WORLDS APART?

How children's bodies are perceived and valued – and the status afforded to childhood generally has a significant impact on a wide range of government policies in all countries. Environment, transport, housing, education and welfare initiatives will be affected directly by the priorities established by agencies engaged and involved with young children's physical health and well-being.

Inevitably this varies greatly across continents – for some countries nutrition, vaccination, water, hygiene and medicine will be the focus – for others it is obesity prevention, access to outdoor play, sporting opportunities and physical activity as an aid to learning – for children growing up in war zones mental health and emotional well-being will highlighted.

On a macro level – children are physically affected and protected by the following global agreements :

- 1989 Governments worldwide adopted the United Nations Convention on the Rights of the Child (UNCRC). Children were to be treated as 'human beings with a distinct set of rights instead of passive objects of care and charity.' These rights describe what a child needs to survive, grow and live up to their potential in the world. All agencies must work together to protect and ensure their physical and mental health
- 2000 Countries signed the EFA (Education For All) agreement - pledging 'to expand and improve comprehensive care and education' for all children
- 2010 (reviewed 2015) – Global Strategy for Women's and Children's Health created to ensure 'universal access to essential health services and proven life-saving interventions'

Global initiatives agree that ECD (Early Childhood Development) is important – that 'it is about the foundation for individual and societal progress that has an economic and social payback for all.'

However, globally investment in ECD is limited and is sourced mainly from health and/or education foundations. In developing countries less than 5% of government budgets are allocated to education and only 2% to health – on average 0.5% of funding is directed at young children.

Despite this, significant progress has been made in a relatively short time span. Childhood is no longer considered a period to be suffered and endured with no particular relevance to society apart from survival. It is now viewed as a critically important stage of human life that has a profound impact on the formation of functioning societies.

How has the concept of childhood developed over time?

In the 16th Century children were considered to be 'lower animals in the form of man.' Child mortality rates were high due to malnutrition, poor hygiene, infectious diseases and basic neglect. Astrological determinism ruled – character, temperament, health and wealth were all decided by planetary alignment – an 'harmonious quality of life' depended on mathematical proportion, ratios and equations. Children just had to survive somehow – playing with toys that were seasonal and accessible. Communal physical activity was encouraged through social and religious celebrations.

The 17th Century saw significant changes in religion and economic circumstance. The communal responsibility to survive developed into an interest in individual freedoms and values. Freed from planetary interference the individual now had some agency and interest in personal growth and development – physically, spiritually and emotionally. Childhood became viewed as an 'isolated event' – one in which, through 'education' – children could become 'perfectable in human hands.' Personal active participation in and involvement with life opportunities and challenges could now supercede anything Mars and Venus had decided previously. Children were beginning to be seen and heard.

In 1762 Rousseau (1712-1778) published 'Emile.' Emile was an imaginary child educated by the natural environment, fresh air and exercise. The impact of his thinking has been far reaching and influenced the future work of Pestalozzi, Froebel and the creation of the Forest School movement. For Rousseau the physical health and well being of children was of paramount importance – physical activity was the ideal preparation for 'mature sorrow, all ailments and for strengthening the soul.' From this point on – the role of physical development in ensuring smooth overall development and the intrinsic importance of physical activity in the process of learning became an established and recognised component in educational thinking.

The 19th Century witnessed some of the most significant health, education and welfare reforms to affect young children.

Francis Galton (a cousin of Charles Darwin) 1822- 1911 was one of the first to gather comprehensive data on the physical comportment of human beings. He took a range of measurements from 93.000 people to establish physical norms and averages. Over time, this led to the development of sophisticated statistical analysis that affects health and education policies and practice to this day.

Influenced by the detailed diaries Darwin wrote that charted the development of his children, the rise of the 'Child Study Movement' and the emergence of psychology as a discrete discipline a growing interest evolved in establishing developmental 'norms' for young children who became increasingly measured and monitored. The data comparing working class children with those from more affluent backgrounds became the basis for many 20th Century child welfare policies.

At this point an explicit link was becoming established between the welfare of children's bodies and the future welfare of the nation – inspiring doctors in the UK, Germany and the USA to review health standards and implement effective welfare plans. Children's emotional state was also considered to mirror their physical state – children who were 'stunted' physically were deemed to be so in every developmental domain.

Arnold Gesell (1880 – 1961) further influenced the concept of 'normality' in child development. From his visual data of 500 children he wrote 'summaries' in which a 'norm' was described for each age group. These 'summaries' had considerable influence on Western views of 'normality.'

By now childhood had a fixed timespan and was intrinsically linked to physical growth and development – indeed- physical change determined when childhood began and ended.

Childhood and the body

Childhood is now considered to be 'a discrete period of time that society allocates for the process of training to become the kind of member that society wants him/her to be.' Every society will thus crystallise its' own rules and regulations that dictate attitudes towards children's development.

Interest in children's bodies over the past 100 years has led to a marked decline in mortality and disease and an increase in weight and height related to age. Parents are now active participants and investors in their children's health and well-being – the beneficiaries of parenting theories and developmental charts that offer support and reassurance. With the decline of belief in cosmic certainties – the physical body as being the main 'constituent of self' has grown ever more important.

The increase in accessible medical knowledge and the rise of state engagement in people's general health has ensured that bodies are continually regulated and defined. The management, maintenance and appearance of 'the body' is now of profound significance – the 'presentation of self' really matters – even to very young children.

For children, their bodies are a 'flexible and shifting resource for interactions, emergent identities and relationships.' They must 'negotiate their own bodies through constant change and changing institutional contexts within which meaning is given to these changes.' What value do we place on learning to point/crawl/walk/talk? How do we value emergent physical independence and do we really understand or appreciate common childhood experiences such as changes in height and weight, hair and nails growing, new shoes?

For young children early socialisation is devoted to 'working on' their bodies – washing, nourishing, resting and moving. They must come to acknowledge and accept the relationship between their physical bodies and the societies they inhabit. Physical independence is highly prized in ours. Being physically 'in control' and able to adapt to

'being controlled' are essential skills to master – the 'moving, managed and disciplined body' is central to 'the business of schooling.' Internal and external restraint are definite pre requisites for a successful Western educational experience.

How does the concept of childhood as : a critically important time for development – a period of emerging agency and personal responsibility – years when physical health and well being must be protected, ensured and maintained – impact on the practice and provision for EY/PD/PA worldwide? How is the legacy of over 100 years of interest in – and policy making around children's physical health affect initiatives today – what differing priorities and tensions emerge – and where do we fit in?

Evidence

A range of colleagues and countries were contacted by e mail and telephone to provide answers to the following questions. Not all the information they provided may be included here – but the main points for discussion will be highlighted in order to give a broad perspective and a context in which our own provision and practice may be reviewed.

Is physical development/activity an established component of the curriculum in your country?

An interesting variation in answers emerged to this question.

Finland undoubtedly demonstrates a high level of commitment and innovation to the field of EY/PD yet it is not officially a curriculum component. Historically, young children have always embraced the 'outdoors culture' and a broad range of activities are offered year round. VALO (the Finnish sports federation) will launch their national EY/PD programme in March 2015 based on three years of rigorous research and data collection.

In the UAE expats (80% of the population) do not have access to centrally funded schools and nurseries so the majority of settings are commercial or 'not for profit' enterprises. The British schools follow the EYFSC and therefore pd/pa is well established – settings are well resourced and specialist teachers are employed to ensure all children experience a broad range of movement opportunities. In contrast – the local Indian, Pakistani and Arabic schools give no importance to pd/pa at all. The emphasis is on desk-bound rote learning to prepare children for the competitive primary school entrance exams.

Kazakhstan, Hungary and China (Chinese schools) all follow accepted pd/pa curricula guaranteed by law. Physical activity is considered a critical component of EY education and all children will experience movement opportunities daily.

For South African children the EYC is very new and although active/outdoor play is encouraged there are no specific guidelines/goals for practitioners to follow regarding pd/pa – it is just 'a natural, important and intrinsic part of the day' – there are no plans at present to develop specific guidelines/goals for this area of the curriculum.

England : PD is a 'Prime Area' of the EYFSC – and is therefore under Ofsted regulations. There are guidelines and accompanying goals to support practitioners – but no data is available as yet to assess their efficacy related to general physical health and starting school. Physical and outdoor play is generally well understood and supported.

Has the PD/PA component of the curriculum been developed centrally – or do local settings have autonomy re content?

In Kazakhstan and China pd/pa programmes are designed centrally and must comply with stringent government guidelines. In Kazakhstan 'physical exercises' (including a range of sports and swimming) are designed as a daily experience 'to harden the health.' In China, the Ministry of Education decides on the form and content of pd programmes to ensure they align with the 'Guidelines of Development and Education for Children 3-6 years.' The British schools in China are , however left to design and deliver their own pd sessions.

In SA and Finland the governments formally acknowledge the importance of pd/pa to children's health and well-being but practitioners have autonomy to decide on practice and provision. In the UAE – the Ministry of Social Affairs (who license all EY settings) has no stipulation regarding pd/pa or outdoor play so this area of development may be ignored without censure or practitioners may choose whatever programme/resources best fit.

In Australia – although all children's services are under the aegis of National Law – autonomy in the provision of pd/pa opportunities for children is energetically encouraged. At local level – there is a wealth of agencies working together to ensure young children may access a broad range of opportunities outside school – and all EY settings are expected to provide resources for children in compliance with National Guidelines to ensure children are ready and able physically for entry to formal schooling.

England : The EYFS provides guidelines and goals for pd – but these are open to individual interpretation and there is no stipulation as to how the goals may be reached. No comprehensive, nationally approved pd programme exists and settings must create or access information from a variety of public and private sources – based on levels of knowledge, interest and financial constraints. Local authorities may be proactive in sourcing programmes – but their effectiveness is difficult to evidence.

Is PD practice linked to Education – or more associated with Health /Obesity initiatives?

Childhood obesity has become a global issue and this is reflected in the range of answers supplied.

In the UAE the different approaches to pd/pa taken by the British and local schools encapsulates the position of this field in relation to education and/or health.

In the British schools pd/pa is evidently a critical component of the curriculum – that ensures smooth overall development. Children have access to outside space and a

swimming pool – and a range of resources are available for them to practice their skills. It is definitely seen as being of educational benefit – the children rehearse and refine a range of competencies that bear direct relation to their learning. In contrast – for the local schools – pa is viewed as a very specific and targeted therapeutic intervention to combat obesity issues. Medically approved pa programmes are implemented to address the health issues that accompany obesity in children – diabetes, joint pain and high blood pressure.

China also presents this dichotomy in the pd practice present in the Chinese schools and the British Chinese schools.

The British settings acknowledge the importance of pd/pa as an aid to learning and make clear links in practice between different areas of the EYFSC. In local Chinese settings – pa is included for entirely health-related reasons. Specific routines are followed at regulated times – and although these may be enjoyed by the children and enthusiastically presented by the practitioners – the message is very clear – strong, skilled, disciplined children will work better and achieve more. Obesity simply demonstrates lack of self-control and is evidently a medical issue to be managed by relevant agencies.

In SA pd/pa has previously been linked to education and learning – the social and communication skills children developed through pa were particularly acknowledged and supported in practice. The physical skills considered necessary to acquire before starting school were rehearsed and refined to ensure smooth entry to primary school. However, with a child obesity problem looming, the National Health Department is now focused on pa programmes that are designed specifically to combat weight-gain – the financial implications of obesity-related conditions have forced this initiative.

In contrast – Finland has always related children's pa to health – that outdoor unstructured physical play was the optimum way to ensure overall well-being. However, a recent comprehensive educational research study has created a growing understanding of the part movement skills play in learning. The data will impact on the design and delivery of pa in EY settings nationally and will ensure that pa has equal status in both education and health spheres.

Hungary is also going through a period of transition regarding EY pd/pa for similar reasons cited by SA. There is now an acute obesity problem in the country and although historically EY professionals have been proactive and inspirational in embracing movement as underpinning learning, they are under increasing pressure to view pa as a preventive measure to combat child obesity. Since 2012 all school children must experience a structured pa session every day and nurseries should ensure children are able and physically prepared to engage in these sessions when they begin formal education.

England : There is evident tension between the status of pa related to health and/or education. All practitioners/professionals are aware of the pd guidelines/goals but these do

not relate effectively to the promotion of health and well-being. Funding is aimed at nutrition/obesity/health initiatives – but those working in the educational sphere are in daily contact with families/children and are in a stronger position to monitor/ evaluate- and co ordinate education/health initiatives.

Do you have any issues concerning 'school-readiness'?

In SA this is a very significant issue. Only 70% of children experience the 1 year EY programme before formal schooling begins. Thirty –three per cent of children ever complete 12 years of schooling and research suggests this is directly related to their lack of pre-school experience. Less affluent children are demonstrably 'less ready' – 50% will drop out of school between 10-12 years old having never managed to acquire the range or level of physical skills needed to access the curriculum.

The UAE also reported 'school-readiness' issues for quite different reasons. Practitioners are under enormous pressure to prepare children for entry tests to primary school. As these tests are entirely paper based pa is not considered relevant to ensuring a pass.

In Brunei – children who are considered 'not-ready' for formal schooling follow a 10 minute daily movement programme to refine their movement, balance and co ordination skills. Children attending British schools in China are also offered a movement intervention programme to ensure they are 'ready' for school.

In Australia – all children take the AEDC (Australian Early Development Census) when they start school. This is a National strategy firmly linked to – and underpinning- policies concerning health, housing, planning, community and education. The 'physical' component covers three areas : readiness for the school day – independence – gross and fine-motor skills. The approach is holistic and aims to identify children who are developmentally 'on track' – 'vulnerable' – or 'at risk.' It clearly acknowledges the critical importance of physical competencies in ensuring children are willing and able to access the curriculum – and is designed to drive policies not simply provide data to support whatever initiative is considered relevant.

England: There is on-going contention regarding terminology and efficacy with no resolution in sight. The EYFS Profiles will be optional by September 2016 and a range of Baseline Tests will be available to practitioners. The current goals for pd produce some very questionable statistics and do not support effectively the health and well-being of children.

Do you experience any cultural issues re children and pd/pa?

The UAE reported significant problems. The country is such a melting pot of cultures that inevitably a wide range of beliefs emerge regarding what education is – and what it is for. Pa is generally not considered 'educational' – and there are issues regarding parents of girls – they do not want them to engage in pa for safety reasons. As the temperature is over 40

degrees for 7 months a year, the children learn to swim very early. This also raises concerns as the girls are not allowed to wear normal swim wear – or change in the same room as the boys – causing staffing issues to arise.

In Brunei the obesity issue is linked to the overfeeding of first-born children – an historical cultural norm. The educational emphasis on learning letter/numbers very early on has a significant impact on the practice and provision of pa.

Finland also reported difficulties in gaining support from immigrant parents regarding their children's participation in pa. They simply do not accept the importance of physical skills and well-being to learning – being particularly unsupportive of girls' engagement – citing safety as the reason.

In China (British schools) – parents are very sensitive to weather conditions and do not approve of children being out in the cold. Pollution issues also have a negative impact on outdoor play.

Australia report that they must provide comprehensive translation and interpretation services to explain to parents why pa is important and how they may access services to support and enhance their children's physical health.

England: No data to suggest that there are significant cultural issues regarding EY pa.

What value do parents /practitioners place on EY/pa/pd?

In SA there is a significant difference between adults living and working in affluent and less affluent environments. For the former – families and educators have access to a range of private sports clubs and planned programmes that support children's pa and health. For the latter – adults are aware of the importance of children's pa but this will be experienced mainly in freely accessible streets and parks – and will not include structured competitive sessions.

In the UAE the difficulty lies in parental reluctance to value pa as an important educational aid – it is considered as 'a break from real work' and as such – has little intrinsic value. Children must produce visible 'evidence of learning' – that pa is not able to create.

In China (local schools) pa is necessary to ensure children are able to 'work and learn more.' Knowledge comes from rigorous application to paper-based learning, perseverance and tenacity – not from engagement with and enjoyment of the real world.

Parents in Finland, Hungary and Kazakhstan play a very important role in supporting children's pa and health – both at school and at home. They are encouraged to be involved and effective role models regarding pa and in Hungary – family 'activity days' are organised by nurseries to encourage healthy lifestyles.

England: Anecdotal evidence suggests that parents and practitioners are broadly supportive. Internet use has ensured easier access to information and encourages the sharing of ideas and initiatives. Much more could and should be done to resolve tensions between health and education professionals.

What training do EY practitioners receive re pd/pa?

This varies greatly.

In Hungary all nursery staff gain at least a BA in nursery education and therefore have a good level of knowledge and understanding regarding the methodology of pa. They are very practiced at designing activities based on observation and need. Finland also employs a multi professional ECE workforce who all have a high level of knowledge and understanding of pd that may be translated into effective practice.

The training of EYP's in SA is limited at present but the situation is slowly changing. Knowledge of pd is therefore limited - as they are not considered 'teachers' they are unable to access relevant training and support. No specific training for pd is available at present.

In China (local schools) all practitioners are expected to deliver competently games based activities in settings. No encouragement is afforded to design their own pa programmes or to develop reflective practice around pd.

England: The pd module in the L3 EYE qualification is now mandatory – a very positive move. However, qualified practitioners must source their own CPD in pd from a range of training providers.

What assessment procedures do you use re pd/pa?

In SA there is no formal testing of pd at EY level as it is not included in the curriculum. Literacy/Numeracy are considered much more important. However, the private school system is known to employ a range of monitoring and assessment measures throughout the school years.

Kazakhstan and Hungary closely monitor the pd of young children. The former uses a range of formal medical assessments to ensure smooth development whereas the latter take a much more holistic and educational approach.

Finnish children have not previously been formally assessed or tested for pd – but with the new emphasis on evidence based practice there is growing interest in the role balance and motor skills play in effective learning. Assessment procedures will be designed to accommodate recent research findings.

In China (local schools) – Health Standards and evaluation systems play a very important role in monitoring children's pd. Tests involve 'scales, measuring tape and a stopwatch.' An

entirely medical model is used to ensure children reach milestones at the right time in the right order – fundamentally 'norm sensitive.'

England: The 2 year old 'Integrated Review' is experiencing some difficulty in implementation. At the same time – the EYFS Profiles are being phased out – and the proposed use of 'ASQ's' is having inevitable teething problems. The future range of available 'Baseline Tests' does not mention pd and is causing major dissent and confusion generally.

Conclusions

The practice and provision for pd worldwide is based on a set of generic beliefs supported by global agreements and aligned to the needs, resources and values of each country.

The UNRC and EFA charters provide effective frameworks to ensure the fundamental importance of childhood is respected as a particular period of time in which children take their first steps to becoming functioning citizens. It is acknowledged globally that early life experiences have a profound impact on children's physical, emotional and spiritual growth – that all domains are linked and equally important.

The priorities for each country vary. For those experiencing war, famine and disease resources will be allocated mainly to maternal health, vaccination and nutrition. In countries where obesity has recently become an issue – medical and family programmes will be developed and funded. A third group of countries (in which highly sophisticated monitoring and measuring procedures are available to assess children's pd) will experience a degree of tension and uncertainty as to which (health or education) should receive most support from central agencies to support levels of pa.

The question is this : If children are becoming more obese – they should be encouraged to move more. But – will this be better effected through engagement with health/fitness/nutrition initiatives – or clear focus on the developmental implications that lack of movement caused by obesity will undoubtedly provoke?

Whatever countries decide, and on what basis (altruistic, financial, ethical, political) the healthy development of young children is supported, we must remember that ultimately it is not really about statistics and justifying budgets.

For young children their physical development is of profound importance – generating interest, amusement, frustration and discovery – a constant source of wonder and delight.

'Acting people are acting bodies' – through their bodies children learn they have agency – they exist, they matter, they communicate – they experience elemental concepts including time and gender.

It is – for them – how life makes sense.

''Do you want to be big?'

''Yes – I want to be five.'

Implications for practice/considerations

- Be aware of the profound effect on children's social and emotional development of their growing bodies. Managing continual changes in shape/height/weight brings many challenges as new found strength/speed/competence/assertiveness is acknowledged and accepted
- What messages about their bodies are children absorbing from adults? What level of control do you exert relating to rituals and expected behaviours – what language do you use and is it always appropriate?
- What level of physical control do you expect children themselves to display – personal hygiene/spatial sensitivity/curricular activities/independence – is it always appropriate and does it cause tension with parental expectations?
- Some parents may hold very different values regarding pd/pa – be sensitive and supportive of their beliefs – but ensure they are aware of your expectations in daily practice

What positive messages should we be sending out?

- All bodies are the same in some ways – but different in many others. Respect and appreciate similarities and differences
- Physical activity is to be enjoyed and celebrated as confidence and competence grows
- Parents adults should be encouraged to support and participate whenever and wherever possible
- Bodies need looking after – eat well- sleep well – good hygiene – fresh air and activity are all required to sustain optimum health and well being

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www.activematters.org

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