived ‘unhealthiness’) highlighting some familiarity with the notion of moderation:

It’s not that you can’t have chocolate, you can, but just, you can’t have it every day... like you could maybe have it once or twice a week (CS1-P12)
You can have fizzy drinks, they’re not good for you, but you can have them. You shouldn’t have them every day though, that wouldn’t be healthy (CS2-P52)

Whilst references to moderation were implicit and infrequent, they did highlight the capacity of these pupils to challenge and be critical of the healthy/unhealthy dichotomy, at least to some extent (discussed further in section 6.8). Nonetheless, it was evident that the vast majority of pupils’ conceptions of what constituted a ‘healthy’ diet were limited.

Pupils clearly distinguished between what they considered to be ‘healthy’ and ‘unhealthy’ foods and drinks, with most articulating this in terms of ‘good’ or ‘bad’, in line with the dichotomous views discussed within section 6.2. Further, some pupils articulated this in terms of ‘right’ or ‘wrong’, with notions of a moral obligation to consume or not consume certain foods and/or drinks being evident within pupils’ talk (discussed further in section 6.6).

Pupils’ conversance with several key recommendations related to ‘healthy eating’ was noteworthy, particularly their familiarity with the ‘5-a-day’ guideline (in relation to the consumption of fruit and vegetables) (PHE, 2016a). For example, two pupils stated:

- You’re supposed to eat five fruits and veg[etables] every day, and they should all be different (CS1-P33)
- If you want to be healthy, you have to have at least five fruits and veg[etables] a day, so you could have maybe two fruits and three veg[etables], or more, but at least that (CS1-P9)

It would seem that the messages proliferated by public health campaigns/programmes (such as Change4Life⁹) had been drawn upon by pupils in formulating their conceptions of ‘health’ as related to diet and these were evidently one source of information that the vast majority of pupils were accessing and/or being influenced by (discussed further in section 6.7). Pupils’ familiarity with such recommendations arguably evidences that public health campaigns/programmes can be effective in transmitting key health-related guidelines to

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⁹ Change4Life is a public health campaign/programme in England, run by the Department of Health (DoH).
children and young people. However, pupils’ uncritical acceptance of these could be somewhat problematic, particularly given how clearly most pupils distinguished between ‘good/right’ and ‘bad/wrong’ foods and drinks. Whilst such guidelines are evidently well intentioned, they can be misinterpreted and can consequentially promote normative conceptions of ‘health’ (as related to diet) that may not be congruent with pupils’ lived experiences. Indeed, as Burrows, Wright and McCormack (2009, p. 164) suggest, ‘what is regarded as ‘right’ and ‘wrong’ food [and drink] shifts over time and across contexts and… is inevitably contoured by class and cultural preferences’. This is particularly noteworthy as despite there being significant differences between pupils’ socioeconomic status and cultural backgrounds, both within and across the two case study schools, their conceptions of what it meant to be ‘healthy’ were remarkably similar. In addition, there is evidence to suggest that messages proliferated by public health campaigns/programmes have been used to ill-effect by some children and young people. It has been noted by several researchers (e.g. Rich, Holroyd and Evans, 2004; Aphramor, 2005; Evans et al., 2008b) that children and young people, girls and young women in particular, can become ‘obsessed’ with consuming ‘healthy’ foods and drinks, which can lead to the development or exacerbation of disordered eating and eating disorders. Evidently, attention must be paid to the ways in which such messages are assimilated within pupils’ conceptions of ‘health’ (discussed further in section 6.7).

Diet was a significant aspect of pupils’ conceptions of ‘health’ and, as has been noted, so too was exercise. However, as discussed within the following sub-section, pupils’ familiarity with health-related messages, at least those proliferated through public health campaigns/programmes, was less evident in relation to exercise.

6.3.2 Feeling the burn: Exercise and health(iness)

Exercise also featured strongly within pupils’ talk around ‘health’ and, as with diet, various references were made by pupils as to what a ‘healthy’ person should/should not do. Almost all pupils considered exercise to be a ‘healthy’ undertaking. For example, pupils stated:

You need to stay healthy by doing lots of exercise (CS1-P22)

Exercise is really important to be healthy (CS1-P35)
I think it’s important to do lots of sports to be healthy, there’s loads you can do! (CS2-P5)  

If you don’t exercise, you won’t be healthy (CS2-P16)

The vast majority of pupils were able to elaborate and provide further details relating to the form, duration, frequency and intensity of exercise that a person should engage in. With regard to form, it was notable that, for most pupils, exercise equated to fitness-based activities (typically, running) and/or organised sports, such as cricket, football and hockey:

Exercise means like running and stuff, it’s about doing things that get you fitter (CS1-P3)

If you’re going to be healthy and do exercise, you need to be playing sports, like football or rugby (CS2-P47)

On account of this, many pupils discounted more incidental forms of activity. For example, two pupils stated:

It has to be running to be good for you, not just walking, that doesn’t get your heart beating fast enough (CS1-P39)

Exercise should make you out of breath, so you need to be running fast enough for that, if you want to get fitter (CS1-P50)

Harris et al. (2016) similarly noted that pupils tended not to regard incidental forms of activity as beneficial, particularly those that might be accumulated over the course of a school day (for example, walking to and from school, or playing in the playground at break times). As such, it may be that many children and young people are not recognising the various ways in which they might be active and as such may not be engaging in as many opportunities to be active as they might. At both case study schools, health-related learning was predominantly addressed through fitness-focused units and games-based activities, which dominated their
respective PE curricula (as discussed in section 5.4). It has been noted by several researchers (e.g. Cale and Harris, 2006; Garrett and Wrench, 2008; Alfrey, Cale and Webb, 2012) that such an approach can limit pupils’ learning and as such may not be the most effective approach to adopt. On this note, it is likely that pupils’ conceptions around the forms of exercise that are ‘healthy’ have been influenced by/through their fitness-focused experiences of curricular PE. Indeed, teachers themselves suggested that this may explain why pupils constituted exercise in such a way (discussed further in section 7.3).

With regard to the duration and frequency of exercise, there was much variance (and little consensus) amongst pupils about how long a person was supposed to be active for, and how regularly (in line with UK government guidelines\(^1\)). Pupils’ suggestions in relation to duration ranged from as little as 15 minutes to as much as 4 hours per day. Whereas, in terms of frequency, whilst many pupils felt that a person should be active on a daily basis, some considered that they need only be active on three or five days per week. Seemingly, pupils demonstrated little awareness of the ‘60 minutes-a-day’ recommendation (PHE, 2016b). Allied to this, pupils were also uncertain as to whether exercise could be accumulated over the course of a day, or whether this needed to be continuous and amassed within a single bout:

I’m not really sure if you can do it bit by bit, I think you can, but I think it’s better if you do it all in one go (CS1-P12)

You need to do it all at the same time, otherwise your heart slows again and it’s not as good for you (CS2-P10)

It would seem that, despite efforts to provide consistent recommendations for children and young people in relation to exercise (Cale and Harris, 1993, 2001), pupils’ awareness of these recommendations is limited, as has been noted by several researchers (e.g. Roth and Stamatakis, 2010; Harris et al., 2016). Accordingly, Harris and colleagues (2016) express

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\(^{10}\) It is acknowledged that the recommendation of ‘60 minutes-a-day’ has been questioned by some (e.g. Gard and Wright, 2005; Campos et al., 2006), based on the causal links proposed between prescribed amounts of exercise and the achievement of health. However, given that this is a government recommendation that is in line with recommendations globally, it is adopted as a guideline within the present study.
disappointment that pupils are so unfamiliar with these guidelines, given that they have been in place for a significant period of time. Pupils’ lack of familiarity with these guidelines is also somewhat perplexing given how conversant they were with recommendations related to diet (as discussed in sub-section 6.3.1). Arguably, this might indicate that public health campaigns/programmes (and the media, broadly) place more emphasis on diet, as opposed to exercise.

Underlying pupils’ conceptions of ‘health’, in relation to exercise, were some disconcerting notions associated with exercise duration, frequency and intensity. Whilst pupils variably described how active they should be, the vast majority considered that ‘the more you do, the better’. Further, the vast majority of pupils also expressed how exercise ‘had to be hard, to be good’. Notions such as these have been identified within early work (e.g. Desmond et al., 1990; Harris 1993, 1994) and later work (e.g. Burrows, 2010) suggesting that such misconceptions are a persistent problem. On this note, Burrows (2010) expressed particular concern about how notions such as these might render pupils’ experiences of exercise as something that is ‘exhausting and unpleasurable’ (p. 152) which was the case for some within the present study (discussed further in sub-section 6.5.1). In addition, and as referred to in the previous sub-section, pupils’ talk evidenced notions of a moral obligation to exercise (discussed further in section 6.6).

Pupils’ talk around exercise also extended to discussing inactivity, with pupils readily identifying a number of sedentary activities that were ‘unhealthy’ including: watching television, playing video games and sitting on the sofa. However, this is discussed further in sub-section 6.4.2. The following sub-section considers the place of hygiene and habits within pupils’ conceptions of ‘health’.

6.3.3: Keeping it clean: Hygiene, (un)healthy habits and health(iness)

Pupils made very few references to hygiene and the role it might play in health. Further, the references that were made were typically allied to diet or exercise. For example, pupils referred to brushing their teeth following the consumption of ‘sugary’ foods or drinks, or showering on account of having become sweaty during exercise, as exemplified by the following quotations:
It’s important to brush your teeth to keep them clean and healthy, especially if you’ve had sweets (CS2-P4)

You can get sweaty if you play sports, so you need to make sure you shower after (CS1-P50)

Interestingly, this contrasts with work by Wright and Burrows (2004) and Burrows, Wright and McCormack (2009) which found hygiene to be a prominent feature within most pupils’ conceptions of ‘health’, alongside diet and exercise. This could be reflective of the different curricula that pupils experience within different countries. Within the HPE curriculum in New Zealand (where the aforementioned research was conducted), ‘bodily care’ (encompassing hygiene) is one of seven key learning areas (MoE, 2014b). Meanwhile, in England, hygiene is not an explicit feature of the PE curriculum, and whilst it features within the PSHEE curriculum, this is a non-statutory subject within the NC in England (DfE, 2013b) and concerns have been expressed about the consistency of PSHEE provision in English secondary schools (Formby and Wolstenholme, 2012). As such, hygiene may not be addressed as explicitly within the curriculum in England as it is within New Zealand. If this is the case, it may highlight the potential effectiveness of curricula (and their enactment) to impact on pupils’ conceptions of ‘health’.

Habits were also referred to by some pupils, in relation to what they considered to be ‘healthy’ and ‘unhealthy’. In terms of ‘healthy’ habits, a few pupils referred to sleep, but only if a person had a ‘good routine’ and ‘got enough hours’ per night. However, almost all of these pupils had difficulty elaborating on why this was ‘healthy’, aside from stating ‘so that you’re not tired’. With regard to ‘unhealthy’ habits, a few pupils referred to consuming alcohol, smoking and taking drugs as behaviours that ‘should be avoided’. For example, two pupils stated:

Smoking is really unhealthy, and if you start, it can be really hard to stop, so you just shouldn’t do it (CS1-P53)
You shouldn’t drink [alcohol] or do drugs, they’re both really bad for you... you can get addicted (CS2-P12)

It is interesting to note how few pupils referred to avoiding ‘unhealthy’ habits such as consuming alcohol, smoking and taking drugs, particularly given their tendency to orientate their conceptions of ‘health’ from a negative perspective (as discussed in section 6.2). However, this may be due to the reduced attention these have received within public health campaigns/programmes (and within the media more broadly) in recent years, with diet and exercise tending to be more of a focus (Burrows, Wright and McCormack, 2009). Arguably though, the age of the pupils participating may have been a contributing factor, given that their age was below the legal limit for smoking/drinking within the UK.

An important point with regard to the aforementioned discussion is the age of the pupils and what can be considered reasonable for them to know with regard to ‘health’. It has been noted in sections 2.4 and 5.3 that the NCPE does not explicitly state what pupils should learn with regard to health. However, as also noted within section 2.4, Harris (2000) produced a publication providing detailed guidance on health-related learning outcomes for each key stage and these have subsequently been adopted in later and more recent publications (e.g. Harris and Cale, 2018). Taking into consideration such guidance, and whilst not intending to refer to the pupils as a homogenous group, nor to present a deficit model of them, it would seem that their health-related knowledge and understandings were generally not at a level that would be considered commensurate with their age/key stage. This is somewhat concerning and raises questions regarding the effectiveness of their health-related learning (discussed further in section 7.4).

6.4 Looking the part? Aesthetic orientations in pupils’ conceptions of ‘health’

A particularly noteworthy finding was the prominence of appearance (taken as a person’s shape, size and weight) within the vast majority of pupils’ conceptions. This is perhaps unsurprising given that pupils conceived ‘health’ as a predominantly corporeal concept (as discussed in section 6.2), though pupils’ talk around appearance in relation to ‘health’ warrants consideration.
The vast majority of pupils considered that a person’s appearance was indicative of their health status. For example, pupils stated:

A healthy person has a fit body, like they’ll be a good shape, maybe with muscles (CS1-P7)

Fat people aren’t very healthy, like if you’re fatter, it’s not good for you (CS1-P45)

Healthy people have a thinner body, like they’re not fat or anything, they’re just a good shape (CS2-P55)

If you’re fat, you’re going to be unhealthy, you can’t be anything else really (CS2-P23)

It was apparent that pupils’ conceptions of ‘health’ placed emphasis on how a person ‘looked’, with most associating thinness with healthiness and fatness with unhealthiness. Findings such as these have been noted by many researchers (e.g. Harris, 1993, 1994; Placek, et al., 2001; Burrows and Wright, 2004; Rail, 2009; Beausoleil, 2009; Burrows, 2010; Lee and Macdonald, 2010; O’Shea and Beausoleil, 2012; Powell and Fitzpatrick, 2015; Harris et al., 2016), all of whom have expressed concern about what they deem to be a simplistic and somewhat fallacious notion. This notwithstanding, there were some pupils who problematised the notion that ‘fat was bad’ and ‘thin was good’. On this note, Dixey et al. (2001) and Rail (2009) similarly identified that some children and young people were critical of such a notion, though they acknowledge that these were in the minority. That said, it does highlight that (some) children and young people have the capacity to challenge simplistic notions related to ‘health’ (discussed further in section 6.8). Disappointingly though, such pupils’ talk was somewhat contradictory in that, whilst they acknowledged that being thin did not necessarily mean that a person was ‘healthy’, most attested that it was better to be thin than to be fat. For example, two pupils stated:

If you’re too thin, that’s not good... but it is better than being too fat (CS2-P23)
It’s not always good to be thin, like it can be bad for you, but it’s better to be thin than fat, that’s worse (CS2-P55)

In line with this, it became evident that, in considering whether a person was ‘healthy’ or not, their weight (or rather, fatness) was a key determinant, as discussed in the following subsection.

6.4.1 Weighing it up: Fatness, fitness and weight as a determinant of ‘health’

The vast majority of pupils indicated that weight was a key determinant of whether a person was ‘healthy’ or not, though typically this was not judged by conventional means (for example, measuring scales). Rather, this was judged by the eyes as pupils variously described how it could be ‘seen’ whether a person was overweight (and as such, ‘unhealthy’):

You can just see if someone is healthy or not; if they’re unhealthy, they’ll be all fat and things (CS1-P37)

If you look at a person, and they’re bigger, well, fatter... you can just tell that they’re not healthy (CS2-P18)

Evidently, pupils were using a person’s weight to determine their health status. Burrows, Wright and Jungersen-Smith (2002) and Beausoleil (2009) noted similar findings, suggesting that pupils described ‘looking’ to see whether a person was of a ‘healthy’ weight or not. Therefore, pupils appeared to constitute a person’s health status as something that can be ‘read off’ the body (Tinning, 1985; Lupton, 1995).

Exercise was described by the vast majority of pupils as the prime means of maintaining a ‘healthy’ weight, with pupils’ talk seemingly constituting it (exclusively) as a tool for weight management:

It’s important to do exercise so that you keep your weight the same, and don’t get fat (CS2-P36)
If you don’t do exercise, you’ll get fat, so it’s good to do lots, so that you don’t (CS2-P38)

It is perhaps unsurprising that pupils readily associated exercise with weight management given the abundance of public and professional discourses that promote and proliferate such associations (Gard and Wright, 2005). In line with this, Evans et al. (2005) note how such discourses have permeated schools (and in particular the subject of PE) and are being assimilated within pupils’ conceptions of ‘health’; they express concern over this, on account of the potential of such associations to lead to the development or exacerbation of disordered eating and eating disorders (ibid.) (as discussed in sub-section 6.3.1). On this note, Harris et al. (2016) propose that curricular PE has a responsibility to ensure that pupils recognise the contribution that being active makes to a person’s health in the broadest sense (discussed further in section 6.5). Again, the PE curricula that pupils experienced at the two case study schools may have been influential in this regard, given their performative foci and the corporeal focus of many of the messages that teachers sought to convey to pupils (as discussed in sub-section 5.4.1 and section 5.4). In addition, there were also a few teachers who explicitly advocated exercise for weight management (as discussed in sub-section 5.5.1), thereby reinforcing such associations. Teachers themselves suggested that this may explain why pupils constituted exercise in such a way (discussed further in section 7.3).

Pupils’ talk around the maintenance of a ‘healthy’ weight is interesting from a Foucauldian perspective. Despite pupils having difficulty in distinguishing between the concepts of health and fitness (as discussed in section 6.2), when discussing weight, the vast majority referred almost exclusively to fitness, as exemplified by the following quotations:

You need to keep your weight in check so that you stay fit, otherwise you’ll get fat (CS1-P3)

It’s important that your weight is good, so you’re fit, not fat (CS2-P15)

It would seem that, in relation to the maintenance of a ‘healthy’ weight, pupils had produced a discursive formation assimilating the distinct discourses of fitness and weight.
Consequently, the number of ways in which they recognised that a ‘healthy’ weight could be maintained were limited. That is to say that, whilst they considered exercise to play a key role, little attention was paid to the role of diet with regard to weight management. This is somewhat surprising, given how prevalent diet was within pupils’ conceptions of ‘health’ (as discussed in sub-section 6.3.1) and it may indicate that pupils had limited comprehension of the notion of energy balance, as identified by several researchers (e.g. Stewart and Mitchell, 2003; Keating et al., 2009; Placek et al., 2011).

The vast majority of pupils regarded a person’s weight as something that needed to be ‘kept in check’ to ensure that they were ‘healthy’ (or perhaps rather, ‘fit’). Given that pupils constituted exercise as the prime means of maintaining a ‘healthy’ weight, it is perhaps to be expected that they considered the amount of exercise that a person participated in to be important. As such, most pupils described how a person needed to ‘check’ on the amount of exercise they were undertaking to ensure that it was sufficient to maintain a ‘healthy’ weight (or rather, avoid fatness). For example, two pupils stated:

*You should check how much exercise you’re doing, so that you know you’re doing enough... if you don’t, it’s really easy to put on weight* (CS1-P9)

*If you’re not careful about how much exercise you’re doing, like if you don’t make sure you’re doing enough every day, you’re going to get fat* (CS2-P15)

Almost all pupils were concerned about becoming fat and felt it necessary for a person to keep their weight ‘in check’. In line with the work of Rail (2009), pupils justified the need for a person to ‘check on’ their weight due to the negative consequences associated with being labelled as fat, discussed further in the following sub-section. The ways in which pupils talked about a person keeping their weight ‘in check’ and the reasons for wanting to do so evidences what Foucault (1990) termed ‘technologies of the self’. These are ‘techniques’ that enable a person to ‘work on’ themselves in order to work towards a happier (and in this case, healthier) ‘self’ (*ibid.*). Within the context of the present study, pupils considered it necessary for a person to ‘check’ their weight and the practices associated with this (namely, exercise) and to take action, if necessary, to ensure that they worked towards being ‘healthy’. There was
an assumption that being ‘healthy’ would lead to a happier ‘self’. However, as discussed within the following sub-section, pupils’ reasons for wanting to enact such technologies are somewhat concerning.

6.4.2 Idle talk: Fatness, unhealthiness and the constituting of laziness

As discussed in the previous sub-section, almost all pupils were concerned about becoming fat, and as a result, most referred to the need to avoid becoming (or being) fat. For example, two pupils stated:

- You don’t want to get fat, that would be really, really bad (CS1-P22)
- It’s not good to be fat, you need to make sure you’re doing exercise and eating right so that you don’t become fat... it’s hard to be fat (CS1-P39)

The negative consequences that constituted pupils’ concerns, and even fears, regarding fat status were plentiful, and whilst they encompassed physical, social and emotional dimensions, those related to social and emotional consequences were the most frequently discussed:

- You don’t get included in things if you’re fat, like people leave you out because they think you’ll not be good (CS1-P31)
- People can tease you if you’re fat, like they make fun of you for being bigger and slower than them (CS1-P45)
- You’d be really sad if you’re fat, because people are mean to you, especially if you do something embarrassing (CS2-P46)
- If you’re fat, you don’t really have any friends, you’re just all fat and on your own (CS2-P58)

Pupils were evidently concerned about being positioned as fat and how they might be treated by their peers. The most common concerns/fears were that they would be teased, taunted,
harassed or bullied and, as a result, they would be made to feel sad and lonely. Findings such as these support the work of other researchers (e.g., Dixey et al., 2001; Burrows, Wright and Jungersen-Smith, 2002; Rail, 2009; Burrows, 2010; Powell and Fitzpatrick, 2015) who identified similar concerns/fears amongst pupils in relation to being positioned as fat. Given how concerned/fearful pupils were, it is perhaps to be expected that, as discussed in subsection 6.4.1, they are resolved to avoid becoming (or being) fat. As Burrows (2010, p. 153) proposes, it would seem that ‘abjection can be a powerful motivator’ in the avoidance of fatness.

Of further concern was that, despite being cognisant of how damaging it might be for a person to be positioned as fat, pupils were inadvertently contributing to the stigmatisation of fat people. Specifically, in discussing what it meant to be fat, many pupils constituted fat people as being lazy. For example, two pupils stated:

*If you’re fat, it’s because you’re not doing enough exercise, so you are just kind of being lazy* (CS1-P51)

*Fat people are always tired and lazy, because they don’t do any exercise, and if they don’t, they just get more fat* (CS1-P3)

The association between fatness and laziness has been noted by many researchers (e.g., Dixey et al., 2001; Burrows, Wright, and Jungersen-Smith 2002; Rail, 2009; Burrows, 2010; Powell and Fitzpatrick, 2015; Harris et al., 2016) and it would seem that this is a persistent problem. Pupils’ talk around the characteristics of fat people highlights their enactment of body pedagogies. As Evans et al. (2008b, p. 401) note, body pedagogies influenced by obesity discourses have ‘particularly strong moral overtones in the notions of the body they prescribe and define. An individual’s character and value, their sense of self, comes to be judged essentially in terms of weight, size, or shape’. In this case, pupils were making assumptions about a person’s character based on their weight status and, in doing so, constituted health as a moral obligation (Gard and Wright, 2005; Tinning, 2010) (discussed further in section 6.6).
The subsequent section explores the wider dimensions of health and their place within pupils’ conceptions.

### 6.5 Missing a trick? The wider dimensions of health and their (potential) contribution to wellbeing

As discussed within section 6.2, pupils predominately conceptualised ‘health’ corporeally with much of their talk relating to the physical dimension of health. However, a few pupils referred to wider dimensions, by discussing mental, social and emotional health. Generally, such references related to being happy or being relaxed. Although, in line with pupils’ tendency to orientate their conceptions of ‘health’ from a negative perspective, these were typically articulated as *not* being sad or *not* being stressed, as exemplified by the following quotations:

*You don’t want to be sad, that’s not good for your health, if you’re feeling down about things* (CS1-P34)

*It’s important to not be stressed, that’s not a good thing... stress can be bad!* (CS2-P4)

There were also a few instances in which pupils’ talk indicated that they considered socialising to be important for a person’s ‘health’, with this typically being articulated as ‘being with friends’. However, such references were infrequent and, in discussing these wider dimensions of health, the focus of pupils’ talk was predominantly on the self (*e.g.* being happy) as opposed to others (*e.g.* being with friends). Similar findings were evident in the work of Burrows, Wright and McCormack (2009) and Rail (2009) who noted the individualistic nature of pupils’ conceptions in relation to these wider dimensions of health. As discussed within the following sub-section, this may be allied to the notions of guilt that pervaded pupils’ conceptions of ‘health’ and the discourses associated with these.

#### 6.5.1 Guilty pleasures: The place of pleasure within pupils’ conceptions of ‘health’

A particularly noteworthy finding was the relative absence of reference to pleasure within pupils’ conceptions of ‘health’. Indeed, few pupils referred to ‘health’ as something that was to be enjoyed. In relation to exercise, pupils variously described how ‘the more you do, the better’ and how it ‘had to be hard, to be good’ (as discussed in sub-section 6.3.2) and, in
relation to diet, many described how foods that many might enjoy eating (such as those considered to be ‘fatty’ or ‘sugary’) needed to be avoided (as discussed in sub-section 6.3.1). Findings such as these, coupled with the perceived need to keep weight ‘in check’ (as discussed in sub-section 6.4.1), meant that exercise and diet became commodified for pupils. In turn, these commodities were linked to the attainment of health, and according to Burrows, Wright and McCormack (2009) and Rail (2009) can lead pupils to a perceive that there is a need for them to ‘work on’ their body. Therefore, it is perhaps understandable that the notion that a person can ‘feel good’ and enjoy their diet/exercise is diminished.

Enjoyment has been widely recognised as a key factor in effective health-related learning (Harris, 2000; Fairclough, Stratton and Baldwin, 2002; Haerens et al., 2011; Harris and Cale, 2018). With consideration of exercise specifically, Harris (2000) proposed seven guiding principles for health-related teaching, with one of these being that pupils should know that ‘exercise can be a positive and enjoyable experience’ (p.18). Clearly, if PE is to work towards meeting the aims set out in the NCPE in England (DfE, 2013a), teachers need to ensure that such messages are promoted to pupils by providing meaningful, relevant and positive experiences. Indeed, teachers themselves expressed that one of the key messages they sought to convey to pupils was that sport, physical activity and PE should be enjoyable (as discussed in section 5.5), though it would seem that many pupils had not ‘heard’ this message. Accordingly, the teachers were (understandably) disappointed to find out about the discord between the messages they promoted and pupils’ conceptions of ‘health’ (discussed further in section 7.2) and as such made recommendations as to how pupils’ health-related learning might be enhanced (discussed further in section 7.6).

Whilst the relative absence of reference to pleasure was disappointing, what was concerning was the motivator that replaced it, namely guilt. It seemed that for many pupils the need to conform to what they constituted as ‘healthy’ practices was significant. Pupils articulated how, if a person did not engage in such practices, they would ‘feel bad’ about themselves:

*If you’re not being healthy, like if you’re eating junk foods, you feel bad about it, because you know you shouldn’t be doing it* (CS1-P46)
The ways in which pupils articulated such feelings of guilt are interesting, in that they were associated exclusively with the failure to engage in individualistic practices for a person’s ‘health’. As such, it seemed that pupils’ conceptions were influenced by healthist discourses, as discussed in the subsequent section.

6.6 Going it alone: Healthist notions in the conception of ‘health’

Healthism evidently influenced pupils’ conceptions of ‘health’ in a number of ways. Firstly, the vast majority of pupils’ talk around how a person might be ‘healthy’ was individualistic in nature (as discussed in sub-sections 6.3.1 – 6.3.3). That is to say that, when pupils described how they could be (or rather, do) ‘healthy’, almost all of the suggested behaviours focused on the individual. Secondly, the vast majority of pupils’ talk described how there was a need to ‘work on’ the body (as discussed in sub-section 6.4.1) which is indicative of healthist discourses which promote health as an individual responsibility and something that an individual should work towards attaining (Powell and Fitzpatrick, 2015). As Rich and Evans (2005) note, discourses informed by healthism lead to ‘individuals [being deemed] largely responsible for their own health and making healthy choices’ (p. 352). Evidently, pupils’ conceptions of ‘health’ were being influenced by these discourses, and they felt compelled to act accordingly:

*But, like, it’s down to you to be healthy though, like... if you’re lazy, that’s your choice, so it’s your own fault you’re unhealthy* (CS1-P20)

*If you want to be healthy, you have to do it for yourself. You need to go do exercise to get fitter, no-one else can do it for you* (CS2-P37)

In addition, pupils’ tendency to outline prescriptive lists of health behaviours (as discussed in section 6.2) is also indicative of the influence of healthist discourses within their conceptions
of ‘health’, demonstrating an acceptance of normative notions of what it means to be healthy (Rail, 2009; Burrows, 2010).

A somewhat problematic (albeit, understandable) finding, in relation to the influence of healthist discourses within pupils’ conceptions was the assumption by many that engaging with health imperatives (such as eating five fruit and vegetables a day) would bring about ‘good health’. For example, one pupil stated:

*It’s not really that hard to be healthy, you just need to make sure you get your 5-a-day and do enough exercise... that’ll make you healthy* (CS1-P20)

Burrows and Wright (2004, p. 203) express concern about pupils’ engagement with such health imperatives, noting how problematic it is to ‘establish a direct and somewhat simplified causal relationship between particular practices and the attainment of health’. Indeed, it creates a certainty which can not only serve to limit pupils’ practices but can also annex pupils for whom engagement in such activities fails to bring about the desired effects (Burrows, Wright and Jungersen-Smith, 2002). This further reinforces pupils’ reductive, limited and limiting conceptions of ‘health’.

The healthist discourses that had influenced pupils’ conceptions of ‘health’ were transmitted to pupils through the various sources of health-related information that they accessed and were subjected to, as discussed within the subsequent section.

### 6.7 Getting mixed messages: Sources of information about ‘health’

Pupils outlined a range of sources from which they received information about ‘health’, which is consistent with the work of many researchers (*e.g.* Burrows, Wright and Jungersen-Smith, 2002; Burrows, 2010; Burrows and McCormack, 2014; Harris *et al.*, 2016). The sources that pupils identified included: parents, siblings, (wider) family, peers, teachers, schools, and various media sources. Media sources, specifically, included: magazines, television, social media platforms (such as YouTube and Instagram) and news-based and/or informational websites (such as BBC News and Wikipedia). For example, pupils stated:
I learn about health from my mum, and my older sister, they tell me things that they learned when they were younger (CS1-P5)

I think you learn mostly about health at school, like your teachers tell you what you need to know about how to be healthy (CS2-P24)

You learn about health from TV programmes and stuff (CS1-P52)

You can watch videos on YouTube about how to get fitter (CS2-P15)

Whilst a range of sources were identified by pupils, parents were the most frequently cited sources of health-related information, with pupils typically describing how they considered parents to be a useful source as they: were knowledgeable in terms of health information (having learned this themselves, when they were younger); were readily accessible (in that they spent most of their time with their parents, when not at school); and would act in their best interests (so they would not (intentionally) misinform them). For example, two pupils stated that:

I think parents are a good source because like, they’ve already grown up and learned how to be healthy, which is what we need to do. So, they know what’s good for you and what’s bad for you and they can tell you (CS1-P5)

You live with your parents, so like, if you’re at home and you need to ask about being healthy, they’re just there, and you can trust them too... they wouldn’t lie to you as they’re meant to look after you (CS2-P12)

Teachers, and schools more broadly, were also reported by pupils as a key source of information. Pupils positioned teachers as knowledgeable in terms of health information (as they too, were adults) and as responsible (given that their job was to educate):
Teachers are like your parents too... they’ve learned how to be healthy and so they can tell you too (CS1-P3)

It’s kind of their job though... they’re supposed to teach you things so that you can learn (CS2-P36)

Interestingly though, despite pupils identifying teachers (and schools) as key sources of health-related information, the subject of PE was not perceived by most to make a particularly significant contribution in this regard:

PE is about playing sports and stuff... like, you learn how to play different sports, which is good, but they don’t teach you about being healthy (CS1-P3)

You don’t learn about being healthy in PE, it’s more about doing sports (CS2-P36)

It would seem that these pupils did not necessarily associate health-related learning with PE. Generally, such pupils considered PE as a context within which they could learn about (and play) sports, and they did not recognise the potential of the subject to contribute beyond this. Evidently, pupils had a lack of educative expectation with regard to PE, which is disappointing given that there is a curricular expectation that the subject will support pupils’ health-related learning (DfE, 2013a). Unsurprisingly, teachers expressed concern regarding this, not least because they considered that they were delivering health-related content within PE (discussed further in section 7.2).

Whilst pupils identified parents and teachers as key sources of health information, it was difficult to definitively discern which (of the many) sources they deemed to be the most salient. This was particularly so given that pupils generally outlined multiple sources, and most had difficulty in identifying from where they had learned specific information. It was clear, however, that the range of sources that pupils accessed and were subject to resulted in confusion for many, often on account of the contrasting/conflicting information they provided:
I just don’t know what’s right sometimes… you might watch something on TV that says that doing this is good for your health, but you could read something that tells you the opposite! (CS1-P14)

It’s hard when one person tells you one thing, and someone else tells you something different – what do you do if your mum tells you this food is healthy, but your teacher says it isn’t? (CS1-P29)

Harris et al. (2016) note how receiving information from a range of sources can be problematic for pupils as it can present challenges with regard to formulating their conceptions of ‘health’, particularly when these sources are contrasting/conflicting. As such, these messages may further compound pupils’ confusion with regard to ‘health’.

Whilst many pupils were confused by some of the health-related messages they were receiving, it was apparent that some messages had been well received and had been assimilated within pupils’ conceptions. Typically, these related to what would be considered as public health messages (such as eating 5-a-day, in relation to fruit and vegetable consumption). Burrows and McCormack (2014) note how such messages have permeated both the formal and informal contexts of pupils’ learning and lives. Indeed, in a context replete with such messages, it is not surprising that pupils are so conversant with these. However, whilst pupils’ familiarity with such information might seem positive, some researchers have expressed concern with regard to this (e.g. Rich, Evans and De Pian, 2011; Welch and Wright, 2011; Burrows and McCormack, 2014). Indeed, as Burrows and McCormack (2014, p. 161) highlight, ‘given the multiplicity and ubiquity of these messages’ there are challenges in ‘disrupting or resisting the call of public health imperatives’.

The veracity of such messages, and the certainty with which pupils accept these can be problematic in that they can result in reductive, limited and limiting conceptions of ‘health’, defined largely by public health messages. However, as discussed in the subsequent section, some pupils were able to engage more critically with these messages, with PE arguably having a role to play in this regard.
6.8 Muddying the waters: Disrupting normative notions of ‘health’

Despite most pupils having rather limited conceptions of ‘health’ that conformed to normative notions (those largely influenced by healthist discourses), some were able to disrupt these and to problematise what it meant to be ‘healthy’. For example:

*But, if you don’t eat your 5-a-day, it’s not going to kill you, is it? Like, it’s probably better if you do, it’s going to be good for you, otherwise they wouldn’t recommend it, but it’s not that important* (CS2-P43)

*I think with exercise though, it’s about what feels right for you too… you might not be able to do 60 minutes in one day, but even doing 15 helps* (CS1-P33)

Burrows (2010) similarly highlighted that children and young people have the capacity to disrupt such notions and to recognise the potential limitations of these which is promising, in that it demonstrates pupils’ capacity to question and be critical of normative notions of ‘health’. Whilst it is accepted that there are guidelines as to what might promote and support a ‘healthier’ lifestyle, it is important to recognise that these are guidelines, not gospels. As Burrows and McCormack (2014, p. 168) suggest:

‘[Pupils’] questioning of and critique of public health missives can be read as emancipatory, as indicative of inquiring minds interrogating the extent to which these missives do or do not mesh with what they know about themselves, their families and their communities’

Evidently, PE has a role to play in fostering critical perspectives within pupils, in order to support them in working towards leading healthy, active lifestyles, in line with the NCPE aim (DfE, 2013a). Such critical perspectives would support pupils in appraising the health-related information that they access and are subjected to and could support them in developing critically-inclined conceptions of ‘health’. A shift towards a socio-critical PE curriculum has
already taken place in countries such as Australia and New Zealand (Bowes and Bruce, 2011; O’Connor, Alfrey and Payne, 2012; Leahy, O’Flynn and Wright, 2013) and a similar shift in England could be a positive step. Whilst it is yet to be seen whether such curricula have an impact on pupils’ conceptions of ‘health’ in these countries, the approach is promising. However, that is not to say that it is just curricular changes that could support pupils to develop critically-inclined conceptions of ‘health’ as, even without this, teachers can adopt alternative pedagogical approaches that might foster such conceptions (as discussed within section 7.6).

6.9 Conclusion

This chapter has explored pupils’ conceptions of ‘health’ and, in doing so, has addressed the primary research questions of the study (PRQ). It highlighted that pupils’ conceptions of health were reductive, limited and limiting. ‘Health’ was conceived as a corporeal concept by the vast majority of pupils, with much emphasis placed on the physical domain. In addition, most pupils demonstrated conceptual confusion (at least, to some extent) and had difficulty in distinguishing between the concepts of health and fitness. Pupils were acknowledged to have relatively dichotomous views that labelled a person as being either ‘healthy’ or ‘unhealthy’ with little recognition of the state(s) that might exist between these. The notion of ‘negative talk’ was highlighted and it was noted that pupils had a tendency to outline what not to do to be healthy, rather than what to do.

The chapter subsequently examined the corporeality of pupils’ conceptions in detail, and in doing so the key components of this (diet and exercise) were explored. With regard to diet, it was found that pupils had a tendency to label foods as ‘healthy’ or ‘unhealthy’ and how they demonstrated limited awareness of the notion of moderation. In addition, it was noted how conversant pupils were with public health messages, such as ‘five-a-day’. In terms of exercise, how pupils had developed conceptions around what exercise was ‘good’ for them, discriminating on account of form, duration, frequency and intensity was outlined. It was noteworthy that pupils discounted more incidental forms of exercise (such as walking) and expressed some concerning notions related to duration and intensity, namely that ‘the more you do, the better’ and ‘it has to be hard, to be good’. Additionally, it was acknowledged that whilst hygiene and habits were evident in some pupils’ conceptions, they were not perceived
by pupils to be significant. Next, the aesthetic orientations of pupils’ conceptions were discussed, and the prevalence of appearance was noted. For the vast majority of pupils, appearance was taken to be indicative of health status and, in turn, health status was something to be ‘read off’ the body. In relation to weight, this was constituted as something that needed to be kept ‘in check’ and exercise was overwhelmingly positioned as a tool to do so. Interestingly, the role of diet in weight management was not generally mentioned by pupils.

Following this, the notion of healthism was considered, and the discussion outlined how healthist discourses could be seen to have influenced pupils’ conceptions of health. For example, it was highlighted that the vast majority of pupils viewed health as an individual responsibility and regarded their bodies as something to be ‘worked on’. Pupils’ engagement with health imperatives was revealed to be somewhat concerning, particularly on account of the assumption that this would lead to ‘good health’. It was identified that pupils drew upon a range of sources of health information, and whilst pupils identified parents and teachers as key sources of information, it was difficult to definitively identify what sources were most salient in forming their conceptions. Links were made, however, to public health messages and pupils’ familiarity with these was identified, though the certainty with which these were accepted was proposed to be somewhat problematic. Finally, the few instances where pupils were able to disrupt more normative views of ‘health’ and to open up wider possibilities for knowing ‘health’ and/or being ‘healthy’ were discussed.

The subsequent chapter explores teachers’ perspective of pupils’ conceptions of ‘health’ and considers what this might mean for their pedagogical practice in this area. It outlines how current practice might be shaping pupils’ conceptions, from the perspectives of teachers, and makes links to chapters 5 and 6. In addition, it discusses what potential there might be for alternative practices that open up to facilitate the development of the aforementioned critical views.
Chapter 7: Lessons to be learned: PE teachers’ perceptions of pupils’ conceptions of ‘health’

7.1 Introduction

Within this chapter, the data generated through phase four are analysed and discussed. The chapter seeks to address one of the study’s secondary research questions, namely:

   What are PE teachers’ perceptions of pupils’ conceptions of ‘health’ within PE?

The chapter initially explores how teachers’ expectations of their pupils’ knowledge, understandings and conceptions of health contrasted with what was found within the present study (as discussed within chapter 6). Subsequently, teachers’ perspectives on how pupils’ conceptions might have been influenced by their practices and their PE curricula are outlined. Consideration is also given to the wider influences that may have impacted on pupils’ conceptions, elaborating on the discussion within section 6.7, which described the various messages which pupils considered influenced them.

Next, teachers’ perceptions of their own knowledge and understanding relevant to health-related teaching are examined. Following this, the support that teachers felt they might require to effectively address health-related learning within (and beyond) PE and the potential need for CPD in this regard is deliberated. Finally, teachers’ recommendations for progressing pedagogical practices associated with health-related teaching and learning are presented.

The codes that were used to identify teachers during chapter 5 are also used to designate the same teachers within this chapter. For example, the code CS1-T1 designates teacher number 1 from case study school 1.
7.2 Meeting expectations? Teachers’ perceptions of pupils’ knowledge, understanding and conceptions of ‘health’

It was identified within the interviews during phase two that teachers considered pupils’ health-related knowledge and understandings to be limited and superficial (as discussed in sub-section 5.6.1). Similar findings were evident during phase four, even prior to teachers being presented with selected findings from the pupil data that supported this. Indeed, teachers’ views had not changed in this regard and, at both schools, they continued to report pupils’ health-related knowledge and understanding to be limited and superficial. However, given that pupils had completed one year of curricular PE at secondary level by the point of phase four of the study, the teachers did expect their knowledge and understandings to have improved. For example, teachers stated:

*I think their (the pupils’) knowledge will have improved, they should know more about how to be healthy... they’ve had a whole year of PE lessons, but what they’ve taken from them, I don’t know* (CS1-T6)

*I’d expect them (the pupils) to have learned more about health over the course of the year in PE ... I’m not sure how much though, and I think it will probably vary quite a lot from pupil to pupil* (CS2-T4)

Evidently, teachers’ expectations of pupils’ health-related knowledge and understandings were rather low. Given this, it was perhaps to be anticipated that teachers would be mostly unsurprised on being presented with findings from the pupil data that supported such expectations:

*I think most of them are as I’d expect... there’s not really anything that surprises me* (CS1-T4)

*I’m not surprised... I don’t think there’s anything that I didn’t already know, or at least think... I guess this just proves we were right* (CS2-T2)
Whilst teachers were mostly unsurprised, certain findings were unexpected, such as pupils’ tendency to describe health in negative terms (as discussed in sub-section 6.2.1), with teachers expecting them to be able to better articulate what to do to be healthy. For example, teachers stated:

_It surprises me that they (the pupils) are talking about health from a negative perspective. I would have expected them to, well, be more positive about being healthy, to like, say what they should do_ (CS1-T2)

_The thing that really surprises me is that... talking about health, but like, what not to do. You’d think that if you asked them (the pupils) about being healthy, they’d tell you what to do, but I guess not!_ (CS2-T6)

Allied to this, some teachers expressed disappointment about the relative lack of reference to pleasure within pupils’ conceptions of health (as discussed in sub-section 6.5.1), though many attributed this to their tendency to describe health in negative terms, with one teacher stating:

_Well, I guess that’s to be expected isn’t it? According to them, being healthy is just about not doing lots of things that they probably enjoy doing!_ (CS1-T3)

Teachers were also surprised (and concerned) that so few pupils made associations between PE and health-related learning. Teachers felt that the links between PE and health were ‘obvious’ and had difficulty comprehending how pupils did not make such associations, as exemplified by the following quotations:

_I’m really surprised by that... you’d expect them to associate PE with learning about health, wouldn’t you?_ (CS1-T3)
You’d have thought that it was obvious that PE teaches them (the pupils) about health, I mean, it’s obvious to us (CS2-T7)

It was apparent that underlying teachers’ talk were notions of a naturalistic relationship between PE and health, with evident links to the data generated during phase two, which identified that teachers assumed that health-related learning happened ‘naturally’ within PE (as discussed in section 5.4). However, as discussed in section 6.7, pupils did not typically associate health-related learning with the subject, and generally had a lack of educative expectation with regard to it. Teachers were understandably concerned by this and as such made recommendations as to how health-related learning might be made more explicit within PE (discussed further in section 7.6).

Overall, teachers considered the findings from the pupil data to support their rather low expectations of pupils’ health-related knowledge and understandings. They were mostly unsurprised by these, but some findings were unexpected, and even concerning for some teachers. However, teachers felt that most of the findings presented to them were explainable, as discussed in the subsequent section.

7.3 Putting it into context: Teachers’ rationales for pupils’ knowledge, understanding and conceptions of ‘health’

The PE context was proposed by teachers at both schools as having considerable potential to influence pupils’ knowledge, understandings and conceptions of health – both positively and negatively, taking into consideration the findings that were presented to them. Reflecting on these findings, teachers considered that their practices and the PE curricula at their schools had been significant in this regard and provided explanations as to how pupils’ experiences within PE might have influenced their conceptions of ‘health’.

Teachers acknowledged that health was taught mostly through fitness-focused units within curricular PE (as discussed in section 5.4) and suggested that what was being taught to pupils was perhaps fitness as health, rather than health through fitness, with one teacher stating:

We teach health through a fitness unit, or at least we thought we did... the more I think
Many teachers suggested that this was likely to have contributed to pupils’ conceptual confusion, demonstrated by their difficulty in distinguishing between the concepts of health and fitness (as discussed in section 6.2). Teachers remarked that, with the former taught as the latter, it is perhaps to be expected that pupils would combine (and confuse) the two concepts. Whilst teachers were not necessarily concerned by this, they did recognise that it may have influenced the ways in which pupils conceptualised ‘health’, predominantly in the physical sense:

It does make sense that they’d just think of health as being physical... like, if you think about what we teach in PE, especially in the fitness unit, it’s all focused on being healthy, but physically (CS1-T2)

You can understand why they would only think about health physically though, can’t you? Especially in PE, we’re only teaching the physical aspect, we don’t touch on mental and social wellbeing (CS2-T1)

Teachers acknowledged that health was a broad concept and were keen for pupils to regard it as such. They expressed that, if pupils were to lead healthy, active lifestyles, they would need to be physically, mentally, emotionally and socially ‘well’. Whilst many teachers questioned whose responsibility this was (discussed further in section 7.4), some were concerned that PE might be contributing to what they considered to be reductive, limited and limiting conceptions of ‘health’, with one teacher stating:

If that’s what they’re learning... if that’s what they’re taking away from PE lessons... that’s worrying. We should be supporting them to develop their knowledge and understanding, to be able to lead healthier lifestyles, but it seems like we might not be doing that (CS2-T3)
The performative notions that pervaded pupils’ conceptions of health (as discussed in subsection 6.3.2) were also problematised by almost all of the teachers. In particular, they were concerned by some of the notions that pupils held in relation to exercise, such as it having ‘to be hard, to be good’. On reflection, teachers recognised how their practices (and their ‘talk’) might have been influential in this regard:

*I think we’ve probably influenced that... you know when they (the pupils) are doing an activity, and they’re not working hard enough, you do just say like “come on, work a bit harder” – maybe we’ve made them think that if it isn’t hard, it isn’t good enough (CS1-T2)*

*We teach them (the pupils) that though, don’t we? We push them to work hard, and we tell them off when they’re not; I guess that could make them think in those sorts of ways. I’ve not really thought about how it might influence them before, but that probably isn’t something I want them thinking (CS2-T5)*

The vast majority of teachers also suggested that the ways in which they talked about health might have influenced pupils’ tendency to describe it in negative terms (as discussed in subsection 6.2.1). On reflection, they recognised that they would (more often than not) tell pupils what they should not be doing, both within PE and across the school more broadly. Teachers noted how within PE they would routinely tell pupils not to sit down during lessons and across the school more broadly they would tell pupils that they should not be eating ‘unhealthy’ foods at break times. For example, two teachers stated:

*I am always telling them not to just sit down during lessons. I don’t mean to be negative...it’s just how you talk about it, isn’t it? I could be more positive though, and tell them to stand up and move around instead... (CS1-T4)*

*I can’t help myself, if I’m on duty at breaktime and I see them eating things they shouldn’t be, I do just go up to them, and tell them that they shouldn’t be eating that stuff. It’s just that there are so many healthier foods that they could be snacking on,
instead of crisps or chocolate or whatever they’ve got. I do try and tell them that, but I guess it’s those negative messages that they remember (CS2-T6)

Teachers expressed that it would be preferential for pupils to be aware of what they should do to be healthy, rather than what they should not do, so that they might be able to engage in health-enhancing behaviours.

With consideration of their ‘talk’ around ‘health’ (or perhaps rather, being healthy), teachers acknowledged how this may be misinterpreted by pupils. For example, one of the teachers (CS2-T5) noted how he told pupils that they should be running in PE lessons, not walking. The finding about pupils discounting more incidental forms of activity (such as walking), made him question whether he may have inadvertently (and negatively) influenced pupils’ conceptions:

You do though, don’t you... you tell them (the pupils) that they should be running in lessons, not just walking around. Maybe I’ve made them think that walking doesn’t count as exercise. If that’s the case, that’s not good - I certainly didn’t mean for them to take that from it (CS2-T5)

Ultimately, teachers concluded that, based on the findings presented to them, health-related learning was not being addressed as effectively as they initially thought, at least not within non-examination PE. Generally, teachers expressed that health actually received rather limited coverage within their PE curricula, with one teacher stating:

Now I think about it, we don’t really do a lot. I’ve always thought that we taught pupils a lot about health, even at Key Stage 3. I’m now realising though that, actually, we don’t do a lot at all (CS1-T5)

Whilst teachers acknowledged that their practices (and in particular their talk around these) and their PE curricula were likely influencing pupils’ conceptions, they were cognisant that pupils were also influenced by other sources. In particular, teachers were of the opinion that
parents and the media were key sources of health-related information and expressed concern about the reliability of some of the messages that they conveyed, as discussed in the following sub-section.

7.3.1 A reliable source? Teachers’ perceptions of pupils’ sources of health information

Teachers recognised that pupils were influenced by a range of health-related information sources, though explained that they considered parents and the media to be the most significant. Whilst teachers acknowledged that the ready availability of information was useful for pupils, many noted how this can mean that they receive contrasting and conflicting information from a range of different sources:

*It’s understandable that they (the pupils) might be confused by health though, they have so much information, it’s almost too much, and it’s never clear is it? Like, you read that one thing is bad for you in one place, and another says that it’s good for you!* (CS1-T2)

In addition, the reliability of the information that pupils accessed with regard to health was considered to be problematic by many teachers, with one teacher stating:

*Some of what they (the pupils) tell you, you just think “where have you got that from?” – you just can’t believe they’ve come to think that. It’s what they’re reading online though, or what they’re being told at home. They think that they can trust it, but you can’t trust everything you read or hear* (CS2-T6)

Evidently, teachers were concerned about the information pupils were receiving from the media (specifically, online media) and their parents. Teachers were of the opinion that parents could make a significant difference to pupils’ health-related learning (discussed further in sub-section 7.5.3), though a few felt that some parents did not take this responsibility as seriously as they ought to:
I don’t think some parents realise how much responsibility they have to teach their children how to be healthy. They don’t lead healthy lifestyles themselves and they’re passing that on (CS2-T6)

In line with this, teachers reflected on their own responsibilities with regard to supporting pupils to lead healthy, active lifestyles, as discussed in the subsequent section.

7.4 In the job description? Teachers’ perceptions of their capacity and responsibility to support pupils’ health-related learning

It was identified within the interviews during phase two of the study that all teachers felt responsible for pupils’ health-related learning, at least to some extent (as discussed in section 5.8). However, in the focus groups during phase four, teachers’ perceptions with regard to both their capacity and responsibility to support pupils were markedly changed, potentially as a result of the findings presented to them, and the reflective discussions around these. In relation to their capacity to support pupils’ health-related learning, many teachers outlined how they felt constrained by the NCPE and, with regard to their responsibility, many questioned how adequately prepared they were for health-related teaching, as discussed within the following sub-sections.

7.4.1 Hands tied: Curricular constraints and challenges around health-related learning within PE

Teachers at both schools were of the opinion that the NCPE constrained their capacity to deliver health-related learning within PE. Some reported that the lack of focus on health within the NCPE meant that they were not able to cover the area as extensively as they would like to within their lessons, schemes of work and curricula. For example, two teachers stated:

I think we ought to cover it more than we do, I’ve always thought that, but we have a curriculum that we have to follow, and it just doesn’t allow that. It’s all about competition now, that’s the focus... there’s nothing really about health in it (the curriculum) (CS1-T3)
We have to teach what we have to teach.... There’s a PE curriculum that we have to deliver, and health isn’t really a part of that (CS2-T4)

It is important to note that the teachers’ argument regarding a lack of focus on health within the NCPE is somewhat fallacious. As discussed within section 2.4, health is represented in two of the four overarching aims of the NCPE across all key stages and so it arguably holds a prominent position within the curriculum. The teachers’ arguments to the contrary may be indicative of a lack of understanding of the current NCPE, which is disappointing given that they have a statutory requirement to work towards delivering it and supporting pupils’ health-related learning. Some teachers did, however, make explicit reference to the overarching aim of ensuring that ‘all pupils lead healthy, active lifestyles’ (DfE, 2013a, p. 1), but felt that this was challenging to meet on account of the limited guidance on this in the NCPE:

Well, it would be helpful if we knew what we were supposed to teach them about health! You’d think if it were that important, they’d have guidance (CS1-T6)

It’s hard, you know... we have to use our best judgement on what to teach them, there’s no guidance, we just have to use our own experience and training, but it wasn’t really that extensive in terms of health-related content (CS2-T1)

The relative lack of guidance provided on health-related learning within the NCPE has been noted, and attempts have been made to address this. For example, in England, guidance has been produced to support health-related teaching within curricular PE (e.g. Harris, 2000; Cale and Harris, 2009; Harris and Cale, 2018). However, teachers may not be aware of such guidance material, with Harris et al. (2016, p. 418) noting that ‘the potential for resources alone to fundamentally change pedagogical approaches to the teaching of health within curricular PE is limited’. Evidently, if such guidance is to be useful, it needs to ‘reach’ teachers, though this may be easier said than done.
In addition to identifying the challenge of the limited guidance of the NCPE with regard to health-related learning, some teachers also questioned how ‘well qualified’ they were for addressing it, as discussed within the next sub-section.

7.4.2 Suitably qualified? Preparedness for health-related teaching within PE

Teachers at both schools expressed concern about their limited preparation to undertake health-related teaching within PE. Teachers’ lack of preparedness in this regard has been variously acknowledged (Cale, 2000; Castelli and Williams, 2007; Alfrey, Cale and Webb, 2012) though interestingly not usually by teachers themselves, as was the case within the present study. Teachers suggested that whilst they had undertaken training to teach PE, the focus on health-related teaching and learning within their respective PETE programmes had been minimal:

*On my PGCE course, like, we didn’t really do anything on health or how to teach it, at least not in core PE. You teach it as part of GCSE PE, but I think that’s different* (CS1-T2)

*We covered health on my PGCE course, I’m sure we did… but there wasn’t much on it at all – it was more about teaching different sports. I can’t really remember what we actually did for health…* (CS1-T3)

Harris (2014) noted that PETE programmes are not sufficiently preparing PE trainee teachers to deliver health-related learning and the findings of the present study support her work. In line with the lack of relevant training to deliver health-related teaching, and allied to the limited guidance provided on this within the NCPE (as discussed in sub-section 7.4.1), some teachers questioned their own health-related knowledge and, in particular, their ability to use their professional judgement to determine what was relevant content to deliver, with one teacher stating:

*I mean, I thought my knowledge about health was reasonable, but I’m not really familiar with the 60 minutes a day message, I thought it was 30 to be honest, and even then, it’s not something that I’d think to teach in my lessons* (CS1-T6)
Furthermore, some teachers noted how, even though they felt they had sufficient health-related knowledge, and were able to determine relevant content to deliver, their skills (with regard to delivery) were lacking. As such, they described how delivering health-related content was effectively ‘another matter’, with one teacher stating:

*I’m not always sure how to actually teach it, like, how do you teach them (the pupils) about health without sitting them down in a classroom? I don’t get how it’s done... it certainly wasn’t something that we covered on my PGCE course, though thinking about it now, we probably should have!* (CS2-T4)

Interestingly, these findings contrast markedly with those from phases one and two of the study, whereby teachers suggested that they had sufficient (and often, extensive) knowledge and skills and were well equipped to deliver health-related learning (as discussed in sub-section 5.6.3). Alfrey, Cale and Webb (2012) outlined what they termed the ‘HRE conundrum’ (as discussed in sub-section 5.6.3), noting how teachers’ misguided confidence in their health-related teaching ability meant they did not perceive there to be any need to access CPD and this led to the maintenance of a perpetuating cycle within which narrow conceptualisations of health are taught through fitness-focused practices in PE (*ibid.*). However, as has been evidenced within the present study, pupils’ voices can be influential in bringing about reflective practice and could potentially offer a ‘solution’ to the ‘HRE conundrum’ proposed by Alfrey and colleagues (2012). It would seem that by making teachers aware of their pupils’ reductive, limited and limiting conceptions of ‘health’, they were encouraged to reflect on their practices and their PE curricula. In doing so, they were able to recognise the limitations of their current practices and curricula (as discussed in section 7.3) and, as a result, made recommendations as to how these might be changed to enhance health-related teaching and learning within PE (as discussed in section 7.6).

On account of identifying that they may not be addressing health-related learning as effectively as they could, and in line with their concerns over their knowledge and skills to teach this, almost all of the teachers described how they may be ‘in need of support’, as discussed in the subsequent section.
7.5 Help wanted: Teachers’ perceptions of their support needs for health-related teaching and learning

The focus groups conducted during phase four revealed that teachers perceived there to be a need for them to access professional development in relation to health-related teaching and learning. This represented a major shift in opinion, given that in the interviews during phase two of the study, most had expressed how they considered CPD for health-related teaching and learning unnecessary (as discussed in sub-section 5.6.3). In addition to reporting that they needed CPD, they also expressed how support was needed across the whole school and at home (as discussed in sections 5.7 and 5.8), with parents being considered to have a significant role to play in pupils’ health-related learning, as discussed within the following subsections.

7.5.1 Shaping up: Teachers’ health-related CPD needs within PE

As discussed within sub-section 7.4.2, PE teachers questioned how well prepared they were to deliver health-related learning with regard to both their knowledge (and their ability to determine appropriate content) and their skills (in delivering relevant content). In line with this, many reported that it would be useful to access CPD in this area:

“We could really do with CPD on health… we could do with some guidance on what should be covered, and how we can cover it in lessons” (CS1-T6)

“CPD for health would be really useful. I think it’s something that we could really improve on within the department, especially in terms of how we actually teach about health in lessons” (CS2-T1)

Teachers were keen to access support in relation to both content and delivery, though it was the latter that teachers reported would be most beneficial. The various guidance material produced to support teachers (e.g. Harris, 2000; Cale and Harris, 2009; Harris and Cale, 2018) would likely be most useful in this regard. However, many teachers expressed particular interest in accessing practical CPD, with examples of how they might deliver relevant content for health-related learning. Evidently, teachers were seeking to enhance the pedagogies that they were using to facilitate health-related learning.
The need for the development of such pedagogies was noted by Armour and Harris (2013) who called for new ‘PE-for-health’ pedagogies that place pupils at the centre of the health-related learning process. Following this, a range of pedagogical approaches for the delivery of health-related learning have been proposed, including models- and principles-based approaches (Cale, Harris and Hooper, forthcoming). The latter, of which Harris and Cale (2018) are key proponents, might be particularly useful for these teachers, given that it combines guidance material with practical CPD.

7.5.2 A team effort: Whole school support for health-related learning

Whilst teachers recognised the potential limitations within their own practice and were keen to access CPD in order to address this, they also felt that support was required at whole school level, for effective health-related learning. As identified in section 5.7, neither school was considered (by teachers) to have a whole school approach to health and teachers had limited awareness of what was covered in other curriculum subjects. However, they did note that PE was often required to assume considerable responsibility for health-related teaching and learning.

Despite teachers at both schools reporting that health-related learning was addressed within PSHE, most noted that this was often delivered by ‘non-specialists’ and in an uncoordinated manner, with one teacher stating:

*PSHE does cover health, but I don’t think that the way we teach it makes pupils appreciate it. It’s covered once a week in form time, for 20 minutes, and that’s all they get. It means you have maths teachers teaching health, and I think they know about as much as the pupils sometimes* (CS2-T5)

Evidently, such teachers did not feel that health-related learning was particularly well addressed within the subject that they considered should be largely responsible for it. At CS2, one teacher (CS2-T3) drew upon her experiences as a teacher in New Zealand and in comparing the curricula as a whole described health as ‘not having a home’ within the English curriculum.
As a result of their concerns regarding health-related learning coverage at whole school level, most teachers advocated for a whole school approach to health. Whole school approaches to health can be particularly useful for enhancing pupils’ health-related knowledge and understandings as they support the development of cross-curricular links and can help pupils to connect learning between different curriculum subjects (Deschenes, Martin and Hill, 2003; Harris et al., 2016).

7.5.3 Keeping it in the family? Parental support for health-related learning

The vast majority of teachers felt that familial support was also important in ensuring that health-related learning was effective, with parents being acknowledged as a key influence in pupils’ lives, as also identified within section 5.8. Teachers reported that parents were responsible for ‘laying the foundations’ of a healthy (and active) lifestyle, though it was not felt that all parents did so:

They (the pupils) don’t all get those messages at home – not all the parents teach them about being healthy (CS1-T4)

You’d like to think that you could rely on parents to teach them how to be healthy, but you just can’t, they don’t all get the same level of input from home (CS2-T2)

However, many teachers questioned the reliability and appropriateness of some of the messages that pupils received from their parents with regard to health, suggesting there could be considerable disparity:

I mean, most parents are supportive, but not all, and just because they’re supportive, that doesn’t mean that they’re passing on the right messages... (CS1-T2)

I do question some of what parents are telling their kids, like, they mean well, but I’m not sure it’s always helpful... that’s why they need school (CS1-T2)

Given their concerns over the reliability and appropriateness of the health-related messages that pupils received from their parents and in the home, many underscored the importance
of the school context in supporting pupils’ health-related learning. In emphasising the importance of this, they asserted that practice needed to be effective, and made recommendations as to how (within PE specifically) this might be improved, as discussed in the following section.

7.6 Requires improvement: Teachers’ recommendations for enhancing pedagogical practice in health-related learning

The focus groups provided teachers with an opportunity to reflect on their practice around health-related learning and, as discussed in sub-section 7.4.2, pupils’ voices were influential in this regard. Consequentially, teachers made several recommendations as to how pedagogical practice around health-related learning might be enhanced. These recommendations related to: making health-related learning explicit; promoting positive conceptions of ‘health’; encouraging criticality within pupils’ conceptions of ‘health’, and; ensuring that pupils’ voices around health-related learning are facilitated effectively. These are discussed further in the following sub-sections.

7.6.1 Explicit content: Making health-related learning evident within PE

A recommendation made by almost all of the teachers was that health should be repositioned within their PE curricula, or at least, positioned more prominently. At both schools, teachers reported using a combined approach to delivering health-related learning. However, it was noted that the focused element (a fitness-focused unit) was the predominant means by which learning in this area was addressed (as discussed in section 5.4). Accordingly, teachers felt that the focus needed to shift to place more emphasis on health as opposed to fitness:

I think the fitness unit needs changing. I think it should focus on health a lot more than it does right now (CS1-T2)

[The fitness unit] needs to better align with the curriculum... it should be focused on healthy, active lifestyles, like the aim (CS2-T1)
In addition, some teachers expressed that the permeated element needed to place further emphasis on health-related learning. These teachers acknowledged that, at present, health-related learning was not being addressed as thoroughly as it might, with one stating:

_We should do more, we talk about warming up and cooling down and think we’ve done enough to cover [the health-related learning] outcome, but we really haven’t... we could teach [health] much more explicitly than we do (CS2-T3)_

Teachers’ comments questioned the effectiveness of their current approaches and a combined approach was suggested as being most effective. Cale and Harris (2009a) would support such a recommendation, as they note that a combined approach draws upon the individual strengths of both focused and permeated approaches and the reinforcement of learning through multiple means implies to pupils that the area is important. Allied to this, teachers within this study felt that health-related learning needed to be made more explicit for pupils. It was suggested by many that the aforementioned changes would be useful in this regard, particularly in relation to supporting pupils to ‘make links’ with their learning, with one teacher stating:

_It’s got to be linked, hasn’t it? We need to make sure that we’re not just teaching health during the fitness unit. If we’re teaching about health in football or gymnastics or swimming, hopefully they’ll realise that PE can teach them about healthy, [active] lifestyles because they’re getting those messages (CS1-T6)_

It may also be that by making learning more explicit within PE, teachers are able to positively influence the educative expectations that pupils had with regard to PE which, as discussed in section 6.7, were disappointingly low.

**7.6.2 Be positive! Promoting positive conceptions of ‘health’ through PE**

The messages that pupils received within PE were also highlighted by teachers as warranting consideration. The vast majority expressed that the messages they conveyed to pupils needed to be expressed positively as opposed to negatively. That is to say that, rather than educating
pupils about what not to do, teachers reported that they should instead be educating pupils as to what to do to be healthy:

*The messages that we put across, they need to be more positive, we need to be sure that we’re more positive* (CS1-T3)

*We don’t want to come across as being negative about it - that’s one thing we’ll need to change. We need to change the way we talk about health* (CS2-T6)

Teachers were of the opinion that, by doing so, they would better support pupils to develop the knowledge, skills and behaviours required to engage in healthy, active lifestyles and also promote ‘health’ as a positive concept. Harris (2000, p. 2) would concur with this, noting that health-related learning requires pupils to be equipped with the ‘knowledge, understanding, physical competence and behavioural skills’ to engage in physical activity and to be supported to develop ‘positive attitudes and confidence’ towards it.

### 7.6.3 Getting critical: Supporting pupils to develop criticality in health-related learning

Teachers were concerned about some of the performative notions that pervaded pupils’ conceptions of ‘health’ (as discussed in section 7.3) and the sources of information that they drew upon in this regard (as discussed in sub-section 7.3.1). As such, many recommended that criticality be encouraged within PE, so as to ensure that pupils are able to interpret (and potentially critique) the health-related messages that they receive:

*We should definitely try and make them think a bit more critically about health... it’s about them being able to take those messages, like ‘being this is healthy’ and being able to think about it in a rational way, weighing up all of the information* (CS2-T4)

*They (the pupils) have so much information available to them, and if they want to know something, they can just Google it, but there’s so much false information, we should be encouraging them to not just believe everything they hear or read, because you just can’t* (CS2-T7)
Teachers recognised that pupils were receiving contrasting and conflicting health information from a range of sources (as discussed in section 6.7) and were cognisant that this might further confound their conceptions of ‘health’. The teachers’ recommendations are in line with the increasing number of calls for PE to adopt a critically orientated approach to health-related teaching and learning (Burrows, Wright and Jungersen-Smith, 2002; Burrows, Wright and McCormack, 2009; Burrows and McCormack, 2014; Harris et al., 2016; Wright, O’Flynn and Welch, 2018). These calls have focused on encouraging PE teachers to address the social conceptions of health within their practice (Burrows, Wright and Jungersen-Smith, 2002) in order to address the limited and superficial conceptions of ‘health’ that many pupils hold. As Burrows and McCormack (2014, p. 168, emphasis as in original) note:

The capacity... to think through health messages, to negotiate what information means to them, to resist, opt out and generate alternative understandings of health, drawing on anomalies to justify their positions suggests that [pupils] can do knowledge, rather than simply receive it.

Evidently, by encouraging a critical approach to health-related teaching and learning, teachers may be able to support the development of critically-inclined conceptions of ‘health’.

7.6.4 Listen up! Facilitating pupils’ voices around health-related learning within PE

Pupils’ voices around health-related learning were identified by many teachers as having much potential to inform and influence their practice. Teachers recognised that in order to enhance pupils’ knowledge and understandings (and in turn, conceptions) of ‘health’, finding out what they knew already was a useful starting point, with one teacher stating:

*It makes sense really... We don’t actually find out what they do know, before we start teaching them, especially with health, they might all know different things, and if we don’t try and find out, we won’t know about all these errors that they have* (CS1-T5)

Armour and Harris (2013) would support such suggestions, as they emphasise the importance of placing pupils at the centre of the health-related learning process. Teachers’ willingness to engage with pupils’ voices demonstrated that they were recognising pupils as competent social actors who had the capacity to articulate their knowledge, understandings and
conceptions of ‘health’ (Sandford, Armour and Duncombe, 2010). However, whilst teachers were willing and often keen to do so, some acknowledged the potential challenges in this regard, with one stating:

*It’s difficult though, as much as we might like to, to have those discussions, to speak with each pupil, it would take a lot of time, and we just don’t have that in lessons, we’re quite limited* (CS2-T7)

Therefore, whilst teachers may be supportive of the notion of ‘youth voice’, their capacity to facilitate this may be somewhat limited, which presents challenges in ensuring that pupils’ voices can be effectively heard, acknowledged and acted upon within PE (Long and Carless, 2010).

### 7.7 Conclusion

This chapter has explored PE teachers’ perceptions of, and perspectives on, pupils’ conceptions of ‘health’ within PE and, in doing so, has addressed one of the secondary research questions of the study (SRQ-2). It has highlighted that teachers had relatively low expectations of their pupils’ knowledge, understandings and conceptions, and the findings presented to them were deemed to provide evidence in support of these expectations. It was identified that whilst teachers were generally unsurprised by the findings presented to them, some were unexpected, in particular pupils’ tendency to describe health in negative terms and their lack of association between PE and health-related learning. Subsequently, the explanations that teachers proposed for pupils’ conceptions of ‘health’ were outlined and particular attention was paid to teachers’ perceptions of how their own practices and their PE curricula might have influenced these. In line with this, it was identified that teachers considered their talk to be relatively influential in shaping pupils’ conceptions of ‘health’.

Teachers’ contributions to health-related learning were also considered and it was suggested that they felt limited with regard to their capacity and questioned their responsibility. In particular, many teachers felt constrained by the NCPE and the relative lack of guidance it provided with regard to health-related teaching and learning. Many also questioned how
adequately prepared they were for health-related teaching and noted the lack of coverage this received within their respective PETE programmes. Teachers identified a need for relevant CPD to develop effective ‘pedagogies-for-health’ and acknowledged that further support was needed from within and beyond the school in order to ensure that pupils’ health-related learning was effective. They advocated for a whole school approach to health, whereby learning was coordinated across the curriculum, and called for familial support to ensure that messages received within school were reiterated in the home.

A number of recommendations were made by teachers as to how pedagogical practice within health-related learning might be enhanced. Teachers recommended that learning be made explicit to pupils and suggested that by making changes to the approach and focus of their curricula, they would be able to do so. They also emphasised that the messages conveyed to pupils needed to be positive and focus on health-enhancing behaviours. A recommendation was also made to encourage criticality within pupils’ conceptions of ‘health’, to help them ‘make sense’ of the various health-related information that they receive. Finally, teachers acknowledged the power of pupils’ voices to inform and influence their practices and curricula and asserted that these should be effectively facilitated within and through PE, though noted the potential challenges of doing so.

The subsequent chapter concludes the thesis, by returning to the research questions and summarising the key points to be taken from it. It reflects on the present study, and its findings, and ruminates on future directions for research in this area.
Chapter 8: Conclusion

8.1 Introduction

The overall purpose of this study was to explore pupils’ conceptions of ‘health’ within PE. Research conducted over a considerable period of time, and across many countries, found that children and young people’s knowledge, understandings and conceptions of ‘health’ were superficial and limited (see Harris et al. (2016) for an overview). Whilst some of this research had been conducted within the context of England, this pre-dated the current NCPE with its increased emphasis on healthy, active lifestyles. As such, a ‘gap’ within the literature was acknowledged, which this study sought to address. In seeking to do so, it was recognised that it would be important to explore how health-related learning was currently addressed within PE in England, as this would provide the context for interpreting pupils’ conceptions of ‘health’. This would also address another ‘gap’ within the literature, by providing an examination of current health-related teaching practices within PE in England. These ‘gaps’, identified through a critical review of the literature in chapter 2, were used to inform the development and refinement of the research questions which guided the study (as outlined in section 1.2).

This chapter concludes the thesis by returning to the research questions and providing an overview of the key findings of the study in relation to these. It also outlines implications for practice with regard to health-related learning which have resulted from the study. In addition, recommendations for future research are proposed. Finally, the thesis closes with concluding remarks on its contribution to research within the field of PE.

8.2 Overview of key findings

Over the course of chapters 5-7, the data generated through the study were reported and discussed. However, in concluding the thesis, it seems pertinent to return to the research questions and to reiterate the key findings in relation to these. The research questions that guided the study, and which were formulated following a critical review of the literature, were:

Primary research question:

- What are pupils’ conceptions of ‘health’ within PE?
Secondary research questions:

• How is pupils’ health-related learning addressed within PE?
• What are PE teachers’ perceptions of pupils’ conceptions of ‘health’ within PE?

The key findings related to these questions will now be outlined in turn, in the order in which they were addressed within the thesis.

Research question (SRQ-1): How is pupils’ health-related learning addressed within PE?

Chapter 5 addressed the above research question and, in doing so, provided an overview of the current context of health-related teaching within PE in secondary schools in England. Key findings related to this were:

• The vast majority of schools had a policy outlining a departmental approach to teaching PE and most of these made explicit reference to health-related learning. However, awareness of these was limited, and it is therefore questionable as to whether or not such policies were being put into practice.
• Teachers purported to value health within PE, though this was not necessarily reflected in the time it was allocated within curricular PE, with most reporting this to be limited.
• A combined approach, comprising focused and permeated elements, was identified as the most commonly used means of addressing health-related learning within curricular PE. The permeated element involved the delivery of health-related learning through traditional sports and activities, with a particular emphasis on (competitive) team games, whilst the focused element typically involved a fitness unit, involving testing and training.
• Permeated approaches seemed to represent an ‘easy’ way to address health-related learning within PE and there was an assumption that health-related learning happened ‘naturally’ through such an approach. Focused approaches were mostly fitness-orientated and often conveyed health as fitness.
• Fitness testing was identified as the main activity through which health-related learning was addressed within curricular PE, and teachers’ talk around this evidenced surveillance practice
• Examination-based PE was reported to be a key driver behind much health-related teaching, with teachers seeking to not only contribute to pupils’ health, but also their academic attainment, with performative notions pervading their talk
• Teachers outlined that they conveyed several messages to pupils about how they might lead a healthy, active lifestyle, though these were focused predominantly on the physical and were often orientated from a negative perspective
• Healthist discourses pervaded teachers’ talk around the key messages that they conveyed to pupils in relation to health-related learning and some concerning notions were evident within this, for example, normalising pain
• Teachers perceived pupils’ health-related knowledge to be limited and superficial and identified several examples of specific misinformation that pupils had espoused to them
• Teachers highlighted that their personal experiences, their studies, and current news/media articles were the key sources of information that they drew upon for health-related teaching, though most perceived their personal experiences to be more significant than their studies. Teachers who had completed both undergraduate and postgraduate studies often reported the former to be more influential than the latter with regard to health-related teaching and most outlined how they considered current news/media articles to represent easily accessible information
• Few teachers had accessed CPD relevant to health-related teaching and most did not perceive there to be a need to access it. There was a perception amongst teachers that, given that they taught examination-based PE, they had sufficient knowledge and skills for the delivery of health-related learning
• The vast majority of teachers demonstrated limited awareness of whole-school approaches to health and most knew little about what contribution other curriculum subjects (such as PSHEE) made to pupils’ health-related learning
• Extra-curricular provision was identified by teachers as making a significant contribution to pupils’ health-related learning and some considered it to be a more important context than curricular PE.

These findings highlight that many of the concerns and criticisms levied at the area (as discussed in sub-section 2.4.3) persist. It would seem that health-related learning continues to be addressed through fitness-focused approaches and practices, influenced by performative notions. Further, it is evident that healthist discourses influence not only these approaches and practices, but also the messages conveyed to pupils within and through the subject. These findings are useful in highlighting the context within which pupils are experiencing health-related learning and provide evidence to suggest how pupils’ conceptions of health might have been influenced by PE, as discussed in relation to the next research question.

**Research question (PRQ): What are pupils’ conceptions of ‘health’ within PE?**

Chapter 6 addressed the study’s primary research question and explored pupils’ conceptions of health within PE in England. Key findings related to this were:

• Corporeal notions were evident within pupils’ conceptions of ‘health’, with the physical dimension predominating
• Whilst references to diet and exercise were frequent, pupils rarely referred to wider dimensions of health, such as the mental, social and emotional domains
• Conceptual confusion was evident, at least to some extent, within pupils’ talk and most had difficulty distinguishing between the concepts of health and fitness
• Discursive formations were evident within pupils’ talk around health and fitness and these may have resulted in pupils conceptualising health reductively
• Dichotomous views were demonstrated by many pupils, with a person being positioned as ‘healthy’ or ‘unhealthy’ dependent on their health-related behaviours
• Pupils were relatively prescriptive in terms of how a person would be ‘healthy’ and often provided an extensive list of what a person should/should not do. Notably, many
pupils were able to describe more behaviours that should be avoided than behaviours that should be engaged in, suggesting that they orientate their conceptions from a negative perspective

- Pupils were particularly conversant with several key recommendations related to diet (such as the five-a-day guideline in relation to the consumption of fruit and vegetables) but were far less familiar with recommendations related to exercise
- Pupils seemingly accepted public health messages with much certainty and most assumed that, by following health imperatives, they would themselves be ‘healthy’
- Aesthetic orientations were evident within pupils’ conceptions of ‘health’ with appearance (taken as shape, size and weight) being particularly prominent. Emphasis was placed on how a person ‘looked’ and most pupils associated thinness with healthiness and fatness with unhealthiness
- The vast majority of pupils regarded a person’s weight as something that needed to be ‘kept in check’ and exercise was overwhelmingly constituted as the means by which a person might do so
- Healthist notions were identified within pupils’ talk and influenced their conceptions of ‘health’. For example, the vast majority viewed health as an individual responsibility and regarded their bodies as something to be ‘worked on’
- Pupils drew upon a range of sources of information about ‘health’ and outlined that parents and teachers were key sources. However, most pupils did not regard PE as making a significant contribution to their health-related learning, highlighting a lack of educative expectation with regard to the subject
- Some pupils were able to disrupt normative notions of ‘health’, for example that ‘thin is good and fat is bad’, but these pupils were in the minority.

Overall, pupils’ conceptions of ‘health’ were found to be reductive, limited and limiting, in line with the work of many researchers (see Harris et al. (2016) for an overview). The vast majority of pupils’ conceptions of ‘health’ were heavily corporeally focused, and aesthetically-orientated, with healthist discourses having evidently influenced their conceptions. On a positive note, some pupils were able to disrupt normative notions of ‘health’ and demonstrated critical and considered conceptions in this regard. Despite pupils not
considering PE to have been influential in their conceptions of ‘health’, it did seem that the subject may have asserted some influence, at least, with PE teachers providing useful perspectives on this, as discussed in relation to the next research question.

**Research question (SRQ-2):** What are PE teachers’ perceptions of pupils’ conceptions of ‘health’ within PE?

Chapter 7 addressed the above research question and explored PE teachers’ perceptions of their pupils’ conceptions of ‘health’ and how their PE curricula and practices might have influenced these. Key findings related to this were:

- Teachers had relatively low expectations of their pupils’ conceptions of ‘health’ and as such were mostly unsurprised by the findings. That said, some findings, such as pupils’ tendency to articulate ‘health’ in negative terms, and their lack of association between PE and health-related learning, were not expected and were concerning for some teachers.
- Almost all teachers considered that their PE curricula and practices may well have influenced pupils’ conceptions of ‘health’ and most concluded that they may not be addressing health-related learning as effectively as they had previously thought.
- Teachers emphasised that whilst PE was likely to have influenced pupils’ conceptions of ‘health’, it was not the only source of information that pupils drew upon in this regard. Accordingly, they reported how they considered parents and the media to be particularly influential. However, teachers expressed concern over the reliability of the information that pupils accessed, particularly that from online sources.
- The vast majority of teachers felt the contribution they could make to pupils’ health-related learning was limited in relation to both their capacity and their responsibility. Specifically, most teachers noted how they felt constrained by the NCPE and many remarked how they did not feel sufficiently prepared for health-related teaching. With regard to the latter, many asserted that there was a lack of coverage of health-related teaching within their respective PETE programmes.
- Many teachers identified a need for relevant health-related CPD and acknowledged that support was needed from within and beyond the school in order to ensure that
pupils’ health-related learning was effective. Accordingly, teachers advocated for a whole school approach to health, whereby learning was coordinated across the curriculum, and called for familial support to ensure that messages received within the school were reiterated within the home.

- Teachers identified several implications for practice and made recommendations as to how they might be able to enhance their curricula and practices with regard to health-related learning.

The findings presented to the teachers (based on data generated with their pupils) were effective in encouraging them to reflect on their curricula and practice with regard to health-related learning. Teachers presented rationales for pupils’ conceptions of ‘health’ and, in doing so, identified the ways in which their curricula and practices might be influencing pupils’ conceptions of ‘health’, although not necessarily in the ways they intended. Interestingly, having been presented with the findings, the position of many teachers with regard to the need for CPD for health-related learning changed markedly, with them subsequently perceiving there to be a need for this. Positively, the teachers collectively identified a number of implications for practice, making recommendations as to how health-related learning within PE might be enhanced, as discussed within the subsequent section.

8.3 Implications for practice

A number of implications for practice were identified in collaboration with PE teachers (as discussed in section 7.6). It was hoped that, by working with PE teachers to identify what the findings of the study meant in relation to health-related teaching and learning within their contexts, they would be able to act on these and to enhance their pedagogical practice in this regard. Evidently, in line with the youth voice agenda that the study sought to work towards, it was important to hear and listen to what pupils said, but to also act upon this. In order to achieve the latter, it was key for PE teachers to be involved within the process. The implications for practice identified by PE teachers are now presented and discussed.
Implication 1: Explicit

The first implication for practice identified was ensuring that health-related learning is made explicit within PE. It was highlighted that pupils had a lack of educative expectation with regard to the subject and they did not necessarily associate health-related learning with it (as discussed within section 6.7). On this note, teachers advocated for a focus on health within PE curriculum as opposed to fitness, the latter of which the vast majority considered to be the main focus of their own PE curricula at the time of the study being undertaken. It was this focus that teachers held responsible for their pupils’ predominantly corporeal conceptions of ‘health’, which they themselves problematised (as discussed in section 7.3). Teachers also felt that health-related learning could be made explicit within PE by using a combined approach for health-related teaching. Whilst it was identified that this was the approach adopted by almost all of the teachers, it was acknowledged that there were limitations in the ways in which the approach was employed (as discussed in section 5.4). Specifically, it was noted that within the focused element, health was largely taught as fitness, and in addition to (potentially) contributing to pupils’ corporeal conceptions, teachers also suggested that this may have contributed to the conceptual confusion demonstrated by most pupils (as discussed in section 7.3). With regard to the permeated element, teachers recognised that health-related learning was being addressed superficially and noted that they would need to ensure that, within this element specifically, explicit reference was made to health-related learning in order to work towards meeting the aims of the NCPE (DfE, 2013a). Teachers proposed that implementing such changes may well also support pupils to ‘make links’ between health-related learning in PE and other curriculum subjects.

Implication 2: Positive

The second implication for practice identified was endeavouring to promote positive conceptions of ‘health’ through PE. Teachers recognised that some of the messages they conveyed within PE may be misinterpreted by pupils (as discussed within section 6.7). On account of this, they suggested that they may have inadvertently (and negatively) influenced pupils’ conceptions of ‘health’, particularly with regard to their tendency to describe it in negative terms (as discussed in section 6.2.1). Accordingly, teachers expressed that they may need to re-orientate the health-related messages conveyed to pupils to ensure that these
were positive as opposed to negative. Teachers were of the opinion that, by doing so, pupils would be more likely to engage in health-enhancing behaviours.

**Implication 3: Critical**

The third implication for practice identified was supporting pupils to develop criticality through health-related learning. It was highlighted that pupils received health-related information from a range of sources and can have difficulty assimilating this within their conceptions of ‘health’, particularly when these sources present contrasting/conflicting information. As discussed in sub-section 7.6.1, teachers also expressed concern over the range of information that was available to pupils and, in particular, the reliability of some of this. Consequentially, PE teachers expressed that within the subject, they needed to support pupils so that they are able to interpret (and potentially critique) the health-related messages that they receive. It was anticipated that, by doing so, they would be able to support the development of critical conceptions of ‘health’.

**Implication 4: Voice**

The fourth implication for practice identified was facilitating pupils’ voices around health-related learning within PE. Teachers recognised that, in seeking to enhance pupils’ health-related learning, it was important to initially consider their current knowledge and understandings (and, in turn, conceptions) of ‘health’, and they acknowledged how useful pupils’ voices can be in this regard. Teachers’ willingness to engage with pupils’ voices was positive, in that it demonstrated that they were recognising pupils as competent social actors who had the capacity to articulate their knowledge, understandings and conceptions of ‘health’. However, whilst teachers may be supportive of the notion of youth voice, they expressed how they felt that their capacity to facilitate this was somewhat limited. Teachers within the study had difficulty in outlining how they might facilitate pupils’ voices within the context of PE and expressed that they needed additional support with regard to the process of facilitating youth voice or perhaps what might be termed ‘pedagogies for voice’. On this point, Baroutsis, McGregor and Mills (2016) note that voice necessitates dialogue between teachers and pupils with Rudduck (2007) highlighting that, within the school context, such dialogue typically takes the form of pupil consultation. Such consultation, according to Fielding (2004), can often fail to result in meaningful action for pupils and as such limits the
influence that their voices can exert. As Robinson and Taylor (2007, p. 14) assert, ‘[consulting with] pupils is itself not sufficient, it is what happens with the information, what is done with it, that is important’. Therefore, it would seem that such ‘pedagogies for voice’ would need to be action-orientated. Given the difficulties teachers expressed with regard to such pedagogies, a key recommendation for future research would be to explore this concept of ‘pedagogies for voice’ and to consider how these might be implemented within PE, as discussed within the subsequent section.

8.4 Recommendations for future research

It is necessary, in concluding this thesis, to acknowledge that whilst this research is considered to have made a contribution to the field, it is by no means definitive and there are several ways in which future research could extend and build upon this study.

The study explored pupils’ conceptions of ‘health’ within two state secondary schools within the East Midlands region of England. Whilst the two schools were contrasting (as outlined in sub-section 3.4.2.1) and the findings relatively consistent, that is not to say that these findings can be taken to be representative of pupils, teachers and schools more broadly. As such, further research in different schools would also be useful, to explore how health-related learning is addressed within such contexts and how pupils conceive ‘health’ within them. Further, the study only conducted research within pupils aged 11-12 (as outlined in sub-section 3.4.2.1.1) and so it would be interesting to conduct research with different age groups, to examine if and how their conceptions of ‘health’ differ. A longitudinal study may be particularly insightful in exploring how pupils’ conceptions of ‘health’ develop and may further illuminate how (if at all) health-related learning within PE influences these conceptions. This would help to address a ‘gap’ within the literature related to concerns that have been expressed over a lack of progression in pupils’ health-related learning (e.g. Harris, 2010; Cale and Harris, 2013).

In line with the call by Armour and Harris (2013), future research might also explore PE-for-health pedagogies. Specifically, based on the findings of this study, it would be recommended that future research examines the pedagogies that might be employed for health-related learning, to support pupils in developing their capacities to receive, interpret and critique
health-related information. Research along such lines would also be advocated by other researchers within the field who have called for PE to explore how it might orientate health-related learning from a critical perspective (e.g. Burrows and McCormack, 2014; Harris et al., 2016).

Future research might explore how teachers can facilitate pupils’ voices within PE as, whilst their potential is recognised, it is acknowledged that teachers are somewhat limited in what they can reasonably achieve within PE, on account of the various demands placed on them. As such, it would be beneficial for research to be conducted exploring the ways in which ‘pedagogies for voice’ can be implemented within PE, given that within this study, these have been found to be both insightful and impactful. Allied to this, it would be recommended that future research within this area (and within PE more broadly) continues to engage with the youth voice agenda for research with children and young people. Pupils’ voices have been illuminated through this study and have been found to be particularly useful in engaging teachers and encouraging them to reflect on their practice in ways in which other researchers have found difficult.

8.5 Concluding remarks
This study has made an important empirical contribution to the field of PE in that it has contributed to a growing body of literature around pupils’ conceptions of ‘health’ (see Harris et al. (2016) for an overview) and has distinctively provided a current and comprehensive study within the context of England specifically. The findings highlight that the vast majority of pupils’ conceptions of ‘health’ were reductive, limited and limiting. These conceptions of ‘health’ were identified as being underpinned by: corporeal notions, aesthetic orientations and healthist influences. In addition, they aligned with normative conceptions of ‘health’, that were influenced by public health discourses, which may well have been promulgated by and through PE. Whilst pupils did not necessarily consider that PE influenced their conceptions of ‘health’, there were evident links, which PE teachers themselves acknowledged and problematised. Positively, it highlighted that there were some pupils who were able to disrupt normative conceptions of ‘health’ and, in doing so, they demonstrated their capacity for criticality. As such, the challenge for PE is now to consider how it might best support pupils to develop their capacities to receive, interpret and be critical of health-related information. If
it can do so, it may well be that critically-inclined conceptions of ‘health’ can be fostered within, through and by PE. Teachers identified a number of implications for practice in this regard (as discussed within section 8.3) and made recommendations as to how practice might be enhanced. On this note, it is important to highlight how influential pupils’ voices have been, particularly with regard to engaging teachers within the study.

The findings from the study are also significant with regard to the continued debate concerning the role that schools might play in relation to health. Despite schools being proposed as a tenable site for health promotion and the subject of PE being highlighted as particularly relevant to this (see Cale (2017) for an overview), questionable practices around health-related teaching and learning have been noted (Cale, Harris and Chen, 2014). Such questionable practices, taken with some of the concerning conceptions evidenced within the present study, may cast further doubt on the capacity of schools (and PE) to address pupils’ health-related learning. However, given that schools have continued to be called upon in this regard over a significant period of time, it would seem unlikely that this will change in the foreseeable future. As such, it is perhaps best to remain sceptically optimistic with regard to what schools, and in particular PE, can achieve in relation to pupils’ health-related learning. Whilst researchers might contest the role that schools (and PE) can and should play in this regard, they nonetheless have a responsibility to ensure that they support practitioners as best they can to facilitate effective health-relating learning within schools.

It is significant to note that the study has also made an important methodological contribution to research within PE in that it has worked towards the youth voice agenda and employed innovative participatory methods/techniques. The research process was designed in such a manner as to facilitate youth voice, for example, pupils were given multiple opportunities to speak and were encouraged to ‘speak’ in various ways. Further, pupils’ voices were shared with teachers in an attempt to ensure that these were acted upon, which Long and Carless (2010) assert is vital in working towards the facilitation of youth voice. A participatory approach was employed within the study, in line with the youth voice agenda it worked towards, and various methods/techniques were drawn upon in this regard. Concept cartoons warrant particular mention, given that they were a novel method/technique within PE research and, as discussed within sub-section 4.4.2, were useful in exploring pupils’ conceptions of ‘health’. On this note, this study has also contributed to methodological
critique and researcher reflexivity within the field of PE which are recognised as important for the advancement of scholarship within the field.

On a personal note, the study has encouraged me to critically reflect on my own experiences of PE at school. As outlined in section 1.3, these experiences were not particularly positive and many of the practices that were associated with ‘health’ only resulted in my disaffection from the subject. It has, therefore, been particularly fulfilling to be able to engage in research that has provided so many pupils with the opportunity to ‘have a say’ in such matters and for their voices to be heard by those with the capacity to positively influence their experiences. I only hope that the teachers who were privileged enough to hear their pupils’ voices have acted on these in ways that served to enhance their experiences of PE at school. If so, this will have been the most significant contribution that this thesis has made.

Despite the aforementioned contributions, as discussed within section 8.4, there is much potential for further research around health-related teaching and learning within PE. Youth voice should be central to such scholarship, and in moving the field of PE forward, children and young people must be encouraged to ‘speak up’, especially in the name of ‘health’.
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Appendix A – Survey for Phase 1

Healthy, Active Lifestyles Study - Teacher Survey

Page 1: Introduction

A Survey of Physical Education Teachers’ Approaches to Supporting Pupils to Lead Healthy, Active Lifestyles

Dear Teacher of Physical Education,

I am currently conducting research exploring what, where and how children learn about leading a healthy, active lifestyle and how they utilise this information in their day-to-day lives. As part of this I am exploring teachers’ approaches to supporting pupils to lead healthy, active lifestyles, as is required by one of the four aims of the current National Curriculum for Physical Education (NCPE). It is anticipated that this research will help inform approaches to supporting children to lead healthy, active lifestyles within Physical Education (PE).

I would be very grateful if you or another full-time specialist PE teacher within your department could find the time to complete this survey as fully and as accurately as possible. The survey should take approximately 15-20 minutes to complete and the deadline for completion is <INSERT DEADLINE HERE>.

The study is being undertaken as part of a PhD programme of study at Loughborough University and is being jointly supervised by Dr. Jo Harris and Dr. Lorraine Cale. It has been granted ethical clearance from the Loughborough University Ethics Approvals (Human Participants) Sub-Committee and will be conducted in accordance with strict guidelines. Further, the information you provide as part of this survey will be kept confidential and the anonymity of you, your colleagues and your school, will be maintained in all reporting of the data.

1/17
If you have any questions regarding this research, please do not hesitate to contact me using the details provided below. Any comments on the survey would also be gratefully received.

Thank you in anticipation,

Oliver Hooper,
PhD Research Student at Loughborough University
Email: o.r.hooper@lboro.ac.uk
Telephone: 01509 223048
Page 2: Section 1 - General School Information

**Q1.1**  Type of School  *Required*

Please select no more than 1 answer(s).
- State Comprehensive
- Academy
- State Faith
- Free School
- Other

If you selected 'other', please specify:


**Q1.2**  Age Range of School Population  *Required*

Please select no more than 1 answer(s).
- 11-18
- 11-16
- Other

If you selected 'other', please specify:


**Q1.3**  Gender of School Population  *Required*

Please select no more than 1 answer(s).
Mixed (Throughout)  
Boys only  
Girls only  
Other

If you selected 'other', please specify:

Q1.4  School Population Size (by number of pupils)  * Required

Please select no more than 1 answer(s).  
<500  
500-1000  
1001-1500  
1501-2000  
>2000
Page 3: Section 2 - Healthy, Active Lifestyles within the PE Curriculum

**Q2.1** Does your PE department have a policy which outlines a departmental approach to teaching PE? *Required*

Please select no more than 1 answer(s).
- Yes
- I think so but am not sure
- No
- I don't know

**Q2.2** If 'yes' to Q2.1, Does your PE department's policy make explicit reference to supporting pupils to lead healthy, active lifestyles?

Please select no more than 1 answer(s).
- Yes
- I think so but am not sure
- No
- I don't know

**Q2.3** To what extent is the aim of supporting pupils to lead healthy, active lifestyles afforded time within the PE curriculum at your school? *Required*

Please select no more than 1 answer(s).
- It is afforded more than enough time
- It is afforded a reasonable amount of time
- It is afforded sufficient time
- It is afforded limited time
- It is afforded little or no time
Q2.4 What status do you feel that leading healthy, active lifestyles has within the PE department at your school? * Required

Q2.5 What key messages about leading healthy, active lifestyles does your department seek to convey to pupils, throughout their time at your school? * Required

Q2.6 Specifically, what key messages about leading healthy, active lifestyles would your department expect pupils to be aware of by the end of Year 7? * Required

Q2.7 How is pupils’ learning about healthy, active lifestyles progressed from one year to the next? * Required
| Q2.8 | What activities are used within the PE curriculum to support pupils to lead healthy, active lifestyles? *Required |
| Q2.9 | What teaching methods, styles and approaches does your department use to support pupils to lead healthy, active lifestyles? *Required |
| Q2.10 | What specific resources, equipment and facilities does your department use to support pupils to lead healthy, active lifestyles? *Required |
| Q2.11 | How does your PE department assess whether pupils are leading healthy, active lifestyles? *Required |
Q2.12 How does your PE department record and report pupils’ progress in leading healthy, active lifestyles? *Required
Page 4: Section 3 - Healthy, Active Lifestyles within the Wider School Context

Q3.1 What status do you feel that ‘leading healthy, active lifestyles’ has across your whole school? *Required

Q3.2 Is the issue of healthy, active lifestyles addressed within any other curriculum area(s) at your school? *Required

Please select no more than 1 answer(s).
- Yes
- I think so but am not sure
- No
- I don't know

If 'yes', please provide further details:

Q3.3 If 'yes' to Q3.2, how much do you know about how healthy, active lifestyles is addressed in other curriculum areas?

Please select no more than 1 answer(s).
- I know a lot about this
- I know quite a bit about this
- I have limited knowledge about this
Q3.4  How involved is your PE department in whole school approaches to health?  
*Required

Q3.5  To what extent does the extra-curricular programme at your school contribute to pupils leading healthy, active lifestyles?  *Required

Please select no more than 1 answer(s).
- Extensively
- To a reasonable extent
- To some extent
- To a limited extent
- Not at all

Q3.6  Do you think that the extra-curricular programme at your school provides opportunities for all pupils to lead healthy, active lifestyles?  *Required

Please select no more than 1 answer(s).
- Yes
- To some extent
- No
- I don't know
Please explain your response: *Required

Q3.7 Does your school have any links with local community provision (such as leisure centres, gym and sports clubs) to support pupils in leading healthy, active lifestyles? *Required

Please select no more than 1 answer(s).
- Yes, it has very good links
- Yes, it has reasonably good links
- Yes, it has some links
- Yes, but it has few or limited links
- No, it has no links

Please explain your response: *Required

Q3.8 Does your school involve parents in supporting pupils to lead healthy, active lifestyles? *Required

Please select no more than 1 answer(s).
- Yes, extensively
- To a reasonable extent
- To some extent
<table>
<thead>
<tr>
<th></th>
<th>To a limited extent</th>
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<tbody>
<tr>
<td></td>
<td>No, not at all</td>
</tr>
</tbody>
</table>

Please explain your response: *Required*
Page 5: Section 4 - Effectiveness in Addressing the Healthy, Active Lifestyles Aim

Q4.1 Does your PE department face any challenges in ensuring that pupils lead healthy, active lifestyles? *Required

Please select no more than 1 answer(s).
- Yes, there are many
- Yes, there are some
- No there are none

If 'yes', please provide further information:

Q4.2 How well do you think your PE department ensures that all pupils lead healthy, active lifestyles? *Required

Please select no more than 1 answer(s).
- Very well
- Reasonably well
- Adequately
- Not very well
- Poorly

Please explain your response:
Q4.3 In what way(s), if any, do you feel that your pupils could be more effectively supported to lead healthy, active lifestyles? * Required

Q4.4 In what way(s), if any, do you feel that your PE department could be supported or more effectively supported to lead healthy, active lifestyles? * Required

Q4.5 Do you think that your PE department needs additional support to address the aim of supporting pupils to lead healthy, active lifestyles? * Required

Please select no more than 1 answer(s).
- Yes
- Maybe
- No
- I don't know
Q4.6 If 'yes' to Q4.5, what additional support would be most useful in helping your PE department to supporting pupils to lead healthy, active lifestyles?

Q4.7 Have you accessed any specific Continuing Professional Development (CPD)\(^1\) relevant to addressing the aim of supporting pupils to lead healthy, active lifestyles?  *Required

Please select no more than 1 answer(s).
□ Yes
□ No

If 'yes', please provide further information:

For the purpose of this questionnaire:

\(^1\)CPD refers broadly to any activity, from the point of Initial Teacher Training that "increases the skills, knowledge or understanding of teachers, and their effectiveness in schools" (DfEE, 2000, p.3).
Page 6: Conclusion

Thank you for your time, you have now completed this survey.

Do you have any feedback?

If you have any feedback or comments in relation to any aspect of this questionnaire, please write these in the space provided below: Optional

Are you willing to be involved in further research as part of this study?

This is the first phase of the study, following which the intention is to select two secondary schools within the East Midlands as case study schools. In future phases of the study, the case study schools will be involved in focus groups with Year 7 pupils and interviews and focus groups with full-time PE specialist teachers. If you are interested in being involved in future phases of the study, please write your contact details in the box below and you will be provided with further information about this at a later date. Please note that this is purely an expression of interest at this stage and does not commit you to participate in the future, should you choose not to do so. Optional

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Page 7: End of Survey
Case Study School – Selection Criteria

**Demographic Factors:**

- Q1.1 State Comprehensive or Academy
- Q1.2 11-16 or 11-18
- Q1.3 Mixed
- Q1.4 1001 pupils +

**Factors relating to HAL and the PE Curriculum:**

- Q2.1 Yes
- Q2.2 Yes
- Q2.3 It is afforded a sufficient amount of time or it is afforded a reasonable amount of time

- Q4.1 Yes, there are some or Yes, there are many
- Q4.2 Sufficiently or reasonably well
- Q4.5 No / Maybe or Yes

**Staff/Research Student:**
- Schools were sought where a departmental policy with explicit reference to HAL was in place, as an indication that the PE department had committed to addressing HALs within the PE curriculum.

**Staff/Research Student:**
- Schools that faced challenges in addressing HALs with pupils were sought so that it could be assumed that schools had recognized and identified difficulties in addressing this.

**Staff/Research Student:**
- Schools that thought there was capacity to develop their practice were sought so that there was the potential for departments to develop their curriculum – with teachers being provided the opportunity to do so via focus groups facilitated by the researcher with the research process.

**Staff/Research Student:**
- Schools that had contrasting views in terms of whether or not they thought they needed support were sought so as explore what support schools do need, in order to effectively address HALs, and to explore why schools might feel that they do not need additional support.
Appendix C – Head Teacher Letter

Dear Head Teacher,

I am a PhD Research Student at Loughborough University and I am conducting a study entitled ‘Children’s (Mis)Information, (Mis)Understandings and (Mis)Conceptions about Healthy Active Lifestyles’. The purpose of this is to explore what, where and how children learn about leading a healthy, active lifestyle and how they utilise this information in their day-to-day lives.

As part of the first phase of the study, a Physical Education (PE) teacher at your school completed an online survey that was aimed at exploring approaches to supporting children to lead healthy, active lifestyles. At the end of the survey, they expressed an interest in being involved in the next phases of the study. I am therefore writing to you to request your permission to involve your school as one of two case study schools within the research project.

The study will involve approximately sixty Year 7 pupils (selected from the year group based on a randomised stratified sample) participating in focus group discussions. These will be conducted in groups of approximately 4-6 pupils and will be approximately 40-50 minutes in duration. The focus groups will be based on a group discussion but will also involve children participating in activities such as categorising images and expressing their opinions in relation to certain statements to promote and stimulate discussion. The pupils will participate in two focus groups in total, one at the beginning of Year 7 and the other at the end. There will be no obligation for pupils to take part in the research and, prior to commencement of the study, letters will be sent to parents enabling them to opt out of the study, should they so choose. The pupils themselves will subsequently be asked to sign a consent form during their first interaction with myself. All of the arrangements for these focus groups will be made in negotiation with, and at the convenience of, members of staff at your school.

Additionally, interviews and focus groups will be conducted with full-time PE specialist teachers with QTS at your school. These will seek to further explore teachers’ approaches and to supporting children to lead healthy, active lifestyles and potentially identify effective approaches to this within curricular PE. The interviews will be conducted individually and the focus groups will be conducted in groups of about 2-3. These will each be approximately 50-60 minutes in duration. The teachers’ participation will be voluntary and all arrangements will be made at staff members’ convenience.

The focus groups and interviews will be audio recorded and transcribed to aid data analysis, however, all of the information obtained will be integrated anonymously into the PhD thesis and written report. The anonymity of the school, teachers and pupils will be maintained throughout all reporting and all data will be destroyed following completion of the study and in line with data protection legislation. A summary of the main findings of the study will be made available to you on completion.

School of Sport, Exercise & Health Sciences
Sir John Beckwith Building
Loughborough University, Leicestershire, LE11 3TU,
Telephone: +44 (0)1509 226303 Fax: +44 (01509) 226379
The research project has been approved by Loughborough University’s Ethics Approvals (Human Participants) Sub-Committee and I will be working within the University’s strict guidelines and protocols for this type of research. I am also supervised by experienced research staff, Dr. Jo Harris and Dr. Lorraine Cale, also of the University. Further, I have an enhanced DBS clearance which can be made available to you at your request.

I appreciate that there are numerous demands placed on your school and the staff working within it. However, I believe that this research could make a meaningful contribution to PE practice and ultimately better support children to lead healthy, active lifestyles. As such, your school’s participation in this study would be greatly appreciated. If you are willing for your school to be involved, I would be grateful if you could complete and return the form on the next page. Equally, if you would like to discuss this research study further, please do not hesitate to contact me (using the details provided below) and I will be happy to answer any questions you may have.

Yours sincerely,

Oliver Hooper  
PhD Research Student at Loughborough University

Email: o.r.hooper@lboro.ac.uk  
Telephone: 01509 223048
Healthy, Active Lifestyles Study

School Consent Form

- The purpose and details of this study have been explained to me. I understand that this study is designed to further scientific knowledge and that all procedures have been approved by the Loughborough University Ethics Approvals (Human Participants) Sub-Committee.

- I have read and understood the information provided on the attached letter and this consent form.

- I have had an opportunity to ask questions about my school’s participation.

- I understand that my school is under no obligation to take part in the study.

- I understand that I have the right to withdraw my school from this study at any stage and for any reason, and that I will not be required to explain my reasons for withdrawing.

- I understand that all the information I provide will be treated in strict confidence and will be kept anonymous and confidential to the researchers unless (under the statutory obligations of the agencies which the researchers are working with), it is judged that confidentiality will have to be breached for the safety of the participant or others.

Please sign this form if you are happy for your school to participate in this research

☐ I am happy for my school to take part in this research (please tick box)

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### Appendix D – Sampling Grids

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Appendix E – Parent Information Sheet and Consent Form

School of Sport, Exercise & Health Sciences
Sir John Beckwith Building
Loughborough University, Loughborough, Leicestershire, LE11 3TU

Dear Parent/Guardian,

Your child’s school is currently involved in a research project exploring children’s knowledge and understanding about leading healthy, active lifestyles. This project is being undertaken by a researcher from Loughborough University as part of a PhD research study. The purpose of this is to explore what, where and how children learn about leading a healthy, active lifestyle and how they utilise this information in their day-to-day lives. This letter requests permission for your child to take part in this study.

What’s involved?

The children taking part will be involved in two focus groups (a small group discussion), one at the beginning of Year 7 and one at the end. Each focus group will involve approximately 4-6 children, and these will all be from Year 7. The focus groups will also involve children participating in activities such as expressing their thoughts in response to images and categorising statements. These will be used to promote and stimulate discussion about healthy, active lifestyles. The discussions, facilitated by the researcher undertaking the study, will be audio recorded and then transcribed to aid data analysis.

What happens to the information?

The information obtained from the focus groups will be integrated anonymously into a written report, with your child’s anonymity being maintained throughout the reporting of the study and with all data being wholly destroyed after 10 years in order to comply with legislation. A summary of the main findings of this report will be made available to your child’s school following completion of the research. Your child will be able to withdraw their data at any point up until 3 months after the completion of the data collection when it will be aggregated in the study, and no longer be able to be withdrawn.

Important information:

The research project has been approved by Loughborough University’s Ethics Approvals (Human Participants) Sub-Committee and the researcher will be working within the University’s strict guidelines and protocols for this type of research. He is also supervised by experienced research staff from the University. The researcher has an enhanced DBS (criminal record) clearance and as such is deemed suitable to work with children.
There is no obligation for your child to take part in the research. Further, each child will be asked to provide written consent themselves before being involved in the focus group discussions and will be able to stop taking part at any point if they wish.

What if I am not happy with how the research was conducted?

If you are not happy with how the research was conducted, please contact Ms Jackie Green, the Secretary for the University’s Ethics Approvals (Human Participants) Sub-Committee:

Ms J Green (Research Office)
Address: Hazlerigg Building, Loughborough University, Loughborough, LE11 3TU
Email: J.A.Green@lboro.ac.uk
Telephone: 01509 222423

The University also has a policy relating to Research Misconduct and Whistle Blowing which is available online at http://www.lboro.ac.uk/committees/ethics-approvals-human-participants/additionalinformation/codesofpractice/

You are advised to use this to take appropriate action.

If I have some more questions, who should I contact?

If you have any questions about this research study, Oliver Hooper (the researcher) will be happy to answer these, as will his supervisor, Dr. Jo Harris. Their contact details are provided below.

Oliver Hooper:
Email: o.r.hooper@lboro.ac.uk
Telephone: 01509 223048

Dr. Jo Harris:
Email: j.p.harris@lboro.ac.uk
Telephone: 01509 223250

What do you need to do now?

If you DO NOT want you child to take part in this study please complete and the form on the next page and return it to their form teacher at school by <INSERT DEADLINE HERE>. Otherwise, if you are happy for your child to participate, no further action is required.

Yours sincerely,

Oliver Hooper
PhD Research Student at Loughborough University
Healthy, Active Lifestyles Study
Parent Opt-out Form

Please only complete and return this form if you **DO NOT** want your child to take part in this study.

I am **not willing** for my child (*please print child’s name*) to take part in this research study: ______________________________

Parent/Guardian’s Name: ________________________________________

Parent/Guardian’s Signature: ________________________________
Appendix F – Teacher Information Sheet and Consent Form

School of Sport, Exercise & Health Sciences
Sir John Beckwith Building
Loughborough University, Loughborough, Leicestershire, LE11 3TU

Healthy, Active Lifestyles Study - Information Sheet for Teachers

What is the purpose of the study?
The purpose of this is to explore what, where and how children learn about leading a healthy, active lifestyle and how they utilise this information in their day-to-day lives. As part of this, the study will explore teachers’ approaches to supporting children to lead healthy, active lifestyles and the role of schools within this.

Who is doing this research and why?
The study is being carried out by Oliver Hooper, a PhD Research Student at Loughborough University, and is being overseen by two research supervisors, Dr. Jo Harris and Dr. Lorraine Cale. The findings from the study should lead to an improved understanding of what, where and how children learn about leading a healthy, active lifestyle and how they utilise this information. It is anticipated that this will help inform teaching approaches to support children to lead healthy, active lifestyles within Physical Education (PE) at school.

Once I take part, can I change my mind?
Yes. After you have read this information and asked any questions you may have, you will be asked to complete an informed consent form to state that you agree to take part, should you choose to do so. However, if at any time, you change your mind and wish to withdraw from the study you will be able to, please just let the researcher know (contact details provided below). You are able to withdraw at any time, for any reason, and you will not be asked to explain your reasons for withdrawing. You are also able to withdraw your data at any point up until 3 months after the completion of the data collection when it will be aggregated in the study, and no longer be able to be withdrawn.

What will I be asked to do and when?
You will be involved in an interview during which you will be asked about how you and your department currently support children to lead healthy, active lifestyles. The interviews will be conducted by the researcher from Loughborough University during the normal school day at a time convenient to yourself and will be audio recorded to help with data analysis.

At a later stage in the study, you will also be asked to participate in a focus group with one or two other full-time PE specialist teachers at your school where you will be presented with selected findings about what the pupils at your school know, understand and think about healthy, active lifestyles, where and how they have learned this information, and how they use it. Following this, you and your colleagues will be asked to discuss these findings and to discuss approaches to teaching that effectively support children to lead healthy, active lifestyles. These focus groups will also be audio recorded to enable subsequent data analysis.
How long will it take?
Each interview will take approximately 45 minutes and each focus group will take approximately 60 minutes.

Will my taking part in this study be kept confidential?
Yes. All the information will be confidential, and no-one will be able to identify who you are from the report. To ensure your confidentiality, all data from this study will be kept on a password protected computer and will be wholly destroyed after 10 years in order to comply with legal requirements.

What will happen to the results of the study?
The results of the study will be written into a report by the researcher from Loughborough University. A summary of the main findings of this report will be made available to your school.

If I have some more questions, who should I contact?
If you have any questions about this research study, Oliver Hooper (the researcher) will be happy to answer these, as will his supervisor, Dr. Jo Harris. Their contact details are provided below.

Oliver Hooper:
Email: o.r.hooper@lboro.ac.uk
Telephone: 01509 223048

Dr. Jo Harris:
Email: j.p.harris@lboro.ac.uk
Telephone: 01509 223250

What if I am not happy with how the research was conducted?
If you are not happy with how the research was conducted, please contact Ms Jackie Green, the Secretary for the University's Ethics Approvals (Human Participants) Sub-Committee:

Ms J Green (Research Office)
Address: Hazlerigg Building, Loughborough University, Loughborough, LE11 3TU
Email: J.A.Green@lboro.ac.uk
Telephone: 01509 222423

The University also has a policy relating to Research Misconduct and Whistle Blowing which is available online at http://www.lboro.ac.uk/committees/ethics-approvals-human-participants/additionalinformation/codesofpractice/

You are advised to use this to take appropriate action.
Healthy, Active Lifestyles Study
Teacher Consent Form
(to be completed after the Information Sheet has been read)

The purpose and details of this study have been explained to me. I understand that this study is designed to further scientific knowledge and that all procedures have been approved by the Loughborough University Ethics Approvals (Human Participants) Sub-Committee.

Yes ☐ No ☐

I have read and understood the information sheet and this consent form.

Yes ☐ No ☐

I have had an opportunity to ask questions about my participation.

Yes ☐ No ☐

I understand that I am under no obligation to take part in the study.

Yes ☐ No ☐

I understand that I have the right to withdraw from this study at any stage for any reason, and that I will not be required to explain my reasons for withdrawing.

Yes ☐ No ☐

I understand that all the information I provide will be treated in strict confidence and will be kept anonymous and confidential to the researchers unless (under the statutory obligations of the agencies which the researchers are working with), it is judged that confidentiality will have to be breached for the safety of the participant or others.

Yes ☐ No ☐

I agree to participate in this study.

Yes ☐ No ☐

Name of school: ________________________________

Your name: ________________________________

Your signature: ________________________________

Signature of investigator: ________________________________

Date: ________________________________

Thank you for taking the time to read this information and complete this form.
Appendix G – Interview Schedule for Phase 2

Interview Schedule

[Set up and start recording equipment and name the file. Ensure that the room is laid out appropriately for the interview.]

- Good morning/afternoon, my name is Oliver and I’m a researcher from Loughborough University, though you’ll probably already know that if you’ve had chance to read the information sheet. So, today you’re going to be taking part in an interview and I’m going to be asking you a number of questions. Before we start though, I’d just like to make sure that you’ve read the information sheet and completed the consent form to say that you’re happy to take part, and check if you have any questions about this?
  [Check that consent form has been signed appropriately.]

- Okay, so now that we’ve checked that, I’ll explain a little more about the interview. The study that you’re taking part in is on children’s learning about healthy, active lifestyles and how you, your department and your school support them with this, so try to bear this in mind. If there are any questions you’re unsure of, or that you need me to repeat or rephrase for you, just let me know as we progress through the interview. I might also ask follow-up questions at times, based on the responses you give, and this is just where I want to find out a little more, or check that I understand what you’re saying to me. I’ll also be referring to a schedule during the interview to make sure that I cover all of the necessary questions.

- Just to remind you, if you want to stop taking part in the interview at any point, you can, and you won’t be asked to give a reason. The information you provide me with today will be kept confidential and won’t be shared with your department or school, so please do your best to be honest with your answers to my questions.

- So, we’re about ready to begin, I’ll just check that the recording equipment is working and then we’ll make a start. This will be on throughout the interview and I might check it now and again to make sure it’s recording. Please don’t worry that the interview is being recorded, this is just so that I can recall what you’ve said, and remember, what you say will be kept confidential, so just try and forget about the recorder.
  [Check that the recording equipment is working correctly.]

Introductory Questions:

- Can you please give me a brief summary of your teaching career so far?
  (Prompts: How long have you been teaching? Have you taught in other schools? If so, how long have you taught here for? What type of ITT did you complete? Where did you complete this? Do you have any specific responsibilities, such as examination PE?)
Main Questions:

Section 1: Healthy, Active Lifestyles within the PE Curriculum

• Does your department have a written policy that outlines a departmental approach to teaching PE?
  Follow up: Does this make explicit reference to supporting pupils to lead healthy, active lifestyles? If so, what does it say about this?

• What status do you think leading a healthy, active lifestyle has within the PE curriculum at your school?
  Follow up: Why do you say this?

• Do you think the National Curriculum aim of ensuring that all pupils lead healthy, active lifestyles is afforded sufficient time in your school’s PE curriculum?
  Follow up: Can you tell me why you think this?

• Can you tell me any key messages associated with leading healthy, active lifestyles that your department conveys to pupils in PE lessons?
  Follow up: Can you tell me some key messages that you’d expect pupils to be aware of by the end of Year 7 that support them to lead a healthy, active lifestyle?

• How does your department currently seek to address healthy, active lifestyles within PE?
  Follow up: What activities are employed to address healthy, active lifestyles in PE? Are there any specific resources, equipment or facilities that are used? Do you or any of your colleagues in PE use any particular methods, approaches or strategies when teaching pupils about healthy, active lifestyles?

• What source(s) of information do you draw upon when you are teaching pupils about leading healthy, active lifestyles?
  Follow up: What source(s) do you find most useful? Why is this?

• How does your department progress pupils’ learning about healthy, active lifestyles from one year to the next?

• Does your department monitor or assess whether pupils are leading healthy, active lifestyles?
  (If yes: Can you tell me more about this? How often are pupils assessed? Is this recorded or reported anywhere? Who is information shared with?
  If no: Why does your department not do this? Do you think it should?)

[Check that the recording equipment is working correctly.]
Section 2: Healthy, Active Lifestyles within the Wider School

• What status do you think that ensuring pupils leading healthy, active lifestyles has across the whole school? Follow up: Why do think this is?

• Is there a whole school approach to the adoption of healthy, active lifestyles? (If yes: Can you tell me who leads on this and how involved your PE department is with this?)

• Is the issue of healthy, active lifestyles addressed within other curriculum areas? If so, which? Follow up: How much do you know about this? Is this learning coordinated with that which is delivered within PE? Do you or your colleagues within PE contribute to this? If so, in what way(s)?

• To what extent does the extra-curricular programme at your school contribute to pupils leading healthy, active lifestyles? Follow up: Does the extra-curricular programme provide opportunities for all pupils to lead healthy, active lifestyles? If not, which groups of pupils does it not support? Why do you think this is?

• What links does your school have with local community provision, such as leisure centres, gyms or sports clubs? Follow up: To what extent do these links contribute to pupils leading healthy, active lifestyles? Can you tell me more about these?

• Does your school involve parents in supporting pupils to lead healthy active lifestyles? (If yes: Can you tell me more about this? If no: What are the reasons for this?)

[Check that the recording equipment is working correctly.]

Section 3: Effectiveness in Addressing the Healthy, Active Lifestyles Aim

• How well do you think that your PE department does in ensuring that all pupils lead healthy, active lifestyles? Follow up: Why do you think this? What does your department do well/not so well? Do you think it is your department’s responsibility to ensure that pupils lead healthy, active lifestyles? Why do you think this?

• Does your department face any challenges in ensuring that pupils lead healthy, active lifestyles? If so, can you tell me more about these?
• In what way(s), if any, could your pupils be more effectively supported to lead healthy, active lifestyles?

• Do your pupils ever express any confusion about information related to leading a healthy, active lifestyle? If so, can you provide any examples of this? Follow up: If pupils do seem confused about information related to leading a healthy, active lifestyle, do you or your colleagues help them to make sense of all this? If so, in what ways do you do this?

• In what way(s), if any, could your department be supported, or more effectively supported, to promote healthy, active lifestyles? Follow up: What support would be most helpful?

• Have you, or any of your colleagues in PE, accessed any professional development to help you address the NCPE aim of supporting pupils to lead healthy, active lifestyles? (If yes: Can you tell me more about this? When was this? How useful was this? Was this information shared within the PE department? Did this make a difference to your/the department’s approach to teaching pupils about healthy, active lifestyles? If no: What are the reasons for this? If professional development had been available, would you have accessed this? What sort of professional development would you find most useful?)

Concluding Questions:

• Is there anything else you’d like to tell me about how you, your department or your school support pupils to lead healthy, active lifestyles that you think might be relevant, and that hasn’t been covered in the questions?

• Well, that just about concludes the interview this morning/afternoon. But, before we finish, do you have any questions for me?

• Just to remind you, should you have any questions after today, you have my contact details so please do get in touch and I’ll be happy to answer these for you.

• Thank you very much for your time today. We’ll conclude the interview there.

[Stop the recording and check that the file has been saved.]
Appendix H – Design Brief for Concept Cartoons

Design Brief

1) This image will be of a child (female) being active in a PE lesson at school, throwing a ball to a peer. The background of the image will be a sports hall and there will be a PE teacher and some other children present. The children will be of different genders, ethnicities, and there will be children of different sizes (height and body weight).

2) This image will be of a child (male) being active in the community at a leisure centre swimming pool. They will be playing around in the pool with their sibling(s). The background of the image will be a pool and there will be two parents present in the water with the children also.

3) This image will be of a teenager (male) playing rugby and making a tackle. They will be relatively large in their build but not excessively muscular or overweight. The background of the image will be a muddy pitch and the rugby player will have grazed knees and be covered in a little mud. The teenagers will be of different ethnicities, and there will be players of different sizes.

4) This image will be of an adult (male) undertaking weightlifting activities (using free weight dumbbells) and the background will be of a gym with others present in the background (for example, on a treadmill). The weightlifter, though they should be ‘bulky’ should not be excessively muscular. The gym-goers will be of different genders, ethnicities and sizes.

5) This image will be of an adult (male) being active in their home and vacuuming. The background of this image will be a lounge and the individual will seem to be vacuuming around in the room. Also, in the background will be a child (female) laid on a sofa watching television.

6) This image will be of a teenager (female) playing on an ‘active’ games console (e.g. Wii). The background of the image will be a bedroom and there will be an energy drink that is noticeable on a desk.

7) This image will be of a family eating a meal in the evening and sat at a dining table, there will be one parent (mother) and three children present. The mother will be eating a healthy meal, with chicken and lots of vegetables whilst the children will be eating fish fingers and chips. One of the three children (the older child) will also have a noticeably larger portion than the other two. There will be a bottle of wine on the table and also a jug of water.

8) This image will be of a child (female) cycling to school. They will be wearing a helmet and have a high-vis vest on, with a rucksack on their back. The child will be using a cycle lane and on the road adjacent to them there will be a car going past.
9) This image will be of a group of three friends (children) sat in a park on a bench chatting, one of the friends will be in a wheelchair sat adjacent to the bench. One of the children sat on the bench will also have a diet fizzy drink in their hand. In the background, there will be another child sat on their own on a bench, looking quite serious and absorbed, and looking down at their mobile phone. The children will be of different ethnicities and there will be children of different sizes.

10) This image will be of a teenager (female) sat at a desk late at night with books around them. The teenager will be doing homework, look stressed and have poor posture. The background of the image will be their bedroom and there will be an alarm clock that noticeably reads 01:34 am.
Appendix I - Focus Group Schedule for Phase 2

**Focus Group Schedule**

*Set up and start recording equipment and name the file. Ensure that the room is laid out appropriately for the focus group and that the resources are ready.*

- Good morning/afternoon everyone, my name is Oliver and I’m a researcher from Loughborough University, though you’ll probably already know that if you’ve had chance to read the information sheet. So that I make sure I use your names, could you please write your first name on one of the stickers in front of you and stick it on your chest so that I can see it?

  *Give pupils name labels and ensure these can clearly be read.*

- So, today you’re going to be taking part in a focus group, which is a small group discussion, and there are going to be different activities for you to have a go at. Before we start though, I’d just like to make sure that you’ve read the information sheet and completed the assent form to say that you’re happy to take part, and check if you have any questions about this?

  *Check that assent forms have been signed appropriately.*

- Okay, so now that we’ve checked that, I’ll explain a little more about the focus group. The study that you’re taking part in is on what, where and how you learn about leading a healthy, active lifestyle, so try to bear this in mind. Today you’ll be completing some activities to help us discuss this; you’ll be working on your own for some of these activities and as a group for others. I’ll also be asking you questions as we go along to find out what you know and think. Please don’t worry if you can’t answer these, and if there are any questions you’re unsure of, or that you need me to repeat or rephrase for you, just let me know. I might also ask some follow-up questions to some of the answers you give, and this will just be when I want to know a little more or check that I understand what you’ve told me.

- Just to remind you, if you want to stop taking part in the focus group at any point, you can, and you won’t be asked to give a reason. The information you provide today will be kept private and won’t be shared with your teachers so please do your best to be honest with your answers to my questions. I’m interested in what you know and think, and it doesn’t matter if what you think is different to what someone else thinks, so always try to give your own opinion.

- So, we’re about ready to begin, I’ll just check again that the recording equipment is working and then we’ll make a start. This will be on throughout the focus group and I might check it now and again to make sure it’s recording. Please don’t worry that the focus group is being recorded, this is just so that I can recall what you’ve said, and remember, what you say will be kept private, so just try and forget about the recorder.
[Check that the recording equipment is working correctly.]

Activity 1:    
(Approx. 10 minutes allotted time)

- Right, let’s make a start with the first activity. Working on your own, I’d like each of you to draw on the sheet in front of you what health means to you. You can draw whatever you think health means and what you draw is completely up to you. There isn’t a right or wrong way to do this activity so just have a go at it. You’ve got 5 minutes to do this and when this time is up we’re going to talk about what you’ve drawn. I’ll let you know when there’s 1 minute to go, just so that you know how long you have to complete the activity.

Follow up Questions:

- Can you show the rest of the group and tell us about what you’ve drawn?
- Why does this drawing mean health to you?

  → Further questions to be determined based on pupils’ responses and phrased using their language.

Activity 2:    
(Approx. 15 minutes allotted time)

- Okay, let’s move on to the second activity. For this, I’m going to put some images on the table and I’m going to give you time to look through these. Whilst, you’re looking through them, I want you to think about anything that you think is to do with health. Once you’ve had chance to look through these, I’d like you to talk as a group about what you’ve seen in the images that you think is to do with health. I’ll then ask you a few questions about what you’ve seen.

  [Present images 1-10 to pupils.]

Follow up Questions:

- What have you seen in the images that is to do with health?
- What do you think about what you’ve seen?
- What makes you think that is ‘healthy/unhealthy’? (If pupils refer to something as ‘healthy/unhealthy’)

  → Further questions to be determined based on pupils’ responses and phrased using their language.
Activity 3: (Approx. 15 minutes allotted time)

- Now, for the third activity, I’m going to give you each a worksheet that has some statements about health on it. I’d like you to read each statement on your own and then put a sticker in the box next to it, to show whether you think it’s true, false, or you don’t know. So, if you think it’s true, put a green tick sticker in the box, if you think it’s false, put a red cross sticker in the box, and if you don’t know, put an orange question sticker in the box. When everyone has done this, we’re going to talk about what you think of each statement. Remember, it’s not a problem if you think differently to others. I want you to tell me what you think, so don’t worry about having different opinions. Also, it’s not a problem if you don’t really know, again, just be honest about this.

[Present statements 1-5 to pupils.]

Follow up Questions:

- So, thinking about this statement (indicating a particular statement), do you think it’s true, false, or don’t you know?
  Follow up: What makes you think this is true/false (depending on response)?
- If you think this is false, what would the correct version of this statement say? (If a false response is decided upon).

- Well done so far everyone, we’re making really good progress! So, now I’d like you to turn over your worksheet and you’ll see there are some more statements on the other side. This time, I’d like you to tell me whether you agree or disagree with each statement or whether you’re not sure. So, if you agree, put a green tick sticker in the box, if you disagree, put a red cross sticker in the box, and if you aren’t sure, put an orange question sticker in the box. Just like with the other statements, when everyone has finished, we’ll talk about what you think of each statement. Again, don’t worry if your opinion is different from others and don’t worry if you aren’t sure.

[Present statements 6-10 to pupils.]

Follow up Questions:

- So, thinking about this statement [indicating a particular statement], do you agree or disagree with this statement?
  Follow up: What makes you agree/disagree (depending on response)?
Activity 4: (Approx. 15 minutes allotted time)

Okay, now we’re going to move on to the fourth activity. For this I’d like you to make a mind map for me on the piece of paper in front of you, and on this I’d like you to show me all of the sources that you get information from about health. So, what’s a source of information? This is someone or something that you might get information from about health. Also, in case you aren’t sure what a mind map is, it’s a diagram where you write what you’re thinking about in the middle and then you put all the ideas you have about this around it. So, your mind map has ‘sources of information’ in the middle so that you can write your ideas around this.

I’d like you to try and think of as many sources as possible that you get information from and there aren’t any wrong answers to this, so if you think you get information from someone or something then write it on your mind map. You’ve got 5 minutes to do this and when this time is up we’re going to talk about what you’ve included in your mind maps. I’ll let you know when there’s 1 minute to go, just so that you know how long you have to complete the activity.

Follow up Questions:

- How many different sources have you thought of?
- What different sources have you thought of that you get information about health from?
- What are the most useful sources of information do you think? What makes them useful?
- Do you ever have any questions about health?
- If you had a question about health how would you go about finding out the answer?
- Do you think that all of the information that you find out about health is accurate?
- Do you ever get different information from different sources (i.e. where they say different things)? If so, can you give me an example?
- What happens if the information you get from different sources doesn’t agree and tells you different things?

[Check that the recording equipment is working correctly.]

- Well, that’s nearly the end of the focus group this morning/afternoon. But, before we finish, does anyone have any questions for me?

- Just to remind you, should you have any questions after today, you have my contact details so please do get in touch and I’ll be happy to answer these for you.

- Thank you very much for your time today everyone, I hope you’ve enjoyed the activities and well done for all working together so well. We’ll stop the focus group there.

[Stop the recording and check that the file has been saved.]
Appendix J - Focus Group Materials for Phase 2

Health

Name: ________________________________________
<table>
<thead>
<tr>
<th>Statement</th>
<th>True, False or Don’t Know?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) You should be active for 30 minutes per day at a moderate intensity (this means at a level that makes you feel warmer and breathe harder than normal).</td>
<td></td>
</tr>
<tr>
<td>2) The amount of time you should be active for each day can be added up bit by bit, you don’t have to do it all at once.</td>
<td></td>
</tr>
<tr>
<td>3) Exercise that feels ‘easy’ can be good for your health.</td>
<td></td>
</tr>
<tr>
<td>4) Being thin is ‘good’ for your health.</td>
<td></td>
</tr>
<tr>
<td>5) It doesn’t matter if you’re not healthy when you’re younger. Health is something that you need to worry about when you’re older.</td>
<td></td>
</tr>
</tbody>
</table>

Name: ___________________________________________
<table>
<thead>
<tr>
<th>Statement</th>
<th>Agree, Disagree or Not Sure?</th>
</tr>
</thead>
<tbody>
<tr>
<td>6) You can tell whether a person is healthy by looking at them.</td>
<td></td>
</tr>
<tr>
<td>7) You can’t rely on health messages you hear or read in the media (for example, the internet, TV and magazines).</td>
<td></td>
</tr>
<tr>
<td>8) It’s important to constantly monitor your health.</td>
<td></td>
</tr>
<tr>
<td>9) School is where children should learn about leading a healthy, active lifestyle.</td>
<td></td>
</tr>
<tr>
<td>10) If you follow health guidelines, such as eating 5 pieces of fruit and vegetables a day, you will be healthy.</td>
<td></td>
</tr>
</tbody>
</table>

Name: ____________________________________________
Appendix K – Pupil Information Sheet and Assent Form

School of Sport, Exercise & Health Sciences
Sir John Beckwith Building
Loughborough University,
Loughborough, Leicestershire,
LE11 3TU

Healthy, Active Lifestyles Study - Information Sheet for Pupils

What is the purpose of the study?
The purpose of the study is to find out what, where and how you learn about leading a healthy, active lifestyle and how you use this information in your day-to-day life.

Who is doing this research and why?
The study is being carried out by Oliver Hooper, a PhD Research Student at Loughborough University, and is being overseen by two research supervisors, Dr. Jo Harris and Dr. Lorraine Cale.

The findings from the study should lead to a better understanding of what, where and how you learn about leading a healthy, active lifestyle and how you use this information. This may mean that teachers can be better supported to help you to lead healthy, active lifestyles through Physical Education (PE) at school.

Once I take part, can I change my mind?
Yes. After you have read this information and asked any questions you may have, you will be asked to complete an informed assent form to state that you agree to take part. However, if at any time, you change your mind and wish to stop taking part in the study you will be able to, please just let the researcher know (contact details provided below). You are able to stop taking part at any time, for any reason. You will not be asked to explain your reasons for not participating anymore, and no-one will mind about this. You are also able to remove your data at any point up until 3 months after the completion of the data collection when it will be combined in the study, and no longer be able to be removed.

What will I be asked to do and when?
You will be involved in two focus groups (a small group discussion) with approximately 4-5 other pupils in your year group, one at the beginning of Year 7 and one at the end. In the focus groups, you will also participate in activities such as expressing your thoughts in response to images and categorising statements. These activities will be used to encourage and support discussion about healthy, active lifestyles. The focus groups will be led by the researcher from Loughborough University during the normal school day and will be audio recorded to help with analysing the data.

How long will it take?
Each focus group will take approximately 45 minutes.
Will my taking part in this study be kept confidential?
Yes. All the information will be private, and no-one will be able to identify who you are from any of the results as these will be made anonymous. To ensure your privacy, all data from this study will be kept on a password protected computer and will be completely destroyed after 10 years in order to comply with legal requirements.

What will happen to the results of the study?
The results of the study will be written into a report by the researcher from Loughborough University. A summary of the main findings of this report will be made available to your school.

If I have some more questions, who should I contact?
If you have any questions about this research study, Oliver Hooper (the researcher) will be happy to answer these, as will his supervisor, Dr. Jo Harris. Their contact details are provided below.

Oliver Hooper:
Email: o.r.hooper@lboro.ac.uk
Telephone: 01509 223048

Dr. Jo Harris:
Email: j.p.harris@lboro.ac.uk
Telephone: 01509 223250

What if I am not happy with how the research was conducted?
If you are not happy with how the research was conducted, please contact Ms Jackie Green, the Secretary for the University’s Ethics Approvals (Human Participants) Sub-Committee:

Ms J Green (Research Office)
Address: Hazlerigg Building, Loughborough University, Loughborough, LE11 3TU
Email: J.A.Green@lboro.ac.uk
Telephone: 01509 222423

The University also has a policy relating to Research Misconduct and Whistle Blowing which is available online at http://www.lboro.ac.uk/committees/ethics-approvals-human-participants/additionalinformation/codesofpractice/

You are advised to use this to take appropriate action.
Healthy, Active Lifestyles Study
Pupil Assent Form
(to be completed after the Information Sheet has been read)

I know what the ‘Healthy, Active Lifestyles Study’ is about

Yes ☐ No ☐

I understand what taking part involves.

Yes ☐ No ☐

I know that everything I tell you is private.

Yes ☐ No ☐

I know that if you think I or others might not be safe, you will have to tell somebody.

Yes ☐ No ☐

I am happy for you to record what I say to you.

Yes ☐ No ☐

I know that you will write a report that will include the things that I tell you.

Yes ☐ No ☐

I know that I do not have to answer all of the questions.

Yes ☐ No ☐

I know that I can stop taking part at any time and that no-one will mind if I want to stop taking part.

Yes ☐ No ☐

Name of school: ____________________________

Your name: ________________________________

Your signature: _____________________________

Signature of investigator: ____________________

Date: ________________________________

Thank you for taking the time to read this information and complete this form.
Focus Group Schedule

[Set up and start recording equipment and name the file. Ensure that the room is laid out appropriately for the focus group and that the resources are ready.]

- Good morning/afternoon everyone, you might or might not remember me, but my name is Oliver. I’m a researcher from Loughborough University, and I visited your school previously to do some research with you. Just to remind me of your names, and so that I make sure that I use them, could you please write your first name on one of the stickers in front of you and put it on your chest so that I can see it?

  [Give pupils name labels and ensure these can clearly be read.]

- So, today you’re going to be taking part in another focus group like the last time I visited. Just to remind you, a focus group is a small group discussion and, like before, there are going to be different activities for you to have a go at. Now, when I visited you last time, I asked you all to read an information sheet and then to complete an assent form, to say that you’re happy to take part. I do just need to check though, that everyone is still happy to take part? Now I’ve checked that you’re all still happy to take part, I’ll explain a little more about the focus group. As a reminder, the study that you’re taking part in is on what, where and how you learn about leading a healthy, active lifestyle, so try to bear this in mind. Today you’ll be completing some activities to help us discuss this; you’ll be working on your own for some of these activities and as a group for others. I’ll also be asking you questions as we go along to find out what you know and think. Please don’t worry if you can’t answer these, and if there are any questions you’re unsure of, or that you need me to repeat or rephrase for you, just let me know. I might also ask some follow-up questions to some of the answers you give, and this will just be when I want to know a little more or check that I understand what you’ve told me.

- Okay, so now I’ve checked that you’re all still happy to take part, I’ll explain a little more about the focus group. As a reminder, the study that you’re taking part in is on what, where and how you learn about leading a healthy, active lifestyle, so try to bear this in mind. Today you’ll be completing some activities to help us discuss this; you’ll be working on your own for some of these activities and as a group for others. I’ll also be asking you questions as we go along to find out what you know and think. Please don’t worry if you can’t answer these, and if there are any questions you’re unsure of, or that you need me to repeat or rephrase for you, just let me know. I might also ask some follow-up questions to some of the answers you give, and this will just be when I want to know a little more or check that I understand what you’ve told me.

- Just to remind you, if you want to stop taking part in the focus group at any point, you can, and you won’t be asked to give a reason. The information you provide today will be kept private and won’t be shared with your teachers so please do your best to be honest with your answers to my questions. I’m interested in what you know and think, and it doesn’t matter if what you think is different to what someone else thinks, so always try to give your own opinion.

- So, we’re about ready to begin, I’ll just check again that the recording equipment is working and then we’ll make a start. This will be on throughout the focus group, just like last time, and I might check it now and again to make sure it’s recording. Please don’t worry that the focus group is being recorded, this is just so that I can recall what you’ve said, and remember, what you say will be kept private, so just try and forget about the recorder.
Activity 1:  
(Approx. 15 minutes allotted time)

- Right, let’s make a start with the first activity. Working on your own, I’d like each of you to draw a poster on the sheet of paper in front of you to try and show someone what a healthy, active lifestyle is and how they might be able to lead one. You can draw whatever you think leading a healthy, active lifestyle might involve and what you draw is completely up to you. There isn’t a right or wrong way to do this activity so just have a go at it. You’ve got 10 minutes to do this and when this time is up we’re going to talk about what you’ve drawn. I’ll let you know when there’s 2 minutes to go, just so that you know how long you have to complete the activity.

Follow up Questions:

- Can you show the rest of the group and tell us about what you’ve drawn and why?

  → Further questions to be determined based on pupils’ responses and phrased using their language.

- How important do you think it is to lead a healthy, active lifestyle?
  Follow up: Why do you think this?
- How easy or difficult do you think it is to lead a healthy, active lifestyle?
- What can affect whether or not someone leads a healthy, active lifestyle?
- What advice might you give to someone trying to lead a healthy, active lifestyle?

Activity 2:  
(Approx. 10 minutes allotted time)

- Okay, let’s move on to the second activity. For this, I’d like you to make an information sheet about healthy, active lifestyles using the worksheet in front of you. On this, I’d like you to write down for me some of the key pieces of information that you have learned about leading a healthy, active lifestyle, and you should fill these in on the left-hand column of the worksheet, where it says ‘information’. The key pieces of information that you write down should include some of the things that you consider to be most important in leading a healthy, active lifestyle. On the right-hand side of the worksheet there’s a second column that says ‘source’, and here, I’d like you to try and think of where you learned this information from, as best you can remember, and there might be more than one source for each piece of information. There aren’t any wrong answers to this, so if you think you’ve learned something then write it on your worksheet. You’ve got 5 minutes to do this and when this time is up we’re going to talk about what you’ve
written. I’ll let you know when there’s 1 minute to go, just so that you know how long you have to complete the activity.

Follow up Questions:

- What different pieces of information have you thought of, that are important in leading a healthy, active lifestyle?
- Where did you learn about these things?
- Have you learned anything new this year about leading a healthy, active lifestyle?
- Of the things you have learned this year, what did you learn at school?
  Follow up: Did you learn any of those things in PE specifically?
- What did you learn elsewhere?
- What do you think are the most useful sources of information about leading a healthy, active lifestyle?
- Do you ever get different information about healthy, active lifestyles from different sources (i.e. where they say different things)? If so, can you give me an example?
- What happens if the information you get from different sources doesn’t agree and tells you different things?
  Follow up: How would you know which is ‘correct’?

[Check that the recording equipment is working correctly.]

Activity 3:  
(Approx. 15 minutes allotted time)

- Now, for the third activity, I’m going to show you four case studies. Just so that you know, a case study is where you’re given some information about a character and particular situation that they’re in. There are a number of different ways that they could handle the situation, and so we’re going to discuss what some of these might be for each case study. These are ‘made up’ case studies, so if you think these sound like you or someone that you know, that’s just a coincidence. I’m going to give out these case studies now, one at a time, and I’ll allow you to read through each one. As you do this, I’d like you to think about the situation that the character is in, and how you might handle it if this were you, or what advice you might give if it were someone that you knew. When you’ve taken the time to do that, we’ll have a discussion as a group about what you think. Just like in the other activities, don’t worry about expressing your opinion even if it’s different to what someone else thinks.

[Present case studies 1-4 to pupils.]
Follow up Questions:

*Discussion to take place around initial prompt questions, followed by further questions specific to each case study*

- What do you make of the situation that this person is in?
- Do you think this person is leading a healthy, active lifestyle?
- What would you do if you were this person?
- If this were someone that you knew, would you give them any advice, or make any recommendations to them, about their lifestyle?

Case study one:

- What do you think is the purpose of PE?
- What subjects do you think you should learn about healthy, active lifestyles in? Follow up: Why do you think this?
- What about in PE specifically? Do you think you should learn about healthy, active lifestyles in this subject?
- Where else might you/do you learn about leading a healthy, active lifestyle?

Case study two:

- What would you do if you got two different pieces of information from two different sources that don’t agree? Follow up: Can you think of any examples, where you have got two different pieces of information from two different sources that haven’t agreed?
- Where might you/do you get information from about leading a healthy, active lifestyle?

Case study three:

- Where might you/do you get information from about leading a healthy, active lifestyle?
- If you had a question about leading a healthy, active lifestyle, how would you go about getting it answered?

Case study four:

- How important do you think it is to be active? Follow up: Why do you think this?
- Can you lead a healthy lifestyle without being active? Follow up: What makes you think that?
Activity 4: (Approx. 15 minutes allotted time)

- Okay, now we’re going to move on to the fourth activity and for this we’re going to think a little more about physical activity as part of a healthy, active lifestyle. For this activity, I’m going to get you to work in two small groups to produce a mind map. In case you can’t remember what a mind map is, it’s a diagram where you write what you’re thinking about in the middle and then you put all the ideas you have about this around it. So, your mind map has ‘physical activity’ in the middle so that you can write your ideas around this. In your groups, I want you to try to think of as many ways that you can be physically active as possible and write these down on the worksheet in front of you, using a black pen. I’m going to give you 3 minutes to do that and then I’m going to ask you to think about something else related to physical activity.

- We’ll move on to the next part of this activity now, and for this, I’d like you to try and think if there are any benefits to being physically active. If you think there are, I’d like you to write these down on the worksheet, using a blue pen. I’m going to give you 2 minutes to do this and then I’m going to ask you to think about something else, also related to physical activity.

- Right, so now that you’ve done that, I’d like you to think about any challenges to being physically active or any barriers that might make it difficult to be physically active and write these down on the worksheet, using a red pen. Again, I’m going to give you 2 minutes to do this. Once you’ve done this, we’ll have a discussion about some of the thoughts that you’ve had in your groups.

Follow up Questions:

- What different ways have you thought of to be physically active?
- Have you thought of any benefits to being physically active?
  Follow up: If so, what are they?
  Are there any drawbacks or potential drawbacks to being physically active?
- Have you thought of any challenges to being physically active or any barriers that might make it difficult to be physically active?
  Follow up: If so, what are they?
  How might you overcome these barriers?

- So, now that you’ve done that, I’m going to show you an infographic about physical activity. An infographic is basically a poster where information is shown visually, using charts, diagrams and images. The one that I’m going to show you provides some
examples of ways to be physically active and highlights some potential benefits of being physically active. I’d like you to have a look at this and see what you think of it. It might be helpful when you’ve had a look at it, to discuss it with the person sat next to you. Once you’ve done this, we’re going to talk about it as a group.

[Present infographic to pupils.]

Follow up Questions:

- Has anyone seen this infographic before?
- What do you think of it?
  Follow up: Can you tell me one thing from the infographic that you found interesting?
- What do you think is the purpose of the infographic?
- What pieces of information from the infographic did you know about already (these might be things that you have included on your mind map)?
  Follow up: How did you learn about these?
- Are there any pieces of information on the infographic that you didn’t know about (these might be things that you haven’t included on your mind map)?
  Follow up: If so, what didn’t you know about?
- Do you think any other information included on this infographic? Do you think anything is missing?
- Is there any information on here that you don’t agree with or aren’t sure about?
  Follow up: If so, can you tell me a little more about this?

- Well, that’s nearly the end of the focus group this morning/afternoon. But, before we finish, does anyone have any questions for me?

- Just to remind you, should you have any questions after today, you have my contact details so please do get in touch and I’ll be happy to answer these for you.

- Thank you very much for your time today everyone, I hope you’ve enjoyed the activities and well done once again for working together so well. We’ll stop the focus group there.

[Stop the recording and check that the file has been saved.]
Healthy, Active Lifestyles – Information Sheet

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Name: ____________________________
Ajay is 11 and does some physical activity. He walks to school, does chores at home and takes his dog for walks, but he doesn’t really enjoy taking part in PE at school and so doesn’t put much effort in during lessons. A PE teacher at Ajay’s school said that he ought to try to be more active and put more effort in during PE lessons. The teacher also suggested that attending an extra-curricular sport session once a week might help to improve his fitness. They said that taking part in PE and sport a little more regularly might help Ajay to concentrate a little better in his other lessons, something which he struggles with. Ajay thinks he’s active enough and, although his mum thinks he should put more effort in during his PE lessons, she has said that you can be active without doing sport and thinks he does just about enough physical activity.

Caitlin is 12 and does quite a lot of physical activity. She takes part in PE twice per week, and does at least three extra-curricular sport sessions each week too. Outside of school, she swims for a club and trains four times per week. She recently went to the doctor with her dad for a routine check-up and the doctor said that Caitlin was a little overweight for someone of her age. Caitlin was a little surprised by this, given the amount of physical activity that she does. She now thinks that she needs to do more. She also thinks she might need to change her diet and the portion sizes of the meals that she’s been eating at home. Caitlin’s dad has said that she is active enough and that her diet is very healthy, telling her not to worry. Caitlin isn’t convinced by this and got the impression that the doctor thought she ought to do more to be a healthy weight.
Josh is 14 and does a lot of physical activity. He always takes part in PE at school and captains his school football team. He is a talented young player and is part of a youth football academy, training six times per week and playing matches at the weekend. In addition to this, he has recently started going to the gym three times a week, after one of the coaches at the academy said that this would help him to build muscle and become an even stronger player. Josh’s parents are a little worried about just how active he is at the moment and don’t think he is getting enough sleep with trying to balance his school work and football training. Josh disagrees with his parents and recently he’s been arguing with them about how much time he’s spending at football training. He’s been left feeling quite upset as he doesn’t think there’s a problem but his parents seem to think otherwise.

Aliyah is 13 and doesn’t do much physical activity. She enjoys school and takes part in PE but doesn’t do anything outside of this as she isn’t very confident in her abilities. In her spare time, she likes to read, watch TV and play with her little sister Sana. She has a fairly healthy diet and isn’t overweight, but her parents think that she should be more active. They have tried to take her to various sports clubs but each time Aliyah has been reluctant to take part. Aliyah hasn’t got many friends and spends a lot of time on her own which also worries her parents, but she isn’t too bothered by this and enjoys spending time by herself.
Physical Activity
Appendix N – Focus Group Schedule for Phase 4

**Focus Group Schedule**

*Set up and start recording equipment and name the file. Ensure that the room is laid out appropriately for the focus group and that the resources are ready.*

- Good morning/afternoon, you might or might not remember me, but my name is Oliver. I’m a researcher from Loughborough University, and I visited your school previously and you participated in an interview with me as part of some research that I’m conducting. So, today you’re going to be continuing to take part in this research, but this time, as part of a focus group with your colleagues. Now, when I visited you last time, I asked you all to read an information sheet and then to complete a consent form, to say that you’re happy to take part. I do just need to check though, that everyone is still happy to take part?

- Okay, so now that we’ve checked that, I’ll explain a little more about the focus group. The study that you’re taking part in is on children’s learning about healthy, active lifestyles. As a reminder, when each of you participated in an interview previously, I was exploring how you, your department and your school supported pupils to lead healthy, active lifestyles. I have since conducted a number of focus groups with pupils at your school, as I’m sure you’re all aware. Today, I’m going to share some of the findings from these focus groups with you and I’d like to find out what you make of these. I’ll highlight these findings using a short presentation and will pose questions to you as we work through it, with some wider discussion afterwards. If there are any questions you’re unsure of, or that you need me to repeat or rephrase for you, just let me know as we progress through the focus group. I might also ask follow-up questions at times, based on the responses you give, and this is just where I want to find out a little more, or check that I understand what you’re saying to me. I’ll also be referring to a schedule during the focus group to make sure that I cover all of the necessary questions.

- Just to remind you, if you want to stop taking part in the focus group at any point, you can, and you won’t be asked to give a reason. The information you provide me with today will be kept confidential and won’t be shared with your department or school, so please do your best to be honest with your answers to my questions.

- So, we’re about ready to begin, I’ll just check again that the recording equipment is working and then we’ll make a start. This will be on throughout the focus group, just like last time, and I might check it now and again to make sure it’s recording. Please don’t worry that the focus group is being recorded, this is just so that I can recall what you’ve said, and remember, what you say will be kept confidential, so just try and forget about the recorder.

*Check that the recording equipment is working correctly.*
Introductory Questions:

- Based on what you know about the research that I've conducted with the pupils at your school, do you have any thoughts about what I might have found in relation to what pupils know about healthy, active lifestyles? 
  *(If yes: Can you tell me more about these thoughts? Why do you think I might have found this?)*

Activity:  

- Okay, so I’m now going to take you through a short presentation. There are four slides and on each are some of the findings from the research. I’ll present each slide to you and ask you to consider the findings on each one before we progress on to the next one. Once I’ve taken you through the presentation and you’ve been able to consider the findings on these, we’ll move on to some wider discussion.

Follow up Questions (to be posed after each slide):

- What do you make of these findings? 
- Are these findings as you might have expected? 
- Are you surprised by any of the findings? 
- Can you suggest an explanation for any of these findings? 

  *[Check that the recording equipment is working correctly.]*

Main Questions:

- What do you make of these findings as a whole? 
  Follow up: Is this similar to, or in contrast with, what you thought would be found? 

- Are there any findings that ‘stand out’ to you in particular? 
  *(If yes: Which ones? Why is this?)*

- Based on these findings, can you identify any positive aspects of your department’s approach to supporting pupils to lead healthy, active lifestyles? 

- Can you identify any positive aspects of your whole school’s approach? 

- Based on these findings, can you identify any aspects of your department’s approach to supporting pupils to lead healthy, active lifestyles that could be improved or
developed?

• Can you identify any aspects of your whole school’s approach that could be improved or developed?

• Do you think any of these findings have any/any other implications for you as practitioners?  
  *(If yes: Can you tell me more about this?)*

• Do you think any of these findings have any/any other implications for you as a department? And what about as a school?  
  *(If yes: Can you tell me more about this?)*

• Overall, what do you think these findings say, if anything, about how well pupils are being supported by your school, to lead healthy, active lifestyles?

**Concluding Questions:**

• You might be interested to know that the findings from your school are fairly consistent with those from the other schools that have been involved in this research. Do you have any thoughts on this?

• Do you have any other thoughts about any of the findings that I’ve shared with you today?

• Well, that just about concludes the focus group this morning/afternoon. But, before we finish, do you have any questions for me?

• Just to remind you, should you have any questions after today, you have my contact details so please do get in touch and I’ll be happy to answer these for you.

• Thank you very much for your time today. We’ll conclude the focus group there.

  *[Stop the recording and check that the file has been saved.]*
Pupils’ conceptions and understandings of healthy, active lifestyles

- Almost all pupils considered leading a healthy, active lifestyle to be important and most considered it to be vital.

- The vast majority of pupils wanted to learn more about how they might lead a healthy, active lifestyle.

- The vast majority of pupils thought that they had already learned ‘a lot’ about ‘health’ before they started secondary school.

Pupils’ conceptions and understandings of healthy, active lifestyles

- Almost all pupils considered ‘health’ to be a confusing topic and the vast majority had gaps or errors in their knowledge (e.g. exercise has to be hard to be good, being thin means being healthy).

- The vast majority of pupils viewed ‘health’ mainly in the physical sense (e.g. diet and exercise), but some described wider aspects, such as mental and social health/wellbeing.

- Most pupils talked about ‘health’ in negative terms, by describing what not to do to be healthy, rather than what to do.
Pupils’ conceptions and understandings of healthy, active lifestyles

- Almost all pupils recognised that being active contributed to ‘good’ health but many were unable to explain how.
- The vast majority of pupils were not aware of how active they needed to be.
- Most pupils were not aware of the range of ways in which they could meet physical activity guidelines.
- Most pupils were unaware of the range of benefits of participating in physical activity.

Pupils’ conceptions and understandings of healthy, active lifestyles

- The vast majority of pupils felt that they learned about health mostly outside of the school.
- Most pupils did not associate learning about healthy, active lifestyles with PE and had difficulty making links between what they had learned in PE and in other subjects (e.g. science).
- Many pupils felt that their family would be their preferred source of health information, ahead of teachers/school.
## Worked Example of Foucauldian Discourse Analysis

### Stage One: Identifying discursive constructions

| Discursive object: Health (Specifically: whose responsibility is it to teach pupils about ‘health’?) |
| Survey respondent 32: We promote healthy, active lifestyles within curricular PE but in terms of actually teaching students about health, we don’t have the time to do it (with only 2 hours per week for Y7-Y10 and 1 hour per week for Y11). |
| Survey respondent 19: We try to teach students about health, but parents can be quick to excuse their [child] from PE when they don’t fully understand the benefits of them taking part in PE. We can only do so much without parents’ support. |
| Survey respondent 3: There are so many sedentary activities that students pursue outside of school rather than being active and it can make them put on weight. If parents don’t encourage them to be active, there’s not a lot we can do in PE. |
| Survey respondent 9: Many parents at the school are reluctant to engage in health-related activities and the students often follow this apathetic approach - it isn’t good for them, but there’s not a lot we can do. |
| Survey respondent 4: We do what we can to provide a wide range of experiences and to give them enjoyable experiences, but whether or not they engage in these is down to the students themselves... and their parents, of course. |
| Survey respondent 11: We try to be proactive within school in promoting health, however, outside of school, responsibility falls to parents, and they don’t always do what they should. |
| Survey respondent 20: Students need to do more to improve their fitness, we can identify where there’s a problem, but we can’t do it for them; only they can change their unhealthy behaviours. Parents need to encourage this too – they can often get quite defensive about their child if you tell them that they’re not fit enough, for example. |
| Interview participant 5 (CS1): School is always held responsible for pupils’ health, but I don’t think we can be. I mean, I try and promote being healthy, it’s part of my job as a PE teacher, but I alone can’t make a child healthy - I think it’s down them, and their parents. |
| Interview participant 2 (CS2): I think it’s part of my role, but I’m not the one that puts a meal in front the child every night, I can’t do anything about what gets put on their plate. I can only do what I can in the limited time I see them each week. |

### Stage Two: Locating discourses

The corpus of statements, and the data that it is comprised of, highlights that several discourses were influencing teachers’ talk. Healthist discourses are evident in many of the teachers’ responses (e.g. survey respondents 4 and 20; interview participant 5 (CS1)) with responsibility for health being situated at the level of the individual. Familial discourses intersect these, highlighting the role that teachers consider parents to play in raising a ‘healthy’ child (e.g. survey respondents 4 and 19; interview participant 2 (CS2)). Risk discourses are also evident, with some teachers...
highlighting the potential dangers to those children who engage in behaviours that they deem to be ‘unhealthy’ (e.g. survey respondents 3 and 20). Discourses around teacher identity emerge from at least some of the teachers’ statements and are allied to the notion of having a role to play in health promotion (e.g. interview participants 5 (CS1) and 2 (CS2)).

Stage Three: Considering action orientation

The teachers who locate their ‘talk’ within discourses of teacher identity might be considered as opening up their opportunities for action by accepting that they have a role to play. Further, by drawing on discourses of risk, they could be seen as legitimating the need to act, in the best interests of their pupils. Contrastingly, for those teachers who relocate responsibility to the student/their parents, it could be that they are closing down their opportunities for action by renouncing their responsibility for contributing to pupils’ ‘health’. For those teachers who relocated responsibility in such a manner, reference to the role they could play was notable only in its absence.

Stage Four: Proposing positionings

The teachers who considered students to be responsible for their own ‘health’ positioned the student as an independent social actor, capable of ‘looking after’ themselves (in line with healthist discourses). Contrastingly, teachers who located responsibility with parents positioned them as the ‘caregiver’ with responsibility for ensuring that they raised a ‘healthy’ child. This position results in the pupil being conceptualised as dependent – needing their parents’ support in order to be ‘healthy’. Both conceptualisations position the teacher as a ‘bystander’ and this in turn affects their possibilities for practice.

Stage Five: Possibilities for practice

The teachers that positioned pupils and/or their parents as being responsible for their own/their child’s health may, in doing so, constrain or limit the extent to which they can make a contribution to a pupils’ ‘health’. That is to say that, despite some teachers stating that they felt this was a ‘part of their role’, by relocating responsibility elsewhere, it could mean that teachers disempower themselves in respect of the contribution that they could make.

Stage Six: Subjectification

The subjective experience of the teachers who position themselves in such a manner may evoke a range of thoughts/feelings. It may be that they feel frustrated on account of not feeling like they can make much of a difference to a pupils’ ‘health’. Allied to this, teachers could experience feelings of guilt, given that some felt that they were responsible. With consideration of pupils/parents, by positioning them as being responsible for their own/their child’s health, it may be that teachers place blame on such students and their parents (again, in line with a healthist discourse).
Appendix Q – Ethics Proposal

Ethics Approvals (Human Participants) Sub-Committee

Research Proposal for Studies Involving Human Participants

Project Details

1. Project Title: Children’s (Mis)Information, (Mis)Understandings and (Mis)Conceptions about Healthy, Active Lifestyles

2. Aims and objectives of the study:

   - To explore children’s knowledge and understanding about leading a healthy, active lifestyle.
   - To investigate where children gain knowledge and understanding about healthy, active lifestyles and how they make sense of information from a range of sources.
   - To ascertain how children act on this knowledge and understanding and how this may influence their lifestyle choices.
   - To identify ways in which teachers currently promote healthy, active lifestyles and how this might be better promoted through curricular Physical Education (PE).

3. Lay summary of the study

   **Note:** This should be understandable to a non-expert and should not be a copy of the research proposal. It should include the reasons for the research, the background to it and why the area is important to investigate.

   The teaching of health within curricular Physical Education has been a topic of continued pedagogical debate (Quennerstedt, 2008) and in recent years there has been growing pressure on school curricula to support children to lead healthy, active lifestyles (McKenzie, 2007; Shephard and Trudeau, 2000). However, it has been argued by some that it is a means of justifying the position of PE within the curriculum (Fairclough, 2005) with some positing that centring the subject around a healthy, active lifestyle approach may actually be to the detriment of the subject (Trost, 2004).

   The current body of evidence suggests that there are limitations in children’s understandings of health and fitness and that their conceptualisations are relatively narrow and simplistic (Harris, 1994). It was also noted by Smith and Parr (2007) that children had relatively superficial understandings of the associations between health and exercise, which is further compounded by misconceptions about what it means to be healthy or fit. For example, Cale and Harris (2005) identified misconceptions such as children thinking that...
exercise needs to be ‘hard’ if it is to be ‘good’ or that ‘thinness is good’ and ‘fatness is bad’. It may be inferred, therefore, that curricular PE is not educating children about healthy, active lifestyles as effectively as it might be.

The shift in contemporary society to one in which information is so readily and widely available to children has meant that health information can be acquired outside of the curriculum and as such children are subject to a public pedagogy (Sandford and Rich, 2006). This can lead to conflicting and disconnected understandings which may not necessarily be to the benefit of children (Dixey and Sahota, 2001). Therefore, it is the intention of this research to explore children’s knowledge and understandings associated with healthy, active lifestyles and to make inferences as to how they conceptualise health information from a range of sources. The research also intends to identify the ways in which teachers promote and educate children about healthy, active lifestyles. Subsequently, it is anticipated that recommendations will be made as to how to effectively educate children about healthy, active lifestyles within curricular PE.

4. Start date of study: October 2014
5. End date of study: October 2017
6. Duration of the study: 3 years
7. Start date for data-collection: June 2015

Note: Data collection should not commence before final ethical approval is confirmed.

8. Location of the study: The study will be located in state secondary schools within the East Midlands with Loughborough University being utilised as a site for analysing, interpreting and reporting the findings.

9. Reasons for undertaking the study (e.g. contract, student research): The research is being undertaken as part of a PhD programme of study.

10. Do any of the researchers stand to gain from a particular conclusion of the research study?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, how do the researchers stand to gain?
Applicant Details

11. Name of Researcher (applicant): Mr. Oliver Hooper (OH)
12. Status: Postgraduate Research Student
13. Email address: o.r.hooper@lboro.ac.uk
14: Contact address: Office 1.42, National Centre for Sport and Exercise Medicine Building, Loughborough University, Loughborough, Leicestershire, LE11 3TU
15: Telephone number: 01509 223048/07902003656

All other researchers (including supervisors if applicant is a student)

16. Name(s): Dr. Jo Harris (JH) and Dr. Lorraine Cale (LC)
17. Status(es): Staff
18. Email address(es): j.p.harris@lboro.ac.uk and l.a.cale@lboro.ac.uk
19a. Contact Address(es): Office ZZ0.02, Matthew Arnold Building, Loughborough University, Loughborough, Leicestershire, LE11 3TU and Office NCSEM2.32, National Centre for Sport and Exercise Medicine Building, Loughborough University, Loughborough, Leicestershire, LE11 3TU
19b. Telephone number(s): 01509 223250 and 01509 226354

20. Experience of all investigators in the methods to be used in this study

Note: Please ensure the experience of all investigators is included in this section.

OH is a Postgraduate Research Student who has previously completed a BSc (Hons) in Sport and Exercise Science at Loughborough University graduating in July 2014 with a First Class degree. As part of his studies, he completed modules centred on Sport Pedagogy and Research Methods and applied these during his 3rd year dissertation project. He is also undertaking further research training as part of his PhD programme. His full profile link can be found below:

http://www.lboro.ac.uk/departments/ssehs/staff/researchstudents/oliver-hooper.html

JH and LC are both members of academic staff within the discipline of Physical Education and Sport Pedagogy and have substantial experience in undertaking school-based research using qualitative methods. Their full profile links can be found below which also contain full publication lists, detailing examples of their former works:

http://www.lboro.ac.uk/departments/ssehs/staff/dr-jo-harris-.html
http://www.lboro.ac.uk/departments/ssehs/staff/dr-lorraine-cale-.html
Participant Information

21. Number of participants to be recruited:

Phase 1: Approximately 60 teachers from mainstream state secondary schools in the East Midlands will be invited to participate in an online survey. The survey will be sent to all state secondary schools in this region (that cover the 11-16 or 11-18 age range), of which there are approximately 250, with an anticipated response rate of approximately 25%.

Phase 2: Approximately 120 school children from two mainstream state secondary schools in the East Midlands will be recruited to participate in school-based focus groups following selection of two of the responding schools from phase 1, as case studies. These children will be from Year 7 cohorts at each school and the focus groups will take place at the beginning of the school year. Additionally, approximately 12 teachers, from the same case study schools, will be recruited participate in school-based interviews.

Phase 3: Approximately 120 school children (who were recruited for focus groups in phase 2) will participate in further school-based focus groups. The focus groups will take place at the end of the school year. Similarly, approximately 12 teachers (also recruited for interviews in phase 2, and from the same case study schools) will be recruited to participate in school-based focus groups.

22. Details of participants (age, gender, special interests etc):

The teachers will initially be recruited through self-selection by voluntary participation in the survey during phase 1 of the study and this will be on the basis that they are full-time PE specialist teachers with Qualified Teacher Status (QTS). It is anticipated that there will be a range of teacher experience amongst them, from newly-qualified to experienced practitioners, and a mix of ages and genders, for example.

The teachers recruited for phases 2 and 3 of the study will be based at one of the two mainstream state secondary schools that were selected as case studies following completion of phase 1. They will be purposefully selected from those who nominated themselves for further participation, taking into consideration the findings of the survey, and similarly it is expected that they will have a range of characteristics.

The children recruited for phases 2 and 3 will be based at one of the two mainstream state secondary schools (selected as case studies) and will be selected from Year 7 school cohorts (i.e. aged 11-12). It is anticipated that children of varying characteristics (such as in terms of gender and ethnicity) will be included in the sample.

23. How will participants be selected?

Note: Include the inclusion/exclusion criteria to be used.

Phase 1: The survey will be distributed to all mainstream state secondary schools (that cover the 11-16 or 11-18 age range) within the East Midlands with a request that a full-time PE
specialist teacher completes the survey. The inclusion criteria applied to this will be that the teachers are full-time PE specialists with QTS.

Phases 2 and 3: The teachers who responded to the survey will be asked within the survey whether they would like to nominate their school and themselves for further involvement within the study. Based on the responses and the findings of the survey, two case study schools will then be purposefully selected. All of the children in the Year 7 cohorts at the case study schools will be provided with the opportunity to be involved in the study and parents will be provided with the opportunity to opt their child out of the study should they not wish them to participate. Subsequently, approximately 60 pupils will be selected using a randomised stratified sampling method. All full-time PE specialist teachers at the case study schools will be invited to be involved in the study, provided they meet the same inclusion criteria as for phase 1.

24. How will participants be recruited and approached?

**Note:** If an advertisement or forum post is to be used, please include this in your application to the Sub-Committee.

The contact emails of all the mainstream state secondary schools within the East Midlands have been accessed via the 9 Local Authority (LA) websites and during phase 1 each school is to be emailed an invitation for a full-time PE specialist teacher to complete the online survey. As part of this, teachers will be able to express an interest in continuing their involvement in the study for phases 2 and 3.

If an interest is expressed, the Head Teachers of two of these schools (selected purposefully based on the findings of the survey) will be contacted and permission will be sought for their involvement in phases 2 and 3 of the study. If approval is granted from Head Teachers, the PE Heads of Department at the selected schools will be contacted to discuss the details of the study and arrange the interviews and focus groups. The children at the case study schools will be recruited by means of nominated participation with the Head Teacher’s permission. Following this, letters will be sent to the parents/guardians of children who may be selected to participate in the study asking them to opt out should they not wish for their child to participate. The documents (such as letters to parents and opt-out forms) that are to be distributed as part of this will first be checked by the Head Teacher of each school so as to ensure that these are of an acceptable standard to them and that they are satisfied that the children and their parents are being provided with sufficient information. Of those whose participation is subsequently agreed, approximately 60 pupils will be selected based on a randomised stratified sampling method.

The teachers and children involved in the study will each be provided with an information sheet outlining the details of the study and the requirements of them as participants. They will also be informed prior to any involvement that their participation is voluntary and that they are permitted to withdraw without obligation and without giving reason at any time during the study. Further, they will be asked to sign a consent form agreeing to their involvement.
25. Please state the demand on participants’ time:

**Note:** Where possible, include a breakdown of how long each part of the study will take, as well as a total time demand.

Phase 1: It is estimated that the online survey will take approximately 15-20 minutes to complete.

Phase 2: It is estimated that each of the focus groups with children will take approximately 40-45 minutes to complete and that the teacher interviews will each take approximately 50-60 minutes.

Phase 3: Similarly to phase 2, it is estimated that each of the focus groups with children will take approximately 40-45 minutes to complete and each focus group with teachers will take approximately 50-60 minutes.

Total time demands: The total demand on children’s time will be approximately 90 minutes and the total demand on teachers’ time will be a maximum of 135 minutes across all phases of the study.

<table>
<thead>
<tr>
<th>26. Will control participants be used?</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If No</strong>, please go to Question 30.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If Yes</strong>, please answer the questions below.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

27. How will control participants be selected?

Note: Include the inclusion/exclusion criteria to be used.

28. How will control participants be recruited and approached?

**Note:** If an advertisement or forum post is to be used, please include this in your application to the Sub-Committee.

29. Please state the demand on control participants’ time:

**Note:** Where possible, include a breakdown of how long each part of the study will take, as well as a total time demand.

30. Please provide procedures for the chaperoning and supervision of the participants during the study.

The focus groups that will take place during phase 2 of the study will be conducted in the school environment. The specific timings and locations of these will be discussed and agreed with an appropriate member of staff from the school. The children will be chaperoned to and from the focus groups by a member of staff and will then be supervised by the researcher.
31. Possible risks, discomforts and/or distress to participants.

It is not anticipated that participants will be subject to any discomfort, distress or duress during the study, however, should such a situation arise, the activities in progress will be stopped immediately and relevant help sought. For example, if a child becomes distressed, a member of staff from the school will be contacted, as will have been agreed in advance.

32. Please provide details of any payments to be made to the participants.

N/A

Researcher Safety

33. Are there any potential risks to the researchers in this study? 

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please answer the following questions:

34. What are the potential risks to the researchers?

The researcher may have children disclose information to them which is of a safeguarding concern, or may be subject to accusations of misconduct when working with the children.

35. What measures have been put in place to address these risks?

The researcher has an enhanced DBS clearance and is therefore deemed suitable to work with children. He has also had additional training in safeguarding children and is fully conversant with best practice guidelines when working with children. In addition, the researcher will ensure that he familiarises himself with the specific safeguarding policies of each case study school.

Study details

36. Brief outline of study design and methodology:

**Note:** It should be clear what each participant will have to do, how many times, and in what order. All of this information should also be included on the Participant Information Sheet.

The study is predominantly qualitative in nature and has three sequential phases. The first phase involves the distribution of an online survey to all mainstream state secondary schools within the East Midlands with a request for a full-time PE specialist teacher with QTS to complete this. It is anticipated that this will take approximately 15-20 minutes to complete. Within the survey, teachers will be able to express an interest in further involvement in the research study and from this two schools will be selected as case study schools for phases 2 and 3, based on the findings of the survey. The purpose of this survey will be to explore how teachers educate children about leading a healthy, active lifestyle.

The second phase involves conducting focus groups with Year 7 children in each of the two case study schools and approximately 60 children will be selected based on a randomised stratified sample from the whole Year 7 cohort within each school. The focus groups will be
conducted in groups of 4-6 and will be activity based to stimulate discussion, with children undertaking activities such as placing images into categories and expressing their opinions in relation to certain statements. The children will take part in one focus group of approximately 40-45 minutes duration. Additionally, full-time specialist teachers from the PE department at each case study school will participate in interviews with the researcher. The teachers will take part in one interview which will be approximately 50-60 minutes in duration. The focus groups and interviews will be audio recorded for the purpose of subsequent analysis. The purpose of these focus groups will be to explore children’s knowledge and understanding about leading healthy, active lifestyles and the purpose of the interviews will be to expand upon and further explore the responses from the teachers’ survey in phase one.

The third phase will involve further focus groups with the same Year 7 children as in phase 2. Similarly, teachers from the PE department will be further involved through focus groups of approximately 50-60 minutes in duration. The same children and teachers involved during phase 2 will participate in phase 3, where possible. The purpose of these follow-up focus groups will be to identify if and how children’s knowledge and understanding associated with healthy, active lifestyles has developed. The focus groups with teachers will involve discussion of the findings from the children’s focus groups in phase 2 and will involve identification of ways to effectively support children to lead a healthy, active lifestyle.

37. Measurements to be taken:

**Note:** All measurements and samples to be taken from participants should be included here. Measurements can include questionnaire and photographic data.

Phase 1: Survey data (from online teacher survey)
Phase 2: Audio recordings and resources generated from focus groups, such as written information generated from activities (from focus groups with children and interviews with teachers)
Phase 3: Audio recordings and resources generated from focus groups, written information generated from activities (from focus groups with children and with teachers).

38. Please indicate whether the proposed study:

<p>| 38a. Involves taking bodily samples | Yes | No |
| 38b. Involves procedures which are physically invasive (including the collection of body secretions by physically invasive methods) | Yes | No |
| 38c. Is designed to be challenging: | Yes | No |
| Physically | | |</p>
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologically</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38d. Involves procedures that are likely to cause:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical distress to participants</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychological distress to participants</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Social distress to participants</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emotional distress to participants</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38e. Involves intake of compounds additional to daily diet, or other dietary manipulation/supplementation</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38f. Involves pharmaceutical drugs (Please refer to published guidelines)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38g. Involves testing new equipment</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38h. Involves procedures which may cause embarrassment to participants</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38i. Involves collection of personal and/or potentially sensitive data</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38j. Involves use of radiation (Please refer to published guidelines and contact the University’s Radiological Protection Officer before beginning any study which exposes participants to ionising radiation)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38k. Involves use of hazardous materials (Please refer to published guidelines)</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38l. Assists/alters the process of conception in any way</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38m. Involves methods of contraception</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38n. Involves genetic engineering</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If Yes, please give specific details of each of the procedures to be used and arrangements to deal with adverse effects:

**Consent**

<table>
<thead>
<tr>
<th>Consent Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>39. Is written consent to be obtained from participants?</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If yes, please attach a copy of the consent form to be used.

If no, please justify.

<table>
<thead>
<tr>
<th>Vulnerable Group</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>40. Will any of the participants be from one of the following vulnerable groups?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>40a. Children under 18 years of age</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>
If **Yes**, to any of the above, please answer the following questions:

41. What special arrangements have been made to deal with the issues of consent?

The permission for schools to take part will be sought from the Head Teachers of the two schools identified as potential case studies. Subsequently, the parents/guardians of the school children who may be involved in the research will be contacted with the opportunity to opt their child out of the study should they not wish their child to participate; by not doing so it will be assumed that they provide consent. The children participating will also be requested to sign to give their assent to being involved in the study. This will occur during their first interaction with the researcher following an explanation of the study.

42. Have the researchers obtained necessary police registration/clearance?

**Note:** Please provide details or indicate why this is not applicable to your study.

The researcher has an enhanced DBS clearance through Loughborough University and is therefore deemed suitable to work with children.

**Withdrawal**

43. How will participants be informed of their right to withdraw from the study?

The right to withdraw will be explained to the school children, their parents/guardians and teachers on the information sheets provided. It will also be repeated verbally during their first interaction with the researcher and any questions regarding this will be answered. Further, the children and teachers will be reminded of this at the beginning of each interview or focus group and the researcher will action this right should they have any concerns relating to the participants, for example, should they seem under undue stress during the interviews or focus groups.

44. How will participants be informed of the issues with withdrawing their data once this has been aggregated in the study?

The teachers, children and their parents/guardians will be informed about this on the relevant information sheet. They will be made aware that they are able to withdraw their data at any point up until such a point that it is aggregated in the study, when it will no longer be able to be withdrawn. The participants will have up to 3 months following data collection completion to action this right.

**Storage and Security of Data**
45. Will the investigation include the use of any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation of participants</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Audio recording</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Video recording</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

If Yes, to any, please provide details of how the recording will be stored, where specifically the recording will be stored, when the recordings will be destroyed and how confidentiality will be ensured?

The audio recordings will be taken using a device, such as a dictaphone, and files will be transferred to a password-encrypted computer as soon as possible following each interview or focus group. The information will be coded and kept in a password protected folder. If there are any hard copies of resources resulting from the focus groups, these will be stored in a locked cabinet on the grounds of the University campus along with any additional information such as paper-based notes taken by the researcher to supplement the recordings. The information may be transferred to a laptop in the possession of the researcher, but similar protection measures will apply (i.e. password encryption). The data will be wholly destroyed on successful completion of the study after a period of 10 years in compliance with legislative requirements.

46. What steps will be taken to safeguard anonymity of participants/confidentiality of personal data?

The identity of the children, teachers and the schools will be protected by anonymising the data and using pseudonyms when reference is made to a particular school or individual. If there is any other identifying information, this will also be removed, as appropriate.

47. Please give details of where the data collected will be stored, and how the collection and storage of the data complies with the Data Protection Act 1998?

The data obtained will only be used by the researcher for the intended purposes and for the purposes for which consent and assent have been sought. The data will be stored securely on the University grounds on a password-encrypted computer. In the case of paper-based records, these will be stored in a locked cabinet on the grounds of the University campus. The data will be retained no longer than is necessary and will be wholly destroyed on successful completion of the study for which it was collected and within the relevant time frames outlined under data protection legislation.

48. If human tissue samples are to be taken, please give details of, and the timeframe for, the disposal of the tissue.

Note: Please also ensure that this information is included on the Participant Information Sheet.

**Sponsorship and Insurance Cover**
49a. Is the study being sponsored?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please state source of funds including a contact name and address for the sponsor:

If No, please go to question c.

49b. Is the study to be covered by the sponsors insurance?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please confirm who will be insuring the study:

49c. Is the study to be covered by the University’s insurance?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please confirm who will be insuring the study:

**Insurance Cover**

Note: It is the responsibility of investigators to ensure that there is appropriate insurance cover for the procedure/technique.

The University maintains in force a Public Liability Policy, which indemnifies it against its legal liability for **accidental** injury to persons (other than its employees) and for accidental damage to the property of others. Any **unavoidable** injury or damage therefore falls outside the scope of the policy.

50. Will any part of the study result in **unavoidable** injury or damage to participants or property?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If Yes, please detail the alternative or additional insurance cover arrangements and include the supporting documentation in this application.

The University Insurance relates to claims arising out of all **normal** activities of the University, but Insurers require to be notified of anything of an unusual nature.

51. Is the study classed as **normal** activity?  

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

If No, please check with the University Insurance Officer that the policy will cover the activity. If the activity falls outside the scope of the policy, please detail the alternative or additional insurance cover arrangements and include the supporting documentation in this application.
Declaration

I have read the University's Code of Practice on Investigations on Human Participants and have completed this application. I confirm that the above named investigation complies with published codes of conduct, ethical principles and guidelines of professional bodies associated with my research discipline.

I agree to provide the Ethics Approvals (Human Participants) Sub-Committee with appropriate feedback upon completion of my study.

Signature of applicant: ........................................................................................................

Signature of Supervisor (if applicable): ............................................................................

Signature of Head of School/Department: ........................................................................

Date: ..................................................................................................................................

Note: Please check to ensure you have attached all necessary documents to your application.
Appendix 1: Application Checklist

Please ensure that you have attached copies of the following documentation to your application:

<table>
<thead>
<tr>
<th>✓</th>
<th>For all applications:</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Participant Information Sheet</td>
</tr>
<tr>
<td>✓</td>
<td>Informed Consent Form</td>
</tr>
</tbody>
</table>

**Where applicable:**

- Willingness to Participate Forms (for studies involving vulnerable participants)

<table>
<thead>
<tr>
<th>✓</th>
<th>Parental/Guardian Information Sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓</td>
<td>Children’s Information Sheet</td>
</tr>
<tr>
<td>✓</td>
<td>Letter of Approval(s) from Head Teacher(s)</td>
</tr>
<tr>
<td>✓</td>
<td>Opt-Out Letters</td>
</tr>
<tr>
<td>✓</td>
<td>Health Screen Questionnaire</td>
</tr>
<tr>
<td>✓</td>
<td>Questionnaires</td>
</tr>
</tbody>
</table>

Please see note below: Example Interview Questions

Advertisement/Recruitment material

Evidence of approval from other Committees (including International organisations)

Additional Insurance Cover

✓ Risk Assessment

**Note:** Example interview questions for the interviews with teachers have not been included as these will be based largely on the questions within the teachers’ survey. The purpose of these interviews will be to expand on the responses from the survey and so interview questions will be devised following analysis of the data generated from the survey and based on the questions within it.

**Additional documentation submitted:**

- Focus Group Schedule