***“How do you feel? What is your heart doing?”... “It’s jumping”:* The body and health in
Early Years Education (EYE)**

Julie Stirrup School of Sport, Exercise and Health Sciences, Loughborough University, UK

Corresponding authors email: j.l.stirrup@lboro.ac.uk

Abstract

Policy agendas for early childhood education in the UK as in many countries elsewhere are driven by expectations that play will impact positively on a child's educational attainment, health and wellbeing. This paper focuses on health knowledge, social class and cultural reproduction within early year education in England, looking specifically at how health discourse is framed by Early Years Foundation Stage (EYFS) policy imperatives and subsequently by practitioners as they re-contextualise health knowledge through play across three socially and culturally different early years education (EYE) settings within England. Across the three settings, fifteen practitioners and eighty children, aged 3-4 years old, participated in the research. Drawing on the theoretical work of Basil Bernstein particularly his concepts, 'pedagogic device' (PD) and 'classification' (c) and 'framing' (f), the paper documents how health is designed, defined, constructed and experienced through play pedagogy within each of these EYE settings. The analyses illustrate how the different organisational and curriculum structures, pedagogical interactions and transactions of each setting cultivate distinctive relationships to health knowledge. These relationships, in turn, play their part in the reproduction of social class and cultural inequalities, despite the best intentions of EYE policy to address these matters.

Key words: health education; early year's education; pedagogy; play

Introduction

Previous research in the UK (e.g., Ball, Vincent and Kemp, 2004; Ball and Vincent, 2007; McEvilly, 2014; 2015) across Europe (Mantovani, 2007) and elsewhere (Cochran, 2001; Bertram and Pascal, 2002) has explored several aspects of Early Years Education (EYE) (including parents' investments in, attitudes towards and choices of childcare provision). Much debate and research already exists around health discourse, EYE play and learning environments, within the social science research on pedagogy, the body and policy. This paper looks to add to these debates by exploring the nature of social transactions within EYE and how these may differ between settings in relation to social class and culture. EYE contexts, as with all other educational settings, are complex assemblages of several discourses (i.e. academic, cultural, social, moral) that together play their part in constructing practitioner and child subjectivities. The focus of this paper however, will be largely upon health discourse, mindful that the knowledge and transactions which this discourse effects cannot be adequately understood outside of its relationship with all other discourses prevailing within EYE settings, not least those defining the virtues of individualised learning and the purposes of play (see below and Rogers and Lapping, 2012). Using Bernstein's (1990) concept, 'the pedagogic device' (PD), the paper first considers the principles inherent in EYE policy and the role of health discourse within this text. Moving on, it addresses the curriculum enacted in each setting, exploring through 'classification and frame' (C and F) (Bernstein, 1973) the classed nature of health discourse within EYE settings and its consequences for the identities of children.

Background to the Study

The study was designed in order to answer the research question 'How is health designed, defined, constructed and experienced as pedagogy in three EYE settings?' In order to investigate this question, the following sub-questions were addressed: 'How is health framed within EYE?', 'How do practitioners and children engage with health and health discourses within the EYE settings?' and 'What role might social class and culture play in how health is framed within each setting?' In addressing these questions, several issues become intertwined (health discourse, EYE play and learning environments), and in the section that follows, we try to explore these issues in relation to existing research in the field.

Principles of the Pedagogic Device... Early Years Learning and health

In England, EYE (both private/fee paying and state/government funded day care) is governed and regulated by the Early Years Foundation Stage (EYFS) framework (DfE, 2012, revised 2014). This policy text sits within a wider neo-liberal education agenda that positions EYE as a critical means of addressing social inequalities and improving the social mobility of 'less advantaged' children (Waldfoegel, 2004; Lucey and Reay 2002a; 2002b). To this end EYE policy encourages Early Years practitioners to work in partnership with parents to promote learning and ensure that children are 'school ready' (DfE, 2014) (i.e., prepared for the next phase of schooling, Primary education). EYE has long celebrated the importance of play as a

learning device, however, in the UK, over recent decades there has been a subtle but significant discursive shift within EYE policy from the progressive (pre neo-liberal) child centred ideology of the post Plowden era (Central Advisory Council for Education, 1967) (which emphasised exploratory free play and individualised, competency based learning) to a more instrumental market driven ideology in EYE (Rogers and Lapping, 2012; authors 2016). This is evident in the EYFS (2014) text which emphasises principles of accountability, ‘managed choice’, pre-defined learning outcomes, with phrases such as ‘well planned’, ‘challenging’, and ‘planned purposeful’ play littering the text. Although the EYFS has little explicitly to say about health, this too in orientation reflects neo liberal health discourse circulating in wider society which reductively celebrates the functional (fitness and health related) rather than intrinsic value of play, physical education and sport (Ayo, 2012; Wright and Harwood, 2009). Imperatives contextualised, for example, in Public Health England campaigns such as ‘*Change for Life*’, encourage families (parents and children) to take greater personal responsibility for their diet, health and well-being.).

Notwithstanding ideological shifts in the political landscape of EYE education over the last thirty years within the EYFS Framework (2014) (as in EYE policy texts elsewhere, e.g. Scandinavia and Australia (NTG, 2014)) play has retained its position as a fundamental essential of children’s development, building their confidence as they ‘learn to explore, to think about problems and relate to others’ (DfE, 2014, p. 8). Through play children putatively are enabled to make sense of their social worlds and engage actively with people and objects (DfE, 2014). In the EYFS specifically, with regard to health and physical development, play is to cultivate;

I. Moving and Handling – (as demonstrated in) children’s ability to show good control and co-ordination in small and large movement, moving confidently in a range of ways.

II. Health and self-care – children know the importance of good health of physical exercise and a healthy diet and talk about ways to keep healthy and safe.

(DfE, 2014, p. 5-8) (our parenthesis)

Like many education policies, the EYFS is decided by policy makers outside the education system and based on the expectation that practitioners are able to implement such policies into their settings. Siong Leow et al (2014) take this argument further suggesting that many health policies could be considered to sit outside the immediate remit of education completely. Whilst this argument cannot be levelled at EYE in the same way it can to formal education, the suggestion that where policies have explicit corporeal dimensions, implementations become moderated by teacher’s own biographies, health practices and what they consider the remit of schooling (Schee, 2009; Evans et al 2011) is evident in our data.

EYFS policy has undoubtedly helped position EYE settings as key sites for addressing health issues wherein children are taught from an early age ‘the importance for good health of physical activity and a healthy diet’ (DfE, 2014, p. 8) For example, EYFS policy stipulates that providers should provide healthy meals (DfE, 2014, p26 3.47 and 3.48), although little information is given as to what ‘healthy’ means. EYFS policy practitioners are then expected to nurture a healthy individual essentially through play in accordance with the expectations of the EYFS. To this end, its health imperatives are set out in relation to (i) age (e.g. by the age of 3, children should be ‘drinking well without spilling’) (DfE, 2014, p. 26); (ii) pedagogy, essentially child and practitioner led play and (iii) key themes (DfE, 2014, p. 3) which foreground;

- A unique child
- Positive relationships
- Enabling environments

The EYFS framework, then, brings to each EYE setting a complex set of expectations constituting what Bernstein (1996, p. 25) would refer to as the ‘pedagogic device’, that is to say, regulating principles that underpin and shape the context and content of learning. Together they implicitly invoke an ideal ‘imaginary child’, in this case one who is able (preferably predisposed), largely independently of the teacher, to display and perform a complex array of characteristics in the right way at the right times in accordance with EYFS expectations. Ideally, a child, for example, who is already predisposed to recognise the value of health (as officially defined), who eats the right foods, is positive about exercise and willing to display such attitudes in their transactions in the EYE setting. Not every child is able or given opportunity to meet these ideals, as we shall see.

Methodology

The research context

The fieldwork was set within three socially and culturally different early year settings in central England. *Busy Buzzy Bees* (BBB) is a publicly (Government) funded early years provider located in a large Midlands town. It provides sixty childcare places for children aged three months to five years old and is commonly utilised by staff and/or students at the local university college. Housed in three mobile classroom units, the setting consists of one unit, divided up into four separate sections; one for each age group (age three months-one year, two-three and three-four), with each ‘section’ catering for up to fifteen children supervised by two or three practitioners at any one time. The other two units were mostly used as office space. The outdoor facilities consist of a large playground, which each group uses at different times of the day. As many of its children are from professional middle class families it provided stark contrast to the families who use ‘*Little People*’ and ‘*Little Stars*’.

Little People (LP) is located within a large housing estate on the outskirts of a large town within the Midlands area. It serves the local community, providing childcare for children aged three to five years old, with provision of nursery education funded places for children

aged three to four years old. The setting has two rooms dedicated to three-four year olds, one for children whose parents paid for their full time care and the other for those who only attended for their entitlement of fifteen hours Government funded 'free care' per week. It was the latter on which this research focused, at any one time catering for twenty-five children, supervised by three to four practitioners. Serving a working class area, this setting facilitated exploration of the opportunities available to working class children to access EYE and their experiences of that provision.

Little Stars (LS) is a preschool located within a market town in England catering for children of a number of ethnic groups (but mainly Bangladeshi families) within the community. This setting was selected because of its cultural diversity. Approximately eighty per cent of the children on roll were from ethnic minorities, of whom forty-five per cent spoke English as an additional language. It occupied three large rooms in one building, offering two daily three hour childcare sessions for three-four year olds, catering for up to forty children at any one time, supervised by four-five practitioners.

This research was part of a larger doctoral research study and involved ten months 'critical' ethnographic fieldwork. While ethnography as a methodology is concerned with the subjective reality of the experiences of those within the social world, in this case, young children, their parents and EYE providers, critical ethnography allows the researcher to look at marginalised groups and develop a greater understanding of their cultural behaviours. Preschool children could be viewed as marginalised within the context of physical activity because there is limited knowledge within physical education, sports pedagogy focused on how children develop, engage and become embodied through physical activity at this age. In selecting an appropriate research method for the study certain fundamental concerns emerged around the practical and ethical considerations of doing research with young children in EYL settings. I needed particular tools and techniques and a methodology which would be sensitive to the complexities of individual lives and social contexts. In attempting to understand the complex world of pre-school children and the seemingly disordered (at least on the surface) life of nursery, I needed research tools, which could be used to collect rich and in-depth data in order to explore the multiple, complex and often contradictory voices of my research participants. I therefore employed an ethnographic approach, which involved immersing myself in the participants' lives (specifically their EYE lives, initially to build trust, rapport and understanding) for 3hours a week across the 10months. In keeping with the tradition of ethnography, I used direct observations, along with semi structured interviews and some activity-based tasks – e.g. poster making, photography and games, designed in line with growing trends in childhood studies to encourage the active involvement of the research participants in the generation of data (see Oliver and Lalik 2000, 2001, 2004; Christensen and James, 2008). Therefore, by engaging the participants over time and creating a rapport with them it was hoped that participants would feel safe and secure; consequently, acting as they normally would (Thomson, 2008). The cohort of participants in this study are considered to be a vulnerable group (EAC, 2006), based on their age. As such, ethical issues were of particular concern when planning and carrying out the collection of data for this study. Three ethical issues were of particular concern; (i) informed consent; (ii) power relations, and (iii)

confidentiality. Whilst these issues are not unique to researching children, it has been argued that they present important and different challenges when researching with children (Mauthner, 1997; Thomas and O’Kane, 1998). Each of these issues were addressed throughout the research. For the purposes of this study, participants (aged three to five) gave assent and parents gave informed consent before partaking in the study. ‘Assent’ was gained from the children rather than consent because it was believed (after discussions with practitioners) that the children may not be able to give full consent due to their age. Furthermore, prior to the research being conducted, it was important that ethical clearance was granted by the University in accordance with their ethical policies.

All eighty children were observed and of these seven were ‘selected’ for further detailed investigation because they opted to participate in informal conversations with the researcher on a regular basis. Often this form of self-selection is seen as not being representative (Bryman, 2012), however, in this research, those who participated were illustrative of the dominant categories *in situ* and representative of those within the settings as a whole. The collected data were first analysed ethnographically to determine the organising categories and concepts of the setting, while second order analyses brought into to play the researcher’s sociological interests in questions of equity, social reproduction and control, imposing another layer of questions on the study. A Bernsteinian theoretical lens was adopted to interrogate the transactions within EYL settings in relation to power and control, while those of others (namely ‘habitus’, ‘physical capital’ and the ‘corporeal device’ - pace Bourdieu, Shilling, Evans and Davies respectively) were used to embellish such understandings and bring processes of embodiment to the fore. In this paper, our data illuminates how children begin to develop their knowledge and understanding of health discourse in relation to practitioners’ recontextualisation of wider health imperatives and the knowledge they believe children arrive with.

Theorising Play Pedagogy

In Bernstein’s view, the pedagogic device (PD) articulates how knowledge (official and lay) is converted into pedagogic communication, which in turn acts on the potential meanings made available for transmission and acquisition (Singh, 2002). The mediation and enactment of ‘official’ EYFS health knowledge by practitioners through play in EYE settings and the potential consequences of such processes for the identities of children is the foci of subsequent analyses. The PD finds expression as three hierarchically inter-related rules; *distributive*¹, *recontextualising* and *evaluation* and together they provide an invaluable analytical framework for understanding how discourses and practices within EYE reproduce inequality through the selective regulation and distribution of different forms of knowledge, identity and consciousness.

Pedagogic social contexts are defined by specific power and control relations between subjects, discourses and agencies and Bernstein (1977) offered the concepts ‘classification and framing’ as one means of analysing such relationships when played out in educational settings. Classification (C) refers to ‘the degree of boundary maintenance between contents’ (Bernstein, 1973, p. 205), while framing (F) determines the structure of pedagogy (the message system). Two aspects of the boundary relationship which framing explores are of particular interest here. Firstly, framing refers to the degree of control the practitioner and child possess over the selection, organisation, pacing and timing of knowledge transmitted and received in the pedagogical relationship. Secondly, to the boundary relationship between the everyday knowledge that practitioners and children bring to EYE settings and the educational knowledge transmitted in their pedagogical relationships. We can, therefore, consider the strength of boundaries between every day and educational (EYFS health) knowledge and variations in the strength of frames regulating access to the two forms of knowledge as they feature in EYE settings.

Understanding how children from different social class catchment areas within different EYE settings construct and embody health knowledge requires analysis of pedagogic discourse as a set of rules which regulate the transmission and acquisition of health knowledge. In Bernstein’s view pedagogic discourse is always an amalgam of ‘what’ is transmitted (instructional discourse) and ‘how’ it is transmitted (regulative discourse) the former always and inevitably embedded in the latter. As the work of McEvilly et al (2013) and Wright (2006) suggests, certain discourses become interlinked with power and knowledge, leading to the privileging of certain practices and embodied identities. Following on from this, our study explores the impact of social class and culture in relation to health discourse and learner identity. Competing discourses health discourses work to become the ‘normal’ leading to the privileging and codification of certain practices and knowledge. We speculate about the impact of ‘health’ discourses/practices have in young children’s learner identity as configured by practitioners’.

Within the context of EYE, practitioners are expected to distribute knowledge and evaluate children’s development in relation to what they are expected to have acquired as defined by the EYFS. For example, across all three settings, children were expected to (i) know that milk and water were ‘healthy’ drinks (and were instructed that both were important to drink if they did not already know– i.e., regulative discourse), and (ii) why milk and water were ‘healthy’ drinks (instructional discourse – although expectations varied across the three settings and children (see below). The use of criteria (e.g. being told, ‘we all need to share at snack time’) made children aware of what was considered legitimate knowledge and means of enacting it within the setting. However, children’s level of achievement in relation to this legitimate text relied on their knowledge, understanding and acquisition of realisation and recognition rules within the home learning environment and EYE setting. These are the principles which permit distinctions between contexts and which underpin the correct production of texts (e.g., language and behaviour) within different contexts. Recognition rules create the means to distinguish between contexts and therefore recognise what constitutes valid knowledge and context, while realisation rules regulate the creation and production of specialised relations

within texts. For example, within an EYE context, some children may recognise fruit as being a healthy snack, but may not be able to realise i.e., articulate why it is healthy or enact being healthy. The work of Guest (2013) and Lareau (2003) highlights the impact of culture and social class on young children's play and which 'forms' of play are valued more. For example, Lareau's (2003) work suggests informal peer play as dominating low SES communities compared to higher SES communities where organised sports dominated children's play. Aware of the impact of social class and culture, our work looks to explore how this impacts on the way in which health discourses/practices are embedded in EYE acknowledging that discourses can be different without being deficient.

Rose (2004) and Morais (2002) have argued that evaluative² criteria are central to identifying pedagogic practice which promotes success in schools especially for 'working class' children, since evaluative criteria specify the requirements for children's successful production of legitimate school text. In light of this, the evaluation criteria outlined in (table 1.1) provide examples of how control can be characterised within EYE settings whilst children are exploring the concept of health.

Insert Tables 1 and 1.1 here

Classification and framing determine the principles which regulate specific pedagogic practices. Classification regulates the recognition rules which at the level of the acquirer, allow individuals to recognise the speciality of the context they are in. By contrast, framing shapes the form of pedagogic communication, with different strengths (+/-) impacting on realisation rules, which allow the acquirer to speak, 'breathe in' legitimate text. Where framing is strong, there are reduced options while weak framing (F-) depicts a range of options available to the practitioner and child. For Bernstein (1990), text production (i.e. talk, actions, and behaviour) in a given context depends on the possession of specific coding orientations to that context. In other words, children need to have acquired (e.g., from the home setting) both recognition and realisation rules to produce legitimate text (and act 'appropriately') within EYE contexts. Children's ability to acquire the realisation rules of their EYE setting may be related to the continuity or lack of continuity between family and EYE setting codes and pedagogic practices. Bernstein argued (1990) that schools privilege certain forms of communication which he termed 'elaborate orientations' and when there is continuity or no interruption between the learning orientations of the home and the learning of the EYE or school, then children are more likely to be defined as 'able' and enjoy success as a learner.

Moreover, he argued, somewhat contentiously, that different social structures generate different and distinctive linguistic codes, which in turn regulate discourse; 'every time the child speaks or listens, the social structure of which he [or she] is part is reinforced and his

[or her] social identity is constrained' (Bernstein, 1964, p.57). Bernstein's articulation of these codes has been much debated and maligned (see Bennett and LeCompte, 1990; Boocock, 1980) despite his (Bernstein, 1996) persistent avowal that rather than being deficient, restricted codes were functionally related to the social division of labour where context dependant language was necessary. The 'elaborated' code of the 'middle class' and 'restricted' code of the 'working class' could, therefore, impact children's access to knowledge if schools favoured one of these codes over the other. Within this paper we use the term 'code' essentially as means of focusing on how individuals variously interact with their environments and shape and are shaped by them.

Shaping subjectivity and the acquisition of elaborate codes

Health discourse in EYE as Pedagogic text

In all three settings the regulating principles of the EYFS with regard to health were not enacted straightforwardly or directly in the classroom, but rather were mediated through practitioners' evaluative interpretations of children's families and the knowledge that children brought to the setting.

The EYFS framework invokes play as the primary medium of learning about health in EYE. However, health knowledge in each of the three research settings did not materialise in this way. Instead, health knowledge was implicitly embedded in the culture and ethos of each setting (i.e. it was part of daily activities such as eating snack/lunch) while occupying a specific space clearly separated (i.e., strongly classified) from all other curricular contents, contexts and learning activities.

Insert Figures A-C here

The above images illustrate the specific space (the 'milk bar') that health knowledge occupied at *Little Stars*, *Busy Buzzy Bees* and *Little People*. At *Little Stars* the health space (the 'milk bar') served as a location expressing a specific discourse and purpose as a snack area 'incidentally' reinforcing healthy choices, such as eating the 'right food', to children. This reinforcement occurred not only through each setting's choice of snack but also via incidental pedagogical transactions between practitioners and children. E.g., often practitioners would use snack time to initiate conversations with children around what food was healthy and what they should be eating. On one level then, health discourse was a constant in children's lives. Pictures on walls, healthy snacks on the tables were assembled in relation to other discourses aimed at developing the 'independent child' imagined by the EYFS. However, on another level, health discourse was also compartmentalised and strongly bounded from all other curricula and, in this respect, was afforded less importance. On the surface, all children appeared to have equal access to the same health discourse, but when we

look at the settings in detail, we see significant differences between them. These differences are expressed in;

- The boundary strength between different forms of play (subject knowledge)
- The boundary knowledge between specific EYL/official knowledge and everyday knowledge.
- The strength of the boundary between spaces used for different types of play and how practitioners and children negotiate the use of space

Table 2 illustrates the indicators developed for the classification of health knowledge in each setting. C++ signifies the strongest classification (boundary maintenance) between categories and C - - the weakest. We might then first look at the *inter*-discursive relations between health knowledge and common sense knowledge and secondly, the classification of health knowledge and physical activity in each of the settings (Table 2.1).

Insert Tables 2 and 2.1 here

The analysis which follows explores some of these classifications in greater detail, in particular focusing on columns 1 and 2.

Boundaries between school, family and 'lay' or 'popular' knowledge (table 2.1, columns 1 and 2)

Across all three settings, visual images were used to reinforce messages about healthy choices, for example, the importance of drinking water and eating 'good' foods, such as fruit, cheese and crackers. However, the voice of 'health' varied significantly across settings.

Insert Figures D – F here

When practitioners in each of these settings were asked 'what do you think children know and understand about health?' several referred to children's home life as having greater influence on children's knowledge than what they are taught at nursery. This was particularly so at *Little People* and *Busy Buzzy Bees*; (examples 1-3 are taken from *Busy Buzzy Bees*),

Example 1:

Researcher: "What do you think the children know and understand about health?"

Alice (practitioner at *Busy Buzzy Bees*): "I think it's quite in the news, I think quite a few parents' kind of have a bit of an influence now, it's kind of, you know, sometimes

depending on what they eat and stuff they'll sort of make comments about whether it's healthy or not healthy, so I think they are quite aware."

Example 2:

James (child): "I'm going 'Little Ninjas' today, I need to eat this fruit don't I Helen, so do exercises? Mummy said so"

Helen: "Yes James, eat up all your banana, it's good for us isn't it....what are your favourite fruits?"

Example 3:

Amy is showing Helen what she learnt at gymnastics (tuck jump, forward roll)

Adam (watching Amy): "That's exercise, I can do exercise, running and football....mummy does exercise, it's good for us isn't it"

Helen: "Yes Adam it is, would you like to show me some exercises?"

Adam touches his toes with his hands

As these extracts indicate, at *Busy Buzzy Bees*, boundaries between 'official' school and home 'lay' health knowledge were weak (C-). The children engage in activities at home which provide them with the knowledge the EYE setting encourages children to have and develop and as such there is no interruption between the elaborated codes of the EYE setting and those of the home. Learning appeared to be contiguous and context independent showing little sign of discontinuity between home and EYE setting. This is in direct contrast with the other two settings. At *Little Stars*, for example, Mrs Hunter (practitioner) commented:

"We encourage them to eat healthy at snack time, we take the opportunity at the snack bar to talk to them but it's a bit much, it's difficult when it is not their culture at home"
(Mrs Hunter)

Here, because 'healthy' eating (defined by Mrs Hunter in terms of eating fruit and vegetables) is perceived as being unimportant within children's homes, practitioners found it difficult to routinely address health matters. Consequently, she, like others in the setting, questioned the need to raise healthy eating issues with children so young. This insight echoes the work of others (McEvilly et al, 2013 and Wright, 2006) suggesting that certain discourses take precedence over others and these power dynamics are configured by practitioners and their interpretation of children's social and cultural backgrounds and attitudes towards health discourses.

Space, time and discourse: the framing of health discourse at Busy Buzzy Bees

In this first transaction (below) located in *Busy Buzzy Bees*, Laura (the practitioner) is observing children at snack time. She stands near the snack table, making sure the children

eat their snack, listening to their conversation around 'what is healthy'. She enters the conversation, asking children questions and challenging their knowledge;

Amy is telling Tom how milk comes from cows (field note)

Tom: "Yes but not all milk...not my milk"

Laura: "Yes you are both right, now who is not drinking their milk? Who knows what milk is for? (Question opens to the whole group)"

Amy: "Makes your bones strong"

Laura: "Yes it makes your bones nice and strong..."

Amy: "And your teeth"

Laura: "Yes and it makes your teeth strong, that's very good Amy"

In this extract, the coding of the evaluation criteria is strong (F++); Laura listened to children's conversation and then questioned their knowledge, in the process assessing their understanding as a group. Laura controlled both the transaction (albeit initiated by the children's discourse) and the nature of the knowledge to be transmitted. This strong framing and classification of knowledge through Laura's control and questioning is indicative of an elaborated code; children were encouraged to develop and demonstrate understandings that were not context dependent but universalistic, progressing beyond the 'technique' of 'yes milk is healthy', to discuss the reasons why.

Another example of elaborated 'health' knowledge at *Busy Buzzy Bees* could be seen as Helen (practitioner) observed children at snack time and listened to them talking about what they did at the weekend. James is telling Tom and Ian about going to a local forest park with his family. Helen enters the conversation asking James what he did there and then encourage others to demonstrate their knowledge of physical activity:

James: "When I when to the forest, we got the train there and then walked and ran through the trees...and... we saw the water wheel and poured water on it"

Tom and Ian: "I've been there too..."

Ian: "Did you go on the train James?"

Helen: "What did you do at the forest James? Did mummy and daddy go too?"

James: "We when [sic] walking and running and played in the park"

Helen: "Very good, I walked into work today because it is lovely weather and it's good to exercise...did anyone else do any exercise this weekend?"

Amy: "I went gymnastics [sic] yesterday"

Matthew: "I played football in my garden"

Helen: “Very good, does anyone know why it’s good to do exercise?”

Ian: “It’s good for you, to run around because it’s fun”

Chloe: “My daddy goes gym to get big muscles”

Similarly, in this extract, the coding of evaluation criteria is very strong (F++); Helen listens to the children’s conversation and then questions their knowledge, in the process assessing their understandings as a group. She controls both the transaction (again, albeit initiated by the children’s discourse) and the nature of the knowledge to be transmitted. The dynamic, between the strong framing and strong classification (strong knowledge boundary between common sense and privileged health knowledge) is again suggestive of an elaborated code. Children are encouraged to develop and demonstrate understandings that are not context specific but universalistic, going beyond the mundane lay knowledge ‘of exercise is good for you’ (or indeed, just fun and necessary to get from A to B) to discuss possible reasons why. At *Busy Buzzy Bees* children were expected to learn to interpret appropriate and desirable health behaviour in ways similar to that which they were held to encounter at home. They were however, deemed already socialised in ‘the school way’ or, in the vernacular of the practitioners, made ‘school ready’.

The framing of health discourse at Little People and Little Stars

In contrast, at *Little People*, practitioners rarely talked to children either about eating ‘healthy foods’ or exercise. They believed that healthy eating was not something that was promoted at home. Stacey a practitioner at *Little People*, for example, suggested;

“We try to after dinner, we will ask what the children have had, with McDonalds just at the corner, lots of them have that, some are still eating it when they come in... it’s quick and easy for parents! We don’t say McDonalds is bad but we try to tell them other things are better. So if they have had a sandwich, we praise them, say oh that’s good and encourage it... But it’s hard, sometimes it depends on the child and what the parents let them eat, if they let them eat what they want or if they encourage them to eat healthy. Like at snack we eat fruit because it’s healthier, lots of children don’t like it when we have tomato and cucumber but we try to say it’s good for you. I suppose it’s hard to understand healthy.”

Similarly, John and Jane (practitioners) suggest that healthy eating is not a priority for many of the children at home:

“For some of the children, snack (at 10:30) might be the first food they have for the day; many come to nursery without breakfast. So we give them healthy foods at snack, like fruit and milk and cheese. They won’t even understand the word healthy.”

In this context there is discontinuity and interruption between home and ‘official’ school knowledge (C+) with regard to health discourse. As such, children are less likely to become socialised in ways that encourage readiness for the next phase of formal education where ‘elaborate’ health knowledge prevails. As previously discussed, the EYFS itself says little

specifically about health imperatives with few direct references to what health is etc. Furthermore, the non-statutory guidance (Early Education, 2012) (that practitioners across the settings used), equally says little in relation to developing health and self-care, with practitioners opting to rely on their own health knowledge to promote health imperatives when suitable. However, as the above extract illustrates, at *Little People* practitioners did not always consider children's health knowledge as valuable or appropriate. In these settings children were thus more likely to be defined as 'less able' when they failed to appropriately enact the imperatives of health discourse if and when required to do so. At *Little People* and *Little Stars*, health discourse tended to focus more on the immediate and specifics, e.g., hygiene and increasing children's technical skills of independence for carrying out the act of drinking milk. For example, during snack time at *Little People*, the following interaction was a common occurrence;

Suzie: "I want some milk please"

Stacey (practitioner): "We need to pour our own drinks, you can do it...Oh Liam you must be careful that's the second time you have spilt your milk, be careful when you pour"

Similar observations were made at *Little Stars*;

As a group of children sit down to have snack, Ms Smith checked they have washed their hands, 'It's not nice not to wash our hands before snack, I'm glad you remembered to wash your hands'.

This is copied by the children as other's join them at snack. When Rebecca joins the table, Gillian tells her 'Must wash hands'

Both extracts feature strong framing (F+) of the evaluation criteria. The children are made fully aware of what is expected of them but offered no further explanation as to why it is important to wash hands prior to eating or pour their own drink. Furthermore, when presented with the opportunity to discuss healthy food choices, practitioners in each setting focussed on asking children if they liked certain foods rather than reinforcing or elaborating messages about other 'healthy' choices. At *Little Stars* for example:

Lola and Kelly are seated at the snack table eating apples

Sally (practitioner) approaches and asks: "Is that nice girls? Do you like the tomato?"

Kelly: "No"

Lola: "Just the apple I eat [sic]"

Sally: "Apple is nice isn't it; sometimes they can be a bit ...mmm...sour can't they"

The evaluative criteria in this extract suggest weak framing (F- -). Sally does not make any attempt to elaborate the health discourse, say, by making reference to tomatoes being a 'healthy food choice', opting instead to focus solely on the girls' expressed likes and dislikes.

Practitioners appeared disinclined to regulate, question or elaborate children's lay understandings of health. McEvilly et al (2015) suggest that developmental discourses underpin PE in preschools. They acknowledge that one of these discourses focuses on learning and developing through play and within this discourse, for practitioners, learning is often linked to age. Our data suggests that within these three EYE settings, learning and therefore health discourse is often linked to practitioners' perceptions of children's home learning environment and parental influence not just age. Like McEvilly et al (2015) and Burrows (2004), we would argue that such discourses and assumptions influence people's views of children and what they can/cannot understand, should or should not know in relation to health discourse.

Discussion and Conclusion

Together the above examples begin to highlight the importance of the 'home learning environment' (HLE) in practitioner understandings and discourse in relation to young children's development of 'health' knowledge. In the UK as elsewhere, government concerns around obesity have, nurtured a health discourse that focuses rather reductively on the notion that 'good diets' and exercise equals fitness and health (Gard and Wright, 2001). This is reflected in EYE contexts where health discourse focuses on making the right food choices, with snack time seen by practitioners as an important site for fulfilling the requirements of the EYFS, ensuring children 'understand the importance of physical activity, and [] make healthy choices in relation to food' (DfE, 2014:8). However, official health discourse (interpreted non- problematically as orthodoxy in all three settings) was mediated somewhat differently by practitioners.

Practitioners' official definitions of health and health promotion were simultaneously constructed and consolidated in relation to their expectations of the social class intake of their settings. At *Busy Buzzy Bees* practitioners considered children to be already aware of 'healthy' and 'unhealthy' distinctions by virtue of their middle class backgrounds and hence focussed on elaborating and enriching children's knowledge of dominant health discourse around foods and exercise. In contrast, practitioners at *Little People* focussed on children lacking appropriate health knowledge and the making of poor lifestyle choices at home e.g.,

"We don't say McDonalds is bad but we try to tell them other things are better. So if they have had a sandwich, we praise them" (Stacey, practitioner).

Here, health was being read through what was considered to be absent from children's working class homes. Practitioners at *Little People* and *Little Stars* thus take on the role of providing 'compensatory' education. The nature of the health knowledge transmitted in each of these contexts further consolidated, rather than eroded, real and assumed differences between children across these settings. In privileging only one sort of health knowledge and the expression of elaborate discourse they in the process inadvertently denigrate other forms of health knowledge and pathologies those who subscribe to it.

The professionalism and commitment of the practitioners in these settings is not in question. Our data allude to structural and systemic not individual shortcomings. They reveal what can happen when a pathogenic health discourse, explicitly nurturing a deficit view of individuals' health behaviour (see McQuaig and Quennerstedt, 2016) is mediated through play pedagogies which inevitably bring to the surface personal information about children's predispositions and family lifestyles. Different forms of knowledge and meaning around health are exchanged within each of the settings. Some children, predominately those from middle class families who attend *Busy Buzzy Bees* are considered 'able' to display more elaborate (officially privileged) understandings of health in contexts where it is also assumed that their families are investing heavily in their child's physical development outside 'school'. *Busy Buzzy Bees'* classification and framing encourages children to go beyond the common sense thinkable. They are routinely encouraged to think beyond the immediate and are presented with greater opportunity to determine their own actions, with the expectation that they will choose correctly. In this process they internalise and consolidate the rules and expectations of elaborate codes within their social setting. Enacted EYFS policy replicates family life ensuring there is a continuous pedagogy at play. Made 'school ready' they are likely to carry this 'advantage' into the next phase of schooling and (more) comfortably recognise its elaborated codes.

By contrast, at *Little Stars* and *Little People*, health policy is enacted differently, in and through a 'restricted discourse', which does not go beyond lay common sense – 'fruit is good for you', reflecting the assumed (pathological) backgrounds of children within the setting and wider community. Practitioners have neither the opportunity nor the incentive (from within official health discourse) to consider children's 'lay' health knowledge as valid and important. Hence they do not encourage children to reach beyond the 'expected' (e.g. I like this, but don't like that) 'lay' knowledge of food and health. In these settings most children do not (and are assumed not to) arrive with the 'ability' to display 'appropriate' health knowledge the acquisition of which requires considerable parental investment (financial, time, knowledge). Consequently, at *Little Stars*, practitioners spend time developing the 'basic' physical skills children require for the next phase of formal education, rather than offering access to and exploring 'privileged' health knowledge. This is *not* to suggest that children who attend *Little Stars* or *Little People* do not have valuable health knowledge (just not the kind valued in official health discourse), or that they are less able to display the 'right' form of embodiment and elaborate understandings for participation in 'privileged' forms of physical activity and health. Rather, children who attend *Busy Buzzy Bees* have already enjoyed more opportunities to develop, refine and display 'elaborate' health knowledge due to the weak cultural boundaries between family and school environments. As Ball (2010) argues, many early years' influences lie outside the range of public policy and are greatly associated with the family dynamics, parenting and home environment. None of this is to imply that practitioners at *Little People* and *Little Stars* are only, or by choice, actively encouraging a restricted code. Given limited resource and time to spend with each child they have little choice but to be purposefully reactive and reductive. That is to say they are responding to the knowledge, dispositions and manifest behaviour that children bring to the EYE setting, within expectations regulated and defined by the EYFS. In these circumstances,

any policy aspiration of eroding social inequalities and enhancing social mobility is unlikely to be achieved. Marsden and Weston (2007) argue that with the increased media focus on health, fitness and sport, discourses around PE and health for young children are high profile. We hope our analysis may contribute towards the establishment of significant preschool PE/health agenda, although we recognise that the analysis we have undertaken in this paper only acts as a starting point for discussing how the health discourses of EYE influence, shape and ‘class’ the corporeal realities of young children and their developing sense of self.

Notes

1. *Distributive rules* act to distribute different forms of knowledge thus creating different orientations to meanings; *recontextualising rules* regulate the formation of specific pedagogic discourse (a discourse which has been reassembled so that it may no longer represent the original) and *evaluative rules* which constitute specific pedagogic practice (i.e. what is seen as valid in terms of both context knowledge (instructional) and regulative text (Singh, 2002).
2. Acknowledging that evaluation within schools normally refers to areas of the curriculum which are accessed formally (e.g. academic subjects). Within the EYFS, children are assessed on all aspects of learning – regulative and instructional, not through ‘formal exams’, but continual observation and learning journeys in preparation for their EYFS profile – The profile describes each child’s attainment against the 17 early learning goals together with a short narrative about their learning characteristics

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