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Exploring participation as a new perspective for child oral health promotion

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Abstract

Background: Despite a call for participatory child-centred approaches in oral health there remains a lack of research regarding children's participation in oral health promotion. The aim of this study is to explore the meaning and dynamics of children's participation within an oral health promotion programme.

Method: This study involved an ethnographic-case study approach. Data collection involved participant observation of children and Early Years Professionals (EYP's) within 2 toothbrushing clubs set in 2 nurseries over a period of 9 months. In addition, 6 semi-structured interviews were conducted with EYP's and oral health promotion professionals. Purposive sampling was used to select the nurseries. Data were analysed using inductive thematic analysis.

Results: The model of children's participation provided by educational pedagogy in early years education provides a better understanding for facilitating and enabling child participation within a nursery setting. Children's participation in the toothbrushing club was significantly shaped by the setting, the practitioners' capacity and their views of children's participation and childhood.

Discussion and conclusions: Children's participation in toothbrushing clubs may be better understood from a *relational* perspective which values interactions and places emphasis on the adult as the enabler of participation. This perspective has implication for health promotion and has yet to be fully appreciated in oral health promotion. There appears to be a discrepancy between policy and practice resulting in the mouth still being separated from the body and oral health viewed in isolation to general health by policy makers. The nurseries in this study each took on a different approach to their toothbrushing club. The capacity of each nursery may influence the approaches that EYPs adopt in promoting oral health. This highlights the importance of the need for capacity building through continuous professional development of staff-human resources.

Keywords: oral health promotion, oral health, child participation, participation, ethnography

Introduction

This thesis provides an in-depth exploration of children's participation in oral health promotion implemented in nurseries. Participation has been high on the agenda of health promotion because it is a key element of the Ottawa Charter; which almost three decades ago stressed its' necessity and outlined it as a key guiding principle in enabling people in matters concerning their health. Around the same time, the United Nations legally acknowledged the rights of the child, including the right to participate in all matters that may affect them. Subsequently, participation as a new perspective of child-health promotion became important. Although the movement and commitment to child participation has been around for quite a while, translating that into practice has been slow. This reflects how children are viewed in society; being traditionally regarded as incompetent and passive subjects, being prepared for the future rather than competent active agents in the here and now. Being viewed from this perspective means children may not be given opportunities to experience forms of genuine participation. The more recent literature on the children's rights discourse coupled with the sociology literature has concentrated on illustrating a new childhood image; the competent child. The presumption that young children are incompetent has been the main reason for their non-active participation in research. Childhood researchers have begun to recognise that age is not a direct indicator of competence and view it as irrelevant and even very young children have the ability to understand their experiences and express themselves.

With the shift in children's place in society, there has been an appreciation of the need to involve them in significant issues that affect their life including health care (James et al., 1998) and as a result the manner in which research should be conducted regarding children has altered to become more inclusive. Traditionally, research involving children meant that they were objects of the study and research was done *on* them which applied 'what adults think children think' (Alderson and Morrow, 2004) rather than *with* them and viewing them as "*competent and reflexive of their own experiences*" (Marshman and Hall, 2008:235).

A systematic review of oral health research reported in the paediatric literature that the majority of oral health research was done on children thus viewing them as objects and only 7.3% of the research was done with children, and thus children's voices were not heard (Marshman et al., 2007). To assess if there had been any changes towards more involvement of children as participants rather than objects a more recent systematic review was conducted revealing an increase in oral health research with children from 7.3% to 17.4% (Marshman et al., 2015) providing evidence of a shift towards more participatory child oral health research, however the majority approximately 83% were done on children and Marshman et al., (2015) have called for future oral health research to incorporate children's perspectives. This is important as gaining an understanding of children's perspectives of oral health and understanding how they experience issues that relate to their oral health could potentially improve the quality of oral health promoting activities and dental services.

Although there has been a strong call for participatory child-centred approaches there remains a lack of research regarding children's participation in oral health promotion. The literature does not provide us with any knowledge regarding the ways in which children participate regarding oral health promotion interventions and indeed can children participate in oral health promotion? What do young children know in regards to oral health, and where has it come from and how has it been structured? Do children view the responsibility of a healthy mouth as one that belongs to them or to parents/ carer or possibly health care practitioners such as the dentist? These views and perspectives help in tailoring oral health promotion to suit children. This raises the question as to what does child participation mean and how does it fit within oral health promotion? Therefore, the aim of this study is to explore the meaning and dynamics of children's participation within an oral health promotion programme.

With the growing emphasis on children's participation in the national agenda there has been a significant increase in activities that involve the participation of children however there appears to be an absence of knowledge around 'how' to involve them in an effective manner that would lead to meaningful and sustainable improvements.

As child participation is an interactional and managed activity that is dependent on specific adult-child exchanges, research into the daily experiences of young children illustrates what participation may look like when translated at the micro-level. There are very few studies on child participation as seen through the lens of their everyday experiences of life. Furthermore, toothbrushing clubs are a relatively new oral health intervention and very few studies exist, despite the pre-school years being recognised to be a critical period for setting the foundations for good oral health (Watt et al., 2001).

This thesis is structured as follows:

Chapter one is a review of the relevant literature which involves concepts of health, health promotion, participation, childhood. This chapter also presents the rationale, aim and objectives of the research.

Chapter two provides an overview of the possible research approaches and describes the qualitative methodology chosen for this study.

Chapter three describes in detail how the study was conducted and discusses methodological challenges.

Chapter four presents the context of the study with a detailed description of each nursery.

Chapter five presents the findings of this study using a structure-process-outcome framework.

Chapter six discusses the findings and their implications for policy, oral health promotion, and oral health promotion practice. Recommendations for future research are also outlined.

Chapter 1 Literature Review

1.1 Public health

1.1.1 History of public health

Through an awareness of the historical underpinnings of public health a better understanding of the logic and rationale of modern public health institutions can be achieved. In the past, Western governments did not feel obligated towards the individual to make efforts to improve their health. The efforts the state made to control disease and/or improve health were done with the economic, military and cultural welfare of the state in mind; the welfare of the people was incidental. While people did expect the state to take measures to protect the welfare of individuals, for instance in times of famine by making food more available and affordable, early modern political theorists did not acknowledge the protection of the health of individuals as an obligation of the state. The main concern regarding the spread of disease was the state itself: the ability to defend the country, the preservation of commerce, and the collection of taxes, during periods of high mortality (Hamlin, 2002).

During the 19th century public health began to undergo (Hamlin, 1992) a radical shift in its goals and vision. It began to recognize the individual as a citizen with rights rather than as a subject and recognised the states obligation towards the health of its citizens; health became a right of citizenship. Public health was no longer limited to maintaining the state. This paradigm shift owed itself to the rise of liberalism which held the concepts of individual freedom, responsibility and usually equality in some form. A significant change involved liberals viewing society with a 'biosocial vision' which saw that it was unrealistic, unfair, and inhumane to set political and economic responsibilities on people who did not have the biological capabilities to fulfil these responsibilities and the perception became that liberty had biological prerequisites (Hamlin, 2002). The best state policies were now those that had the most potential to improve human worth and welfare (Haskell, 1985). The efforts to translate human rights, by the pioneers of liberalism, into health rights were very limited as it was fundamentally contested (Hamlin, 2002). The choices people make of their own free-will

may not necessarily be in their best interest or that of their community. This subsequently entails ethical issues of where the government ought to stop when it comes to the regulation of the people.

Over the past two centuries there have been four main prevailing systems of public health. Firstly, the quarantine phase which dominated up until the mid-19th century, the sanitary phase, the personal hygiene phase, and lastly the ‘new’ public health movement (Armstrong, 1993). The word ‘quarantine’ originates from the Italian word for forty days and was thought to be the time needed for an ill person to be isolated in order to not pass on the disease. This was considered to be the first public health measure used to control the spread of disease. This measure was based on a contagionist model which viewed that illness was transferred from body to body and by isolating those who were diseased transmission to non-infected bodies could be prevented. The other major dominant theories of disease causation, the miasmatic and humoral theories have driven public health strategies for many centuries.

The basis for the modern day understanding of health promotion can be traced to the public health movements of the nineteenth century in North America and Europe (Lincoln and Nutbeam, 2006). These movements mainly occurred as a result of the great epidemic diseases which killed many thousands. At the time the dominant theory of disease transmission was the miasma theory which suggested that disease was spread through ‘bad air’ however, the impact of the epidemics on the population was the impetus for physicians to focus on gaining a better understanding of disease transmission. In particular, the cholera epidemic had a devastating effect across the Western world, at the beginning of the nineteenth century it was thought to be a non-contiguous miasmatic disease but through scientific achievements by the end of the nineteenth century it had become recognised as a specific contagious disease caused by a specific micro-organism.

Occurring alongside this interest from physicians were the efforts of social reformers who called for sanitary reform for industrial cities. Their efforts were directed at promoting political action which was meant to benefit the population as a whole. Over time these early public health reforms resulted in improved sanitation, clean water and food supply, safe disposal of waste, and safe working and housing conditions for the majority of the

population. Consequently, there were significant improvements in the health and longevity of the population (McKeown, 1979). Edwin Chadwick, a prominent social reformer, founded sanitary reform in the late 1830's. Chadwick argued that it would be more economical for the state to invest in comprehensive systems of water and waste disposal in order to save particularly the lives of male breadwinners as this would lead to less widows and orphans needing financial support. He also argued that the underclass could be moralized. The efforts of Chadwick resulted into a series of legislative measures, initially the Public Health Act of 1848 and culminating with a comprehensive act in 1875 (Hamlin, 1992).

Although the improvements in sanitation during the *sanitation phase* improved the health of the population its inadequacy did not go unnoticed, and in 1904 the Interdepartmental Committee on Physical Deterioration emphasised the effects of social and economic determinants on ill health (Hamlin, 1992). The public action that the State needed to take was a broad approach; a comprehensive improvement of living conditions. This included the provision of personal and environmental cleanliness, providing housing that is sanitary and not overcrowded; the provision of sufficient food, fuel and clothing; a safe work place, and a non-exhausting work day (Hamlin, 1992). It could be argued on one level that these are all the basic physical and social requirements that contribute towards a healthy individual.

From a political standpoint sanitation was rather popular. In contrast, other general reforms were profoundly controversial. Reforms to improve working conditions were challenged by powerful industrial establishments. Reforms meant to lower food prices such as permitting free trade in grain were unacceptable to influential agricultural interests and reforms regarding education and religion were hindered by sectarianism. The more comprehensive actions suggested in the name of protecting the state were also viewed as threatening to the state in the ways they could transform it. Transforming its institutions of property, social distinctions as well as the recognition of political rights meant that rather than addressing these determinants, public health redirected its focus on personal hygiene and education and thus assigned responsibility of health to individuals by focusing on their behaviours and lifestyles and by default removing responsibility from the community or state. A concern with personal hygiene arose from the scientific discoveries in disease causation and transmission and with these discoveries social reformers were able to defend their arguments

for the state to regulate public and personal hygiene (Duffy, 1990). This was known as the *personal hygiene* era and health education dominated. The Central Council for Health Education was established in 1927. The traditional rationale for health education was that disease and illness are largely preventable, that human behaviour is strongly linked to the aetiology of many diseases. Unfortunately, this approach often led to victim-blaming when individuals were given information on how to improve their health without consideration as to whether they had the resources required to implement the changes demanded by the information they had been given.

Throughout most of the twentieth century up until the late 1970's public health focused on health education and major immunization campaigns. Some critics argued that public health had lost its direction by focusing on disease rather than health and implementing individual preventive strategies, as opposed to community health oriented strategies to improve population health (Ashton and Seymour, 1988).

In the late 1970's with the return of liberalism the 'new' public health movement emerged. This is sometimes referred to as the renaissance of public health, which directed its attention once again to the relationship between health and socio-environmental conditions. The three seminal documents that set health promotion in the policy agenda were the Lalonde Report *New Perspectives on the Health of Canadians* (Lalonde, 1974). The WHO's *Global Strategy for Health for All by the Year 2000* (WHO, 1981) and the *Ottawa Charter for Health Promotion* (WHO, 1986). Also, highly influential were the writings of McKeown (1976) who argued that the improvements in health and longevity in Western societies over the past two centuries had been mainly as a result of preventive measures put in place to control infectious diseases and not due to medical developments or immunizations. In addition the work of Illich (1977) who suggested that medical professionals could cause more harm than good in that they were more likely to cause iatrogenesis (illness caused by medical interventions than by improving people's health) was also highly influential. These arguments enabled a refocusing on prevention as opposed to the technologies of medicine. Improving social and environmental conditions as a form of prevention occurred as a result of a recognition of the limitations of the biomedical model and the individualistic and victim-blaming approach of health education. The modern health promotion movement sought to move beyond the

confinement of the previous individual lifestyle approach and is considered to be the central pivot of the new public health movement.

It is important to note that similar to the economic motives of the original public health movement; the objective of health promotion in warranting productive citizens is still very much a major priority for public health. In the end the logic behind these preventative measures is not solely to achieve human happiness by minimizing pain and illness but to redirect and preserve the limited resources available for health care. Therefore, public health and its new concept of health promotion are and have always been inherently political.

1.1.2 Social values and public health

It has been noted that the actions of public health depend on the interaction of disease with two other domains, social values and science. During his time as Secretary of the Medical Research Council, Geoffrey Vickers regarding the role of factors that set the public health agenda suggested that

“The landmarks of political, economic, and social history are the moments when some condition passed from the category of the given into the category of the intolerable. I believe that the history of public health might well be written as a record of successive redefining of the unacceptable” (Vickers, 1958:600).

Vickers’ analysis has been considered significant in that it highlights the dynamic interplay between social values and science (Turnock, 2011). From this perspective we are able to better understand why and how various societies have responded to health risks differently at different times and circumstances. This suggests that public health actions are based on an amalgamation of knowledge and social values. Seedhouse, (2004) and Lupton, (1995) have both identified the relationship between health promotion and social values.

“Health promotion is a political enterprise rooted in human values, choices and prejudices and these add greatly to its capacity to mislead” (Seedhouse, 2004:163).

“Yet just as biomedicine is socially and culturally constructed, public health and health promotion are socio-cultural products, their practices, justifications and logic subject to change based on political, economic and other social imperatives”
(Lupton, 1995:4).

Both authors suggest that health promotion cannot be considered without considering the social environment and that health promotion is not a result of merely a health agenda but is affected by political, economic and social factors as well.

1.1.3 New public health movement

One of the major strategies of the new health promotion is formulated in the concept of empowerment. Health, empowerment and community participation are multidimensional and contested in nature. A question that is often asked of health promotion is what is it exactly trying to achieve? Is the main goal to improve the health status of individuals and populations and thus health is perceived as an end? Or is social justice (Beauchamp, 1976) seen to be the main objective and thus health as a means? Emanating from this confusion are other related philosophical debates including macro-level (structural) as opposed to micro-level (individual) change; community-centred actions as opposed to individual lifestyle approaches and public ownership as opposed to professional ownership.

An important aspect of public health is social justice. The concept of social justice first appeared in 1848 and is said to be the foundation of public health (Turnock, 2011). This philosophy views public health as a public issue and ‘that its results in terms of death, disease, health, and well-being reflect the decisions and actions that a society makes, for good or for ill’ (Krieger and Birn, 1998). It also argues that important forces within society hinder the equal distribution of benefits and burdens, such forces include racism and social class distinctions.

Robertson and Minkler (1994) argue that much of what is in conflict regarding concepts such as empowerment and community participation and their operationalization in health promotion relies on whether a macro or micro perspective is taken of the meaning of health and the manner in which it is to be achieved. They discuss the importance of analysing these

contested concepts and using a macro/micro perspective as a critical lens (Robertson and Minkler, 1994).

This framework places the economic, political, cultural and organizational factors as the larger structural factors in any population that shape the everyday lives of individuals on a micro-level. It is important to note that the relationship is reciprocal in that the everyday actions of individuals contribute to the construction of the macro-level structural factors. This argument tempers the doctrine of social determinism which views that human behaviour is solely determined by social phenomena with the concept of human agency. Kelly and Charlton (1995) discuss the importance for health promotion advocates to recognise the relationship between social autonomy and social structure. For example, it has been recognized that the health status of individuals is affected by political, social and economic factors however individuals have also shown the ability to alter their social surroundings and as a result improve their health (Haan, et al., 1987; Marmot et al., 1978; Miller, 1987; Ratcliffe, 1978; Syme and Berkman, 1976; Syme, 1987). Robertson and Minkler (1994) view the macro level and micro level as two spheres in a dialectical relationship '*each informs, produces, and reproduces the other, mediated by the mid-level sphere of social organizations*' (Bellah, 1991; Glendon, 1991; Moody, 1988). Examples of social organizations include neighbourhood groups, schools, churches, mosques voluntary groups and the network that connects them.

These organizations have also been recognized as 'mediating structures' (Berger and Neuhaus, 1977). Robertson and Minkler (1994) describe how individuals have been able to challenge the tobacco industry. This has been achieved by mobilizing colleagues to establish a smoke-free workplace or actively opposing advertising that targets individuals of certain racial or ethnic backgrounds in low-income status neighbourhoods. Moreover, they point out the achievements of disability rights activists that have helped to reshape disability from an individual pathology to being a social pathology. The environment was inaccessible to people with disabilities and hindered them from participating in society. Physical and social environments needed to be transformed into spaces that individuals with disabilities could access (Driedger, 1989). Disability rights groups reconstruct disability as a public or social matter instead of an individual 'problem' (UPIAS, 1975). These actions help contribute to

wider changes on an institutional and/or policy level. This brings us to the nature of health promotion in public health.

1.2 Health promotion

1.2.1 Definition and principles of health promotion

It has been suggested that there is no single accepted definition of health promotion and that the definition is rather controversial (Laverack, 2004). Indeed health promotion has been described as a meaningless concept (Tannahill, 1985) and is frequently criticised for suggesting many different things to different people (Seedhouse, 2004). Furthermore, Robertson and Minkler (1994) argue that it is the multidimensionality of concepts such as health, and health promotions' strategic domains of empowerment and community participation that confound the definition of health promotion. In this section and further sections, I will seek to explore these concepts further.

Many definitions have been proposed for health promotion but the most widely accepted definition of contemporary health promotion is the World Health Organisation definition provided by the European Regional office in 1984:

“Health promotion is the process of enabling individuals and communities to increase control over the determinants of health and thereby improve their health. Health promotion represents a mediating strategy between people and their environment, combining personal choice and social responsibility for health to create a healthier future” (WHO, 1984).

Therefore, the ultimate goal of health promotion is to enable people to increase control over, and to improve their health and its determinants. The definition was further elaborated on in the Ottawa Charter:

“Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and realize aspirations,

to satisfy needs and to change or cope with the environment. Health is, therefore seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy lifestyles to well-being” (WHO, 1986:1).

There are issues regarding this definition as the definition of health on which health promotion is based can also be ambiguous (Seedhouse, 1986). Moreover, the WHO introduces a new term, ‘well-being’, which is equally vague and this will be discussed in more detail later.

The Ottawa Charter identifies three basic strategies for health promotion. These are advocacy for health to create the essential conditions for health; enabling all people to achieve their full health potential; and mediating between the different interests in society in the pursuit of health. These strategies are supported by five priority action areas as outlined in the Ottawa Charter (WHO, 1986) for health promotion:

1. Create supportive environments: appreciating the impact of the environment on the health and making changes that are conducive to health.
2. Build healthy public policy: all organisations must consider the potential health effects of the policies they develop and implement
3. Strengthen community action: involves increasing the ability of communities to identify and alter those aspects of their environment that are detrimental to health
4. Develop personal skills: supports individuals to take action to promote health through the development of personal, social, and political skills.
5. Reorient health services: redirecting attention from providing clinical services to promoting health for an overall health gain.

The Bangkok Charter (WHO, 2005) later suggests:

“The United Nations recognizes that the enjoyment of the highest attainable standard of health is one of the fundamental rights of everyday human being without discrimination. Health promotion is based on this critical human right and offers a positive and inclusive concept of health as a determinant of the quality of life and encompassing mental and spiritual well-being. Health promotion is the process of enabling people to increase control over their health and its determinants, and thereby improve their health. It is a core function of public health and contributes to the work of tackling communicable and non-communicable diseases and other threats to health” (WHO, 2005:1).

Through the five priority action areas set out in the Ottawa Charter, the aim is to promote equity by enhancing everyone’s opportunity to be healthy and diminish inequalities by ensuring that each individual achieves their health potential. However, individuals have different opportunities and resources and this is often associated with their socioeconomic status (Marmot and Wilkinson, 2009). It has been well-established that poverty affects the health of individuals illustrated by increased mortality, poorer health and mental health, poorer educational attainment, lower levels of social support networks and social exclusion (Marmot and Wilkinson, 2009; Fabian Commission on Life Chances and Child Poverty, 2006; Wilkinson, 2005; Melzer et al., 2004; Muntaner et al., 2004; Brooks-Gunn and Duncan, 1997). One question underscores the ethos of health promotion and that is whether it will be able to overcome major determinants of health such as poverty although there are other structural determinants that need to be addressed as well.

Whereas the Ottawa Charter described a framework that health promotion practitioners may use, the Bangkok Charter (WHO, 2005) targeted a different audience other than health practitioners; it was directed at governments, politicians, the public health community, private sector and international organisations. It makes four commitments which include setting health promotion at the heart of the global development agenda, a fundamental responsibility of all sectors of the government, to make health promotion a chief concern for communities, and a requisite for good corporate practice. It does not however, propose a form

of action plan describing the manner in which these objectives will be achieved. In order to understand health promotion, the concepts of health, empowerment and community participation must be critically examined. These will be discussed in further sections.

1.2.2 Conceptualisation of health

Central to the health promotion agenda is its conception of health. There has been much debate on how to define health and so far there is no consensus about the nature of health (Bircher and Wehkamp, 2011). Bacon (cited in Seedhouse, 1986) suggests that when the meaning of a word is unclear, ambiguous, or vague it can act as a 'verbal smokescreen' and these words become 'barriers against understanding'. The conceptualization of health and illness is challenging, and it is influenced by our complex and continually changing lifestyles. For example, Locker (1997) argues that the difficulty in defining health is that it denotes multidimensional complex events that are essentially subjective in nature. Health may also be said to be a dynamic state and may vary depending on the surrounding environment in which the concepts are being operationalised and measured.

According to the WHO (1986) definition of health, health is a resource, viewed as a means rather than an end. This macro perspective on health takes into consideration the complex multi-dimensions of health but also makes it more challenging to define and operationalize. Whereas the more narrow micro or medicalised versions of health frame people within their illness or disability and thus the individual is not distinct from the disease and therefore may lead to victim-blaming, marginalisation and/or stigmatization. The WHO definition attempts to propose a socialized or macro notion of health that makes the distinction between people and their health or lack of health. Nonetheless, it has been criticised that the everyday embodied experiences of people with illness or disabilities are not taken into account through focusing solely on the social environment (Robertson and Minkler, 1994).

The lack of a clear definition of health inhibits its understanding and hinders the constructive interdisciplinary dialogues about health values. As a consequence prioritisation in the field of health becomes controversial and open to power struggles (Bircher and Wehkamp, 2011). Furthermore, the definition assigned to health is of paramount importance as it has

implications for healthcare services and the manner in which society responds to resolve a particular health issue or to maintain and promote the health of society as a whole. The interplay between health definitions and concepts of health education and promotion may initially go unnoticed. However, each person's own subjective definition of health will affect how that person interacts with the environment, including the responses they make to health education and promotion messages. Furthermore, health care providers and policy makers also have their perceptions of health and their views will be reflected in the strategies designed for healthcare services and their delivery. There have been other attempts to elucidate health, for instance; *Saving lives: our healthier nation* (DOH, 1999) and *Health of the Nation* (DOH, 1992) however it is noticeable that they also have not been able to focus on one single definition of health.

In addition to these problems of definition it appears that different people identify contrasting aspects of being healthy as important and we can suggest that due to the variety and complexity of the ways in which people conceptualise health, it becomes a construct that is difficult to measure. There has been much research documenting lay people's varying concepts of health which serves to add further complexity to the area and may sometimes be in tension with professional concepts (Beattie, 1993; Hughner and Kleine, 2004; Kleinman, 1988; Stainton, 1991). In the next section the main concepts or models of health will be discussed.

1.2.3 Professional concepts of health (Models of health)

Health has traditionally been viewed from the perspective of the medical model, which simply put measures health negatively; as an absence of disease. This reductionist approach uses a linear cause-effect model that focuses on the science of pathogenesis (Engel, 1992). So basically, a lack of fundamental pathology meant that the individual was 'healthy' and the presence of biological pathogens and conditions meant the individual was 'diseased'.

Traditional ways of thinking about health in Western society stem from the medical model which received its major impetus during the nineteenth century as a consequence of the rise of modern scientific medicine, particularly the 'germ theory'. It has been suggested that in

view of its characteristics as well as its historical development, this model should, perhaps more properly be called the biological model. The biological model contends that aetiology and treatment are disease-specific (Bloom, 1965).

The philosophical roots of the model stemmed from the Cartesian revolution which encouraged the idea that the body and mind are independent or not closely related. From this philosophy the body is perceived to function like a machine with its parts individually treatable (Bloom, 1965). The mind is viewed as a separate entity; “the body is isolated from the person and as a result the persons’ subjective experiences of health and illness are ignored” (Locker, 1997). Furthermore, it fails to consider the social environment and treats the disease as an independent entity; it allows behavioural disorders to be explained through somatic processes (Engel, 1992). Dubos (1987) argues that the human trait of man’s dignity to value certain ideals above comfort and life itself renders medicine a philosophy that ought not be restricted merely to the medical sciences and must encompass not only man as a living machine but also the collective aspirations of mankind. Therefore, a framework of health and illness that is not multi-dimensional and fails to take into account the intricate relationships a persons’ body has with the mind and external factors would be inadequate.

This does not imply that the medical model is not beneficial; it has been hugely successful. An advantage of the medical model is that it constitutes a framework within which to understand and treat disease. Its focus is on treatment; professionals diagnose and treat, although some analysts have expressed concern at the increased medicalisation of life (Illich, 1977). Diagnosis is based on biological variables and the provision of treatment is given accordingly. For many physical ailments such a narrow vision is sufficient. For example, peptic ulcer disease was for a long time thought to be a classic psychomatic illness, however it was later established that it was caused by the pathogen *Helicobacter pylori* (Ghaemi, 2009). Although we could also add that there are other factors involved in acquiring the pathogen such as stress, and although we can diagnose and treat, we are still dealing with something physical and its outcomes without exploring the underlying reasons for the acquisition of the cause.

Alternatively, there are endless conditions that straightforward medical diagnosis using laboratory tests and clinical observations would fail to resolve for example, mental illnesses and behavioural disorders (Bloom, 1965) which would not necessarily show any deviation solely based on biological indices. This would render those that meet the biological criteria of 'no disease' to be considered as healthy individuals regardless of their developmental, psychological and mental condition. This also implies that biological abnormalities must be removed for the individual to be considered as 'no disease' this raises issues for example regarding the health of people with disabilities, taking a medical approach; they would never be able to achieve the state of being 'healthy'. Also, by serving as a guideline and justification for medical care policy biomedicine has contributed to a multitude of problems (Engel, 1992). This narrow scope on health may be said to limit our understanding of wellbeing, confine treatment efforts, and perhaps more importantly, suppress prevention.

In an attempt to provide a definition of health in a positive light the (WHO, 1946) expressed that health is "*a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity. The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition*" (WHO, 1946:29).

The WHO definition broadened the medical model and highlighted the idea of positive health. This definition was a shift from interpreting health solely in a negative sense to including a positive aspect as well in which health is acknowledged to be more than being just free from disease. Another important merit of this definition is that it opposes the notion of dualism of the mind and body and introduces a mental and social dimension of health. This formed the basis of the holistic model. However, this definition has been heavily criticised for its limitations and described as pertaining a paradoxical quality and some view it as being utopian with unrealistic expectations (Callahan, 1973; Seedhouse, 2001). This has dire implications on health services and raises the question of how would health services be assessed based on this definition and concerns over individuals, communities, and nations expecting to achieve '*a state of complete physical, mental, and social well-being*' all the time. Moreover, it is interesting to note that the WHO does not go on to define 'well-being' leaving the reader to their own interpretation of well-being. This is congruent with the explanations

proposed by Seedhouse (1986) as to why the WHO definition and other definitions of health are elusive and inadequate. He suggests that due to the inability of people to fully understand the world they live in they may feel justified by defining things in their world unambiguously. Nonetheless, he goes on to illustrate that they have failed to do so and that their lack of understanding is reflected in the elusiveness and lack of clarity in the words used to describe health. So in effect the WHO definition of health clarified an ambiguous term with another ambiguous term.

The criticisms made by Seedhouse however, do not acknowledge that the goal of this definition was to develop the underlying philosophy of 'positive health' which was in turn developed to inspire governments to promote health and thus was a political statement (Locker and Gibson, 2006). Siepp argued that the interpretation of the WHO definition stemmed from the need to emphasise health as a human right and the significance of the effect of social and economic factors on health and in turn the responsibility of governments to address these underlying issues.

“The concept of positive health implies that the responsibility for the provision of health is located not merely in the doctor's office but rather lies with society as a whole” (Siepp, 1987 cited in Locker and Gibson, 2006:163).

At the time, the WHO definition was a significant advance as it was the first official recognition that mental and social factors were important for health. The WHO definition broadened the approach to health, moving beyond the medical model as it was highlighting the idea of positive health. Further to the definition of 1946 it was later amplified in the Ottawa Charter for Health Promotion. Health was perceived as a resource for everyday living; a positive concept, emphasising social and personal resources, as well as physical capacities (WHO, 1986) this became viewed as the wellness model.

Seedhouse (1986) proposed a definition that envisages the subjectivity of health and referred to this as the 'foundation for achievement'.

“A person's optimum state of health is equivalent to the state of the set of conditions which fulfil or enable a person to work to fulfil his or her realistic

chosen and biological potentials. Some of these conditions are of the highest importance for all people. Others are variable and dependent upon individual abilities and circumstance” (Seedhouse, 1986:61).

Although it has been argued that defining health is complex (Bircher and Wehkamp, 2011, Seedhouse, 1986, 2001, Locker, 1997) definitions must still be attempted and used as frameworks because as Callahan (1973) argues that defining certain words have social, ethical and political implications.

“Defining general terms is not an abstract exercise but a way of shaping the world metaphysically and structuring the world politically” (Callahan, 1973:78).

This suggests that one must not simply seek to understand the meaning but also critically consider the implications the definition might subsequently have. It also highlights the importance and relevance of how health is defined. There is much rhetoric about health being more than the absence of disease through the holistic model (WHO, 1946), or the wellness model (WHO, 1986) and alternative concepts have been suggested using the biopsychosocial model (Engel, 1977), ‘foundations for achievement’ (Seedhouse, 1986), or ‘sense of coherence’ (Antonovsky, 1979, 1987) Meikirch model (Bircher and Wehkamp, 2011) which have developed as a result of the recognition of the limitations of the medical model.

1.2.3.1 The biopsychosocial model

The biopsychosocial model (Engel, 1977) prompted a revolution in medical thinking because it claimed to address the factors that were lacking in medicine’s dominant medical model (Smith, 2002). It prescribes a fundamentally different path; besides the biological aspects it encompasses psychosocial dimensions. It arguably provides a framework in which both the objective biomedical data along with the person’s subjective experiences may be analysed; offering a model of causation that is more comprehensive and naturalistic than linear reductionist models (Borrell-Carrió and Epstein, 2004). This model has been deemed to be more humanistic than the biomedical model (Smith, 2002) however it has been criticised for not being humanistic enough and it is claimed that biopsychosocial model, rather than bridging the dichotomy between science and the humanities with medical humanism, led to a

tendency for 'psychologised scientism' (Ghaemi, 2009). This referred to the process of psychologisation of illness where medical professionals over emphasise psychosocial factors when underlying pathology is not clearly defined therefore differential diagnoses may be dismissed prematurely while psychological explanations are readily accepted (Goudsmit and Gadd, 1991). For example, a medical professional diagnosing an individual's complaints of breathlessness as purely stress related without thoroughly investigating an underlying physiological cause (ibid). Psychologisation does not include cases where all the arguments are discussed and the evidence points to psychological factors to be the most likely underlying cause.

The biopsychosocial model has gained wide acceptance; it is taught in most medical schools and many practitioners are familiar with the term and its meaning. However, the criticisms of the biomedical model have not been properly explored and analysed and it has yet to replace the biomedical model as the dominant model of health and illness (Novack et al., 1993). It has been pointed out that this model provided the content for the subsequent patient-centred approach. Previously, the implementation of the medical model which is inherently power dominated by medical professionals and the patients' views tended not to be taken into consideration resulted in a physician-centred approach. The patient-centred approach, developed as the process for operationalising the biopsychosocial model (Levenstein et al., 1989; 1986; McWhinney, 1989; 1981). In contrast, to the physician-centred approach the patient-centred approach allows the patient to share their subjective views and experiences with the health professional and power is shared.

1.2.3.2 Salutogenic model

The salutogenic model works prospectively it focuses on identifying, defining, and describing pathways, factors, and causes of positive health rather than focusing on the causes of disease and illness which works retrospectively. This meant that more than simply prevention efforts were required for health it introduced the principle of being proactive towards health (Antonovsky, 1996). This was a fundamental shift from the traditional perspectives that mainly stemmed from the biomedical model of health and disease (Dean and McQueen, 1996). Antonovsky (1979, 1987) argued that the ideology of salutogenesis would shift the

attitude of professionals using pathogenesis or the medical model from being reactive to proactive this means focusing on supporting the person to creating a new higher state of health. There has been growing evidence of the effectiveness of the salutogenic model as a positive and health-promoting framework (Eriksson and Lindström, 2005, 2006; Lindström and Eriksson, 2005, 2006; Nammontri et al., 2013).

Salutogenesis is fundamentally based on the idea one cannot assume to achieve a positive state by eliminating a negative state (Herzberg, 2003; Keyes et al., 2002). Health and illness are viewed as a continuum where health is more than just the absence of disease. Antonovsky (1987) explained that the ability to move towards the health pole in the health/disease continuum depended on the particular individuals' generalised resistance resources (GRRs) and their sense of coherence (SOC). Antonovsky (1987) described SOC as *'a way of seeing the world which facilitated successful coping with the innumerable, complex stressors confronting us in the course of living'* Antonovsky (1987) An individual with strong SOC is more capable of identifying and using resources needed to solve emerging problems. The SOC concept includes three core dimensions: meaningfulness, manageability and comprehensibility that have been documented to be associated with better health (Antonovsky, 1987, Eriksson and Lindström, 2005). People with a strong SOC are generally high in these dimensions in contrast to those who have a low SOC.

Comprehensibility refers to the cognitive dimension of SOC and is the extent an individual believes that the events and challenges that they encounter occur in an orderly, clear and predictable manner as opposed to unstructured, random and unpredictable. Individuals who enjoy high comprehensibility have a sense of understanding of their life and believe they can to a certain extent predict the stressors in their life.

Manageability refers to the behavioural dimension of SOC and is the extent to which an individual perceives their personal skills and resources to be sufficient to manage stressors when they arise. A person with a high manageability views stressors as a challenging life experience that can be coped with and controlled.

Meaningfulness refers to the motivational dimension of SOC and this is the extent to which an individual gives meaning or values their experiences and believes that the stressors they

encounter as experiences to learn from rather than burdens. They believe that life and its challenges are interesting, and worth the effort to resolve them. It is this component which Antonovsky (1987) argues is the most fundamental for whether or not an individual feels it is worth trying to overcome their personal challenges. People with high meaningfulness are more likely to be highly motivated in overcoming their burdens.

It is thought that the salutogenic model of health has influenced the development of health promotion (Eriksson and Lindström, 2008). The salutogenic perspective is concerned with strengthening peoples' health potential using good health as a tool for a productive and enjoyable life which is in line with the principles of health promotion to enable individuals and communities to increase control over the determinants of health.

1.2.4. Settings-based health promotion

The settings approach to health promotion has developed during the past 30 years and was encouraged by the Ottawa Charter for Health Promotion (WHO, 1986). Different terms have been used inter-changeably to describe this approach these include: the settings-based approach, settings for health, the settings approach, health-promoting settings, and healthy settings. Kokko et al., (2013) argue for the term health-promoting to be used as opposed to healthy setting as they believe the latter gives the notion of a static setting that is always healthful. On the other hand they suggest that the term health-promoting represents the dynamic nature of settings and the health promoting activities that are involved in the process thus recognises the constant need for settings to adapt to changing circumstances.

As mentioned in earlier sections, the Ottawa Charter recommended five priority action areas which included building healthy policy, creating supportive environments, strengthening community action, developing personal skills and reorienting services. The Charter recognised the role settings played in the health of individuals.

“Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love” (WHO, 1986:4).

This resulted in a shift from merely viewing settings as means of intervention delivery to appreciating the inherent health potentials in social structures. Traditionally health education and health promotion have been structured around settings such as hospitals, schools and workplaces (Mullen et al., 1995). These provide convenient channels for reaching defined populations. From this perspective, settings in addition to population groups and health issues form the traditional three-dimensional matrix used to design health education interventions targeted at individual behaviour change (Dooris, 2004). In contrast, the settings approach is more holistic, and moves beyond a mechanistic view of intervention delivery (Dooris, 2007) and acknowledges that the settings in which people live their daily lives have a significant effect both directly and indirectly on peoples' health and well-being. From these descriptors of settings we can suggest that they are themselves determinants of health.

The rationale for the settings approach stems from the work of Antonovsky on salutogenesis and socio-ecological models such as that by Bronfenbrenner (1979) which emphasise the dynamic interrelations among various individual and environmental factors. The approach shifts away from a reductionist view of illness towards a holistic perspective of health that takes into consideration the complex interaction of organisational, environmental, socio-economic and cultural factors in the individuals' contexts within communities and the wider society (Scriven and Hodgins, 2012). Thus, a settings approach is concerned with the physical, organisational, and social contexts in which people occupy as the objects of inquiry and intervention and not merely just the people. This is not to be confused with individual interventions, that focus on single issues and risk factors, operating as part of a settings initiative.

The literature around this time began to distinguish between delivering health promotion activities in a setting and settings evolving into 'healthy settings', but Wenzel (1997) criticised it for maintaining 'the mechanistic view of health promotion as primarily concerned with individual behaviour change' (Scriven, 2012: 20). Wenzel described settings as cultural, temporal, and spatial domains of interaction in daily life which from a health promotion point of view is essential in developing and maintaining a healthy lifestyle. His view of settings was reiterated in the WHO definition for healthy settings.

The WHO defines ‘settings for health’ as:

“the place or social context in which people engage in daily activities in which environmental, organizational and personal factors interact to affect health and well-being.... where people actively use and shape the environment and thus create or solve problems relating to health. Settings can normally be identified as physical boundaries, a range of people with defined roles, and an organizational structure” (WHO, 1998:19).

The argument against using settings as merely vehicles of delivery was also supported by Green et al. (2000). Furthermore they point out that the WHO definition assumes that health is a focus for many settings and they go on to suggest that settings are *“not only physically-bounded space times in which people come together to perform specific tasks, usually orientated to goals other than health, but also arenas of sustained interactions with pre-existing structures, policies, characteristics, institutional values and both formal and informal sanctions on behaviour”* (Scriven and Hodgins, 2012:21).

This suggests that settings are subject to complex interactions between the patterns of social arrangements which emerge from and are determined by the action of individuals; so we could argue that any particular setting will have a pre-existing context. Pawson and Tilley (1997) support this position and argue that it is this pre-existing context with its social norms, values, rules and interrelationships which set boundaries for the effectiveness of any health promotion programme. Therefore, context is fundamental to health promotion but appears to have been typically ignored during the planning, implementation and evaluation stages of health promotion settings-based interventions (Dooris et al., 2007). Viewing each particular setting as unique may be said to present a lack of neatness which is dreaded by those with an administrative mentality focused on standardised procedures (Malpas, 2003) and as a result of the potential messiness in exploring the context, there appears to be a tendency for it to be viewed as a nuisance, leading it to be neglected or overlooked.

However, a conceptual framework for the settings approach based on values such as participation, partnership and equity has been suggested (Dooris, 2005). This framework focuses on three characteristics. Firstly, as discussed previously a settings approach should

adopt a socio-ecological model (Bronfenbrenner, 1979) and move away from the reductionist view of health towards salutogenesis (Antonovsky, 1979, 1987). It's main concern is with populations within particular contexts rather than focusing on single health problems and linear causality taking on a holistic approach aimed at developing supportive contexts within the places that people live their lives (Dooris, 2013). It emphasises the fact that health is created outside of health services and therefore investment in social systems is key to improving health.

Secondly, the settings approach draws on organisational theory and as it is underpinned by the socio-ecological model. This approach views settings as complex dynamic systems. The systems perspective recognises the interconnectedness and synergy between different components and that settings interact with other settings and the wider environment. Referring to the work of Bronfenbrenner (1979, 1994) with its focus on the interconnections within the microsystem, mesosystem, exosystem, macrosystem and chronosystem Dooris et al. (2007) emphasise the importance of recognising the nested nature of settings.

Thirdly, this approach requires a whole system focus (Pratt et al., 1999) which involves a comprehensive range of complementary interventions to embed health within the everyday routine and culture of a specific setting and interact with and promote the health of the community (Dooris, 2013).

An important aspect of the settings approach is the appreciation that the nature of the settings is influenced by different groups and is not limited to just groups involved in health improvement. For example, this may include engineers, the retail sector and urban planners who may or may not realise their potential influence on health. Recognising key figures is important however in establishing and working in partnerships for effective health improvement Furthermore, internal motivation of the individuals and groups implementing health interventions as part of the settings approach is vital (Green et al., 2015).

Dooris (2004) notes that there exists a tension between the conceptualisation of the settings approach and its actual implementation and that it may not live up to the theoretical ideal. Whitelaw et al. (2001) has proposed a typology to describe the different forms of real-life settings practice that takes place within a health promotion initiative and distinguishes

whether the intervention is concerned more with the individual or the setting/system. Five models have been suggested (Whitelaw et al., 2001) the passive; active; vehicle; organic; and comprehensive models. According to Whitelaw et al. (2001), these should not be considered as discrete entities as they may overlap, or the success of one model facilitates the progress into another.

For example, within a passive model the setting is viewed as a passive platform from which to access populations using traditional educational activities (e.g. using mass media, health counselling and developing personal skills for health. The problem and solution are seen to be found within the behaviours and actions of individuals. An active model also focuses on individual behaviour change; however efforts are made to address some organisational barriers and draws on organisational resources or enablers. The targeted problem of concern is still viewed with a focus on the individual, for example the need to change specific health related behaviours such as healthy eating. In this model however, the solution is widened to include addressing features of the setting in which the individual exists. Thus the setting is viewed as potentially contributing to the shaping of healthy behaviours. Actions involved range from educational activities such as learning about healthy food and its effects on the body, to actions aimed at addressing any of the principles of the Ottawa Charter (policy, developing supportive environments, extending community action, developing personal skills and service re-orientation). Within the vehicle model, health promotion efforts focus on having an impact on the features of the wider settings and moves beyond the aim of topic specific individual behaviour change. The problem is viewed to be within the setting, learning from individually based health promotion initiatives is seen to be the solution and as a means to broader setting development. For example, Health promoting schools that implement multiple component interventions such as classroom-based education, social skills training, community-wide education and parental participation components aimed at reducing issues such as smoking rates among school children and the wider community, while having a principle focus on structural change and policy development. An organic model focuses on changing the setting through facilitating and strengthening community action through grassroots participation. Finally, a comprehensive model aims at fundamental and lasting change in setting structure and culture focusing on broad settings policies through the use of

powerful leaders and policy levers. The organic and comprehensive models are more consistent with the ideal vision of the settings approach (Green et al., 2015).

1.2.5 Health promotion and empowerment

One argument suggests that the conflicting issues relating to the definition of health may be better understood if one considers health as having both micro-level and macro-level elements (Robertson and Minkler, 1994). It follows from this argument that these elements should be recognised not only in health promotion literature but also in its implementation, and in order to do so the notion of empowerment must be understood.

The concept of empowerment can be traced back to the social movements for women's rights and civil rights (Riger, 1981; Solomon, 1976; Swift and Levin, 1987), the social movements of the 1960's (Alinsky, 1971) and the self-help movements of the 1970's (Eng et al., 1992; Gutierrez, 1990; Rissel, 1994; Wallerstein, 1992). It then gained more momentum as the core theory of community psychology (Chavis and Wandersman, 1990; 1981, 1985, 1987; Rappaport et al., 1984; Zimmerman and Rappaport, 1988). At the heart of the concept of empowerment is the concept of power. According to Pinderhughes (1983):

“power and powerlessness operate systemically, transecting both macrosystem and microsystem processes. The existence or nonexistence of power on one level of human functioning (e.g., interactional) affects is affected by its existence or nonexistence on other levels of functioning—for example, intrapsychic, familial, community-ethnic-cultural, and societal” (Pinderhughes, 1983:332).

Wallerstein (1993) explains that there is a relationship between the level of power or powerlessness a person feels and their health status. It has been argued that feelings of powerlessness or lack of control over one's life increase an individual's susceptibility to disease (Haan et al., 1987, Syme, 1987). This appears to support Antonovsky's (1987) argument in that individuals with feelings of powerlessness may be considered to have a low SOC and thus more susceptibility to disease.

The concept of empowerment embodies the essence of health promotion as a ‘process of enabling people to increase control over and to improve their health’ (WHO, 1986) this is the rationale behind it being the aim of every health programme (Bellow, 1992; Braithwaite and Lythcott, 1989). The term however has been exploited with examples from the literature supporting the empowering ability of projects from different disciplines (Fleury, 1991; Lowery et al., 1992; McKay et al., 1990; Pizzi, 1992) while neglecting to examine the meaning of empowerment and subsequently what that would include and involve.

1.2.5.1 Definitions and principles of empowerment

Empowerment has been described as the opposite of powerlessness. In the literature powerlessness has been recognised as having both a subjective and objective element (Swift and Levin, 1987). It may be subjective where people feel estranged from their surrounding environments (Seeman, 1959), people may exhibit learned helplessness (Maier and Seligman, 1976); or they may have an external locus of control (Rotter, 1971). It may also be objective when the individual is in poor living conditions and lacks economic and political power which they then identify as feeling powerless (Albee, 1981; Gaventa, 1980). Many definitions of empowerment only address a change in the subjective dimension of powerlessness separating individuals from their social context. This narrow definition may be said to encourage victim blaming because it assigns responsibility to the individual for not having the motivation or ability to escape powerlessness (Ryan, 1976). Thus empowerment programmes taking on this perspective have focused on promoting self-esteem, health literacy, developing skills, which although important, neglect to direct change towards socio-environmental conditions contributing towards the root of powerlessness.

Rappaport’s definition is one of the earliest definitions in the literature that defines empowerment not as the opposite of powerlessness and states that it “*aims at enhancing the possibility for people to control their own lives*” (Rappaport, 1981:5). Rissel (1994) suggests that in the earlier definitions of empowerment, including that of the WHO, there is no distinction between people as individuals or collective groups. Subsequent definitions began to take a more constructive broad approach to defining empowerment and made a distinction

between the subjective dimension of psychological empowerment and the objective world of efforts to alter the structural setting and the reallocation of resources (Rissel, 1994).

Examples of definitions that capture this:

“Empowerment is viewed as a process: the mechanism by which people, organizations and communities gain mastery over their lives” (Rappaport et al., 1984:122).

“Empowerment is a construct that links individual strengths and competencies, natural helping systems, and proactive behaviours to matters of social policy and social change. It is a process by which individuals gain mastery or control over their own lives and democratic participation in the life of their community” (Zimmerman and Rappaport, 1988:726).

“The ability to act collectively to solve problems and influence important issues” (Kari and Michels, 1991:722).

“A social-action process that promotes participation of people, organizations and communities towards the goals of increased individual and community control, political efficacy, improved quality of life and social justice” (Wallerstein, 1992:198).

If we examine these broader definitions of empowerment for example the definition proposed by Zimmerman and Rappaport (1988) which suggests that people (individually or collectively) gain mastery over their life through changing their social and political environment in the context of participating in that environment (Zimmerman and Rappaport, 1988, Rappaport, 1987). It describes a process that involves change on the micro and macro levels and defines empowerment as a multilevel construct that may be applied to organizations, communities, and social policies. It also points to the notion that empowerment is not something that can be awarded but must be gained it must come from within an individual or group and they can only empower themselves (Rappaport, 1985). Furthermore, in these broader definitions a distinction between psychological and community empowerment has been made, where psychological empowerment is considered at an

individual level and community empowerment is viewed as a collective experience including a psychological component (Rissel, 1994). This distinction is quite significant as it has been argued that the major obstacle for the development and implementation of empowerment theory has been the ambiguity of the actual focus of empowerment (Tones, 1992). The dynamics involved in individual psychological empowerment are quite different from those of community empowerment requiring political action these differences consequently affect the manner in which health promotion is practiced.

1.2.5.1.1 Psychological empowerment

Psychological empowerment can be defined as “*a feeling of greater control over their own lives which individuals experience following active membership in groups or organizations, and may occur without participation in collective political action*” (Rissel, 1994:41).

According to Zimmermann and Rappaport (1988):

“Psychological empowerment is the expression of the empowerment construct at individual level. Its elements are perceived efficacy, self-esteem, and a sense of causal importance. Psychological empowerment is the connection between a sense of personal competence, a desire for, and a willingness to take action in the public domain” (Zimmerman and Rappaport, 1988:726).

These definitions illustrate that psychological empowerment involves the individual having a sense of control and a sense of self-worth but does not necessarily include participating within the wider community to bring about change.

1.2.5.1.2 Community empowerment

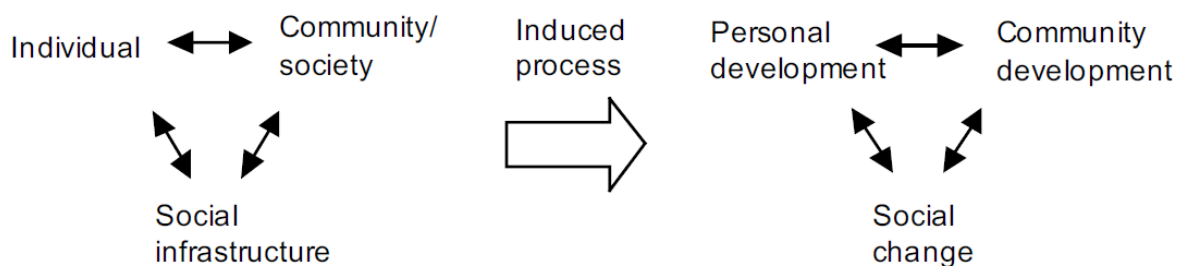
Rissel, (1994) defines community empowerment as a process that “*includes a raised level of psychological empowerment among its members, a political action component in which members have actively participated, and the achievement of some redistribution of resources or decision making favorable to the community or group in question*” (Rissel, 1994:41).

Community empowerment represents an additional aspect to psychological empowerment in which individual members of the community take collective action to address matters important to them. While it may be argued that it is important to move away from the victim-blaming lifestyle approach it is equally important to not overlook the multidimensionality of power; the fundamental interdependence between psychological empowerment and empowerment as a result of political action. Health promotion tends to politicize health and health promotion approaches, however this does not indicate that health promotion is limited to just political action but rather that health issues need to be addressed with their economic, social and political context taken into consideration. This has been highlighted by Shor and Freire (1987).

“While individual empowerment, the feeling of being changed, is not enough concerning the transformation of the whole society, it is absolutely necessary for the process of social transformation. The critical development of [people] is absolutely fundamental for the radical transformation of society ... but it is not enough by itself”
 (Shor and Freire, 1987:6).

This reflects Robertson and Minkler’s (1994) argument earlier that health promotion strategies must operate on both the micro-level and macro-levels of society in order to empower a group or community. This has been represented diagrammatically by Eklund (1999) with the induced process representing health promotion strategies (see figure 1).

Figure 1. Three cornerstones of community empowerment development



(Adapted from Eklund, 1999)

While Eklund, (1999) has depicted the reciprocal relationship between the individual and/or community and the social infrastructure, we can suggest that this diagram is nonetheless too simplistic. It cannot account for the intricate processes that are involved in development and social change. Such processes are not neat and clear but overlap and intersect and as a consequence a simple linear diagram may not be truly representative.

1.3 Participation

1.3.1 Participation background

Participation began to gain attention towards the late 1960's in the USA in the field of politics, where it was presented as an inherent part of citizenship (Eklund, 1999). Perhaps the most seminal theoretical work on the subject of participation was by Arnstein, (1969) who argued that active participation was an expression of citizenship and in effect citizen participation was the equivalent of citizen power. Arnstein's (1969) definition is: "*Citizen participation is a categorical term for citizen power. It is the redistribution of power that enables the have-not citizens presently excluded from the political and economic processes to be deliberately included in the future*" (Arnstein, 1969:216).

What Arnstein (1969) claimed was that the redistribution of power would allow for citizens, who were side-lined in political and economic processes, the opportunity to contribute. Participation aims for the transformation of capacity gaps, social relations and organizational practices that lead to social exclusion. For example, people often feel that health and social services are beyond their control because the decisions are made outside their community by unknown bureaucrats and politicians (Ferguson, 1999). Therefore, Arnstein (1969) stresses the importance of redistribution of power in participation strategies otherwise they would be pointless and impact negatively on the powerless. This would impact negatively as it would simply be a form of tokenism and the community involved may feel they have been given a genuine chance to have their voice heard, however if their concerns and needs are not translated into outcomes this sustains inequalities and social injustice.

Through meaningful participation the empowerment of individuals and communities is intended to be achieved. It has been noted that empowerment cannot be bestowed by others, depending on the context those that have higher levels of power and those that seek it need to work with one another to actualize the conditions necessary to make empowerment possible (Laverack, 2004, Rappaport, 1985). This is possible through building capacity and enabling social activities that address the structural, social and economic determinants of health. Alternatively, participation has been portrayed by some to be a new tyranny of development and critics remain doubtful of the extent of empowerment that participation aims to bring about (Cooke and Kothari, 2001). Although participation includes marginalized individuals in projects concerned with the development of their community it is their ability to understand and question the projects being undertaken that has been criticized (Kothari, 2001).

1.3.2 Participation definition

The term ‘participation’ is associated with a number of related ideas, such as ‘taking part’, ‘involvement’, ‘consultation’ and ‘empowerment’ (Simovska and Jensen, 2009). Participation is a rather elusive term and can display a multitude of meanings. For example, it may be used to imply simply taking part in an activity at any stage or may refer to a much more meaningful involvement in which individuals are actively engaged in democratic processes at the level of decision-making. Rahnema (1992) proposes that,

“Participation is a stereotype word like children use Lego pieces. Like Lego pieces the words fit arbitrarily together and support the most fanciful constructions. They have no content, but do serve a function. As these words are separate from any context, they are ideal for manipulative purposes. ‘Participation’ belongs to this category of a word” (Rahnema, 1992:116).

This illustrates the intangible nature of the term participation and without context means very little and thus participation is a highly contextualised concept. In academic discourse participation is viewed either as a process, a methodology, a programme or a technique and there is no agreement as to how it should be defined (Oakley, 1989). The distinction between viewing participation as a means or as an end is noted by Oakley (1989). The nature of the

term and lack of consensus has implications on how participation is designed and what it is intended to achieve. Although, there continues to be a lack of consensus of opinion regarding the definition of participation, there is a growing understanding among professionals that participation is best seen not as an outcome of a programme or intervention but as a process (Rifkin and Kangere, 2002). This means participation is viewed as a continuum as opposed to stages.

The lack of agreement on what participation means naturally poses difficulties in the assessment of such interventions (Rifkin and Kangere, 2002). Participation has conventionally been assessed quantitatively through quantifying the number of participants. However, this only confirms their presence and does not indicate their understanding of the objectives of the activity or if they did in fact participate. According to Rifkin et al. (1988) participation activities must have three main characteristics. Firstly, they must be active; being a passive recipient of health interventions or services does not constitute participation. Secondly, the potential for control over health-related conditions is inherent in participation. Lastly, there must be potential effective mechanisms for its actualisation otherwise this would be meaningless. Amongst researchers, planners and professionals there appear to be quite polar opinions regarding participation; some do not acknowledge its value whereas others consider it to be the solution to improving community development (Rifkin and Kangere, 2002).

1.3.3 Participation and health

Citizen participation did not emerge as a key issue in health policy until it was associated as a vital part of the development of primary health care towards the late 1970's as a consequence of the declaration of the Primary Health Care at Alma Ata (WHO, 1978) which highlighted the merits of citizen participation and its significance as a tool for promoting health. Community participation was established as one of the founding principles of Primary Health Care, which is the fundamental concept of the WHO's goal for 'Health for All' (WHO, 1981). This policy placed an emphasis on community participation as a value in itself and as a tool for promoting health in the community thus emphasising its significance both as an outcome and a process. Many definitions of health and health promotion subsequent to the

Alma Ata declaration incorporated the concept of participation but as discussed earlier the concept of participation lacks a clear agreed upon definition and thus adds to the ambiguity of the concepts it is being incorporated into.

The WHO presented four main arguments for incorporating participation as an important theme in Primary Health Care (WHO, 1978) as health policy:

- the health services argument,
- the economic argument,
- the health promotion argument,
- the social justice argument

The health services argument suggests that the reason services are not used efficiently is that the people intended to use them were not involved in their development. The health promotion argument focuses on the limitations of medical interventions and that greater improvements in health would result if people were more enabled regarding their health. The social justice argument emphasizes the right and duty that all people have to be involved in matters that impact their everyday lives. The economic argument claims that all financial and human resources should be mobilised to efficiently improve surrounding conditions (Rifkin and Kangere, 2002).

These arguments have been supported by Rifkin (2009) who maintains that community participation is important for health improvements as people constitute a major resource, both individually and in groups. She suggests that people understand and are interested in the circumstances and events that influence their health and that encouraging public participation assists people to take control over the factors which affect their health. This then creates a climate whereby people are more likely to act in ways that preserve or improve their health because they have been involved in the decision process regarding issues that concern them. We can suggest that by creating an environment that fosters public participation, people are enabled to gain information, skills, creativity and experience which then aids them to assert control over their lives and challenge social systems that have sustained their deprivation. Their skills can then be channelled into the national effort to achieve health.

1.3.4 Participation and health promotion

As we have previously identified, the WHO argues that health promotion is the process of enabling people to take greater control over the conditions that affect their health (WHO, 1984). This definition has been instrumental in the shift of the discipline of health promotion adopting a lifestyle approach to one that is directed at the determinants incorporating participatory socio-ecological approaches (McLeroy et al., 1988; Schwab, 1997). Inherent in the definition is the concept of empowerment which is an enabling participatory process through which individuals and communities take control of the contextual factors that affect their lives (Rissel, 1994, Robertson and Minkler, 1994, Wallerstein, 1992, Bracht and Tsouros, 1990, McKnight, 1985, Rappaport, 1985). It has been suggested that participation has benefits both on an individual and community level. On an individual level, participation enhances personal skills and social competence this includes assertiveness, effective communication and cooperation as well as decision-making. Community benefits include increased community capacity that will allow for a more supportive social, physical and psychological environment (Labonte, 1994). If we briefly revisit the Ottawa Charter's five key actions for health promotion:

- Building healthy public policy
- Creating supportive environments
- Developing personal skills through information and education in health and life skills
- Strengthening community action
- Reorienting health services towards prevention and health promotion

We can identify that this charter reaffirmed the need for community participation to achieve better health. The subsequent Jakarta Declaration (WHO, 1997) and Bangkok Charter (WHO, 2005) reinforce this focus, giving priority to increasing community capacity and empowering individuals with an emphasis on the need for participatory initiatives.

The Ottawa Charter (WHO, 1986) emphasised the need for participation, particularly for promoting health and addressed it as an important guiding principle (Rootman et al., 2001). A fundamental principle of health promotion is the acceptance that if people have no control over the determinants of health they will not have the ability to achieve their full health

potential (Wallerstein, 1992). This appears to be the rationale behind the necessity that ‘lay’ people or community members are actively involved in the development and implementation of health promotion programmes and policies. Furthermore, their participation is viewed as key to recognizing health issues that are of concern to them and to develop initiatives that take into account their values and practices.

1.3.5 Community participation

Community participation is seen as the defining feature in the new health promotion movement and has been suggested to be the most ‘chameleon like’ due to the many ways in which both ‘community’ and ‘participation’ are defined (Robertson and Minkler, 1994). For example Rifkin et al. (1988) has proposed different definitions for community where a community can be defined with its geographical boundaries taken into consideration “*a group of people living in the same defined area sharing the same basic and organisations*” or a more fluid definition based mainly on the relationships between the individuals in the community “*a group of people sharing the same basic interests*”.

Rifkin et al. (1988) proposes a definition for community participation;

“Community participation is a social process whereby specific groups with shared needs living in a defined geographic area actively pursue identification of their needs, take decisions and establish mechanisms to meet these needs”(Rifkin et al., 1988:993).

This means that full community participation occurs when communities and health professionals have equal roles in defining relevant health issues and addressing those health issues and therefore develop the health agenda together. Using this definition, we may suggest that the professional takes on a role of facilitator and consultant for the community rather than one of an expert; mobilizing the community through providing informational and technical support. This moves away from provider/client arrangement towards more of a partnership between the professionals and the community. Nonetheless, critics have highlighted issues regarding community participation (Cooke and Kothari, 2001) for example, behind this movement are realities of power, control and ownership and the structural distinctions that exist between professionals and individuals or

communities and must not be overlooked for instance health professionals ‘institutional embeddedness’ (Gruber and Trickett, 1987) which gives them the power to decide the health agenda. This means that health professionals may view themselves as giving power to individuals or communities; returning us to the previous provider/client relationship and as mentioned previously, power cannot be given to empower individuals and communities but rather they need to be enabled to take power to pursue their goals.

1.3.6 Participation, empowerment and health promotion

Health promotion, empowerment and participation have much in common. In summary, since the Alma Ata Declaration (WHO, 1978) and the Ottawa Charter (WHO, 1986), the principles of participation and empowerment have been central to health promotion. Participation and empowerment are highly overlapping concepts that represent the core values of health promotion, and with each of these concepts, the processes and the outcomes are equally relevant.

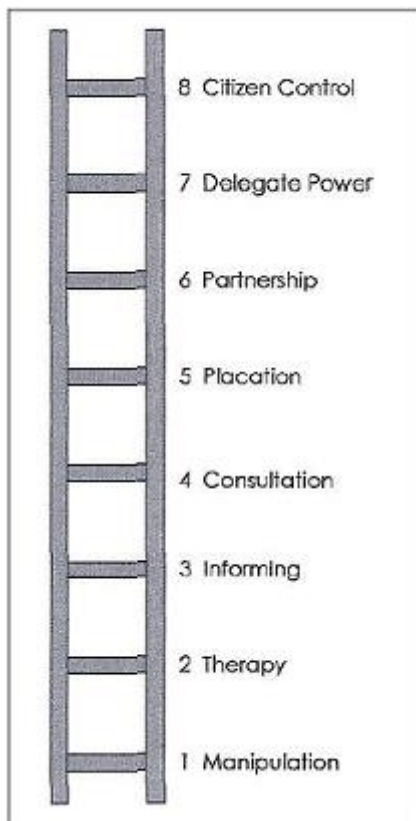
According to the WHO, health promotion is the process of enabling people to take greater control over the conditions that affect their health (WHO, 1984). A fundamental principle of health promotion is the acceptance that if people have no control over the determinants of health they will not have the ability to achieve their full health potential (Wallerstein, 1992). Whereas empowerment is generally viewed as an approach to enable people who lack power to become more powerful and gain some degree of control over their lives and health. Participation is often described as a prerequisite of or a strategy for empowerment as it is a vital precursor to communities and individuals in building their capacity and act to achieve their own goals (Rappaport, 1987) thus linking the concept of participation with the concept of empowerment. Through meaningful participation the empowerment of individuals and communities is intended to be achieved. This is possible through building capacity and enabling social activities that address the structural, social and economic determinants of health.

1.3.7 Participatory frameworks

1.3.7.1 Arnstein's ladder of participation

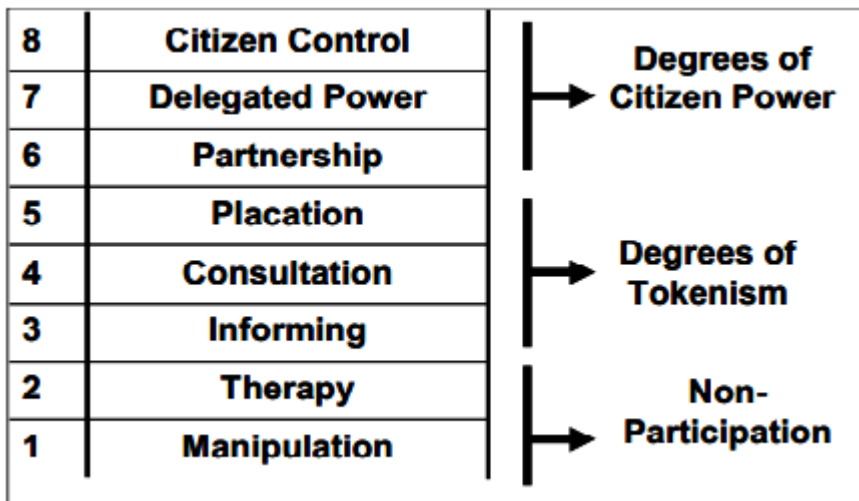
The recognition of different types and levels of participation is paramount and this has been depicted through the development of participation frameworks. There have been a multitude of metaphors, the one most influential being the ladder of participation by Arnstein (1969). Arnstein (1969) proposed a framework depicted as a ladder metaphor in which each rung represents a different level of participation (see figure 2a). As a framework it has been a key foundation stone for many participation processes in that it attempts to showcase the different levels of participation or access to power beginning with non-participation to degrees of citizen power.

Figure 2a. Ladder of participation



(Adapted from Arnstein 1969)

Figure 2b. Ladder of participation



(Adapted from Arnstein 1969)

The metaphor of the ladder of participation has become an acknowledged part of academic study, policy and practice as a tool to design, implement, critique and evaluate participatory processes since its inception (Collins and Ison, 2006). Despite being published over 40 years ago it remains the benchmark for many practitioners working on participation (ibid). The issue of participation has been discussed in the academic discourse across different fields such as, public administration (Bishop and Davis, 2002; Yang, 2005), development studies (Hayward et al., 2004) health planning (Longley, 2001; White, 2003) and child studies (Hart, 1992; Shier, 2001).

Possibly the simplicity of the ladder metaphor has led to its appeal to a wide range of audiences, simultaneously it is this simplicity that brings about a number of limitations and the ladder has increasingly become the focus of critical analysis and its limitations scrutinized.

1.3.7.2 Limitations of Arnstein’s ladder of participation

Each of the different levels corresponds to a very broad category containing a diverse range of experiences. It may be more practical to interpret the levels of participation as representing

a more intricate continuum as opposed to a simple series of steps. For instance, at the level of informing the type and quality of information being disclosed could differ significantly.

Another limitation is the usage of a ladder to illustrate the framework. This portrayal implies that the higher you go up the ladder the better, in other words having more citizen control is preferred to less citizen control. Whereas in certain situations increased control may not always be desired by the community. Moreover, allowing for an increase in citizen control without the proper support may lead to negative outcomes and failure which may leave the community worse off than it began.

1.3.7.3 Theoretical frameworks beyond Arnstein

Many increasingly elaborate theories of participation have been suggested since Arnstein. A new perspective has emerged in which participation is understood in terms of the empowerment of individuals and communities. This has developed from a shift towards viewing citizen as consumers where choice among alternatives is seen as a means of access to power. From this perspective people ought to accept responsibility and do so by taking part in the decision-making process of public services. It is from this viewpoint that Burns et al. (1994) suggested a model of citizen power based on a modified version of Arnstein's ladder of participation. Burns' ladder fundamentally translates community participation as a marketing exercise, in which the desired aim is 'sold' to the community. Davidson (1998) argued that the ladder implied a hierarchical structure and proposed a new model in the form of a wheel. This wheel of participation offered a non-linear model distinguishing objectives and techniques under the four quadrants of information, consultation, participation and empowerment. Hart (2008) argued that the wheel metaphor had more significant limitations in that the wheel represents all forms and levels of participation as equal and this is not the case. As this thesis is concerned with child participation, the following section considers the frameworks that are specific to children.

1.3.7.4 Hart's ladder of child participation

Hart stresses that there are many factors affecting the extent to which children participate other than the design of a programme. He points out that children do not necessarily have to

participate to the degree of the highest rungs of the ladder. Different children at different times may vary to which extent they have the capacity, want to be involved and the degree of responsibility they are willing to take on. The key principle underpinning genuine participation is one of choice “*programmes should be designed which maximize the opportunity for any child to choose to participate at the highest level of their ability*” (Hart, 1992).

Figure 3. Ladder of child participation

8. Child-initiated, shared decisions with adults
7. Child-initiated and directed
6. Adult-initiated, shared decisions with children
5. Consulted and informed
4. Assigned but informed
3. Tokenism
2. Decoration
1. Manipulation

The first three rungs of the ladder (see figure 3) are not considered to be forms of participation; these include manipulation, decoration, and tokenism.

Manipulation

Manipulation is the lowest rung of the ladder of participation. This is when children do not understand the issues and consequently have no understanding of their actions. This occurs

even when well-intending adults view the end to justify the means and this may be a result of the adults being misguided rather than intending to manipulate the children nonetheless, if done under the pretence of participation then it is categorised as manipulation. Hart gives the example of pre-school children being used to convey political messages regarding the repercussions that social policies have on children.

Decoration

Decoration is illustrated as the second rung on the ladder and is when children are involved in a programme and are used for decorative purposes; they have little understanding of the issue at hand and are not included in the organisation stages of the programme. They may be wearing clothes related to the cause, may sing or dance and are there basically for show and not the cause. This is considered a level higher than manipulation as the adults do not claim that the cause is motivated by children.

Tokenism

Tokenism is depicted as the third rung on the ladder and refers to situations when children have an understanding of the issue, appear to be listened to but actually have little or no opportunity to affect the subject, methods of communication, or develop their own opinions.

The remaining five rungs are considered to be represent levels of participation these are assigned but informed, consulted and informed, adult-initiated shared decisions with children, child-initiated and directed, child-initiated shared decisions with adults.

Hart (1992) argues that for a project to be considered to be genuinely participatory it must fulfil four important requirements:

1. The children understand the intentions of the project.
2. They know who made the decisions concerning their involvement and why.
3. They have a meaningful and not simply a decorative role.
4. They volunteer for the project after the project was made clear to them.

Assigned but informed

This represents the fourth rung and refers to the situation in which children have not-initiated the activity themselves, but they are well-informed about the problem and its causes and may feel sincere ownership of the issue and thus appreciate why they are being asked to participate. Hart (1992) gives the example of children assigned as ‘pages’ at a World Summit for Children held at the United Nations Headquarters. The children had the responsibility of ushering presidents and prime ministers to their designated place at the designated time. Their roles were important both functionally as well as symbolically and were transparent. Interestingly, Hart points out that had the children been presented as spokespersons with the intention of representing the views of children this would not have been genuine participation but rather a form of tokenism as these children were the children of diplomats and were chosen for pragmatic reasons and did not represent any particular group.

Consulted and informed

The fifth rung represents children being well-informed, consulted and then given the feedback or results of the project in which their consultation was intended to improve. The example provided by Hart (1992) is of children being consulted on new ideas for a television programme, afterwards low-budget pilots of the programme are developed and shown to the children and they are asked for their feedback. Their feedback is then taken into consideration and the programme is redesigned and they are asked once again for their opinion. This example shows how the children’s’ involvement is not limited to consultation but the resulting findings are shared with the children in order for them to understand that their participation was taken seriously.

Adult initiated, shared decisions with children

This is the sixth rung of the ladder which includes activities that are initiated by adults and the children are involved in the decision-making process.

Child initiated and directed

This is the seventh rung of the ladder and represents the situations in which children enjoy supportive conditions in which they can initiate and direct an activity. It appears that this type

of participation is not common in community projects as adults' lack of understanding and appreciation of children's evolving capacities and competence make it difficult for them to refrain from taking on a directing role.

Child initiated, shared decisions with adults

The eighth rung of the ladder represents a rare form of participation in which children recognise an opportunity to initiate an activity or identify an issue that they feel needs to be addressed while consulting with adults and welcome them to the decision-making table.

1.3.7.5 Criticisms of Hart's ladder of child participation

As the ladder proposed by Hart was based on Arnsteins' ladder of participation many of the critiques that apply to Arnsteins' ladder were also directed towards the ladder by Hart in addition to critiques that are specifically relevant to children.

After proposing a 'ladder of participation' modified for children Hart addressed his critics and clarified how he intended the ladder to be utilised offering some corrections to how the ladder has been interpreted. First and foremost, he points out that many people have chosen to use it as a comprehensive evaluation tool for measuring their accomplishments and he maintains that it was never intended to serve that purpose.

Stemming from the criticism that the ladder is hierarchical in nature Hart's ladder has been criticised for portraying the levels of participation to be sequential and implying the sequence to be a requisite of children's developing competence in participation (Kirby and Woodhead, 2003; Reddy and Ratna, 2002). Hart (2008) explains that development does not necessarily have to occur in steps and he stresses that the ladder illustrates the different degrees to which children are enabled to participate by adults and institutions.

Some authors have questioned the need to view participation as levels (Jensen and Simovska, 2005; Mannion, 2003; Treseder, 1997) and have suggested that it would be more appropriate to identify them as different forms rather than levels. Thus models for child participation that are non-hierarchical have been suggested (Jensen and Simovska, 2005; Simovska and Jensen, 2009). While Hart does acknowledge that the metaphor of the ladder may be misleading in that the ladder portrays the higher rungs to be superior to the lower

ones he argues that the different forms of participation are *not* equal and that illustrating them as different levels is justified. This justification is on the grounds that the purpose of the ladder is to depict that the extent to which children are enabled, supported and allowed to initiate their own activities and make decisions in implementing them with others may differ significantly. Thus the forms of engagement that are not commonly allowed to children and young people are represented as the higher rungs to show the value of these less attainable forms of participation.

Other criticisms have questioned the validity of the ladder concept with its hierarchical implication and the goal of striving for the highest rung (Treseder, 1997) with the highest rung being seen as the imperative goal and therefore creating a situation which some critics have called ‘participation as tyranny’ (Cooke and Kothari, 2001) furthermore; it has been argued that different levels of engagement may be suitable for different responsibilities and thus higher rungs are not necessarily needed or better (Shier, 2001).

Hart also discusses in particular the eighth rung of the ladder which represents ‘child-initiated, shared decisions with adults’ and challenges the call by some to amend it to be ‘children’s decision-making without adults or ‘children in charge’ (Melton, 1993). He notes that the aim of his representation was never to see all adult participation dismissed but was more concerned with children’s potential as citizens to be acknowledged.

Hart argues that when children or adults feel that they can bring about change as well as appreciate and accept inviting others to contribute by understanding that ‘others’ as fellow-citizens have rights as well and will also be affected showcases the highest possible degree of citizenship. Thus he argues that ‘child-initiated, shared decision with adults’ is superior to ‘children’s decision-making without adults or ‘children in charge’ from a moral perspective.

So far we have reviewed the concepts of health, health promotion and more centrally participation in health promotion. In this review we have uncovered the central role that participation plays in health promotion which is focused on enabling change. Also some of the participatory frameworks have been discussed. The following section discusses what is generally meant by children and childhood.

1.4 Children

In the previous section we saw that participation has become a central mantra of health promotion. This mantra has however not been discussed to any great depth with respect to children. This is important because whilst a key aspect of health promotion has been to promote empowerment and control through participation as we shall see this becomes even more complicated when we consider children. As we shall see the history of childhood reveals some interesting paradoxes when it comes to children's participation in society.

1.4.1 History of the concept of childhood

It is currently recognised that childhood is not merely a period of biological immaturity (James and Prout, 1990). There is no definitive or universal account of what constitutes childhood, when it ends or what children should be (King, 2007). Since conceptualisation of childhood is not universal; childhood should not be viewed as a homogenous category. For example, the manner in which it is experienced is affected by social factors such as social class, gender, ethnicity, religion and geographical location (Buckingham, 2003). These social structures do not necessarily determine the individual's experience but they shape them by imposing boundaries of what is possible, accepted and expected (Morrow, 2011) moreover, the experience of childhood varies across time and space. Not all children experience the same childhood and not all societies view childhood with the same lens. There is a various array of childhoods that are geographically, historically and socially constructed and thus the term childhood is not as simple and straightforward as it may first seem. For example, in some societies childhood ends at a certain age whereas in others it is when they get married. The age in which they are allowed to get married also differs from one society to another, for example in Vietnam the age for girls is 18 and for boys is 20 whereas in Chile and South Africa girls may marry at the age of 12 and boys at 14 (Melchiorre, 2004).

Aries (1962) in his historical account of family life and the conception of childhood made the famous and controversial claim that:

“In medieval society the idea of childhood did not exist: this is not to suggest that children were neglected, forsaken, or despised” (Aries, 1962:128).

His main argument was that the 'idea of childhood' is socially constructed in that childhood could take on different forms and children have different responsibilities and engage in different activities in different cultures and in different historical periods this was significant as it drew attention to the diversity of childhoods. According to (James and James, 2012) childhood is a term *“that glosses both the biological phase of early human development and the ways in which different societies classify and deal with this by providing institutions and services that are specifically for children; the incumbents of childhood”* (James and James, 2008:16). Based on this perspective, it has been suggested that in order to be able to understand and appreciate childhood both the biological and sociological aspects must be examined, particularly the relationship between them (Prout, 2005).

In Western societies, the conception of the notion of childhood traces back to the fifteenth century to eighteenth century promoted by a rise in education and middle class romanticism of a childhood 'ideal' (Aries, 1962). Aries argues that the particular nature of children that distinguished them from adults was not recognised and that children existed alongside adults as miniature versions (Aries, 1962). They dressed in the same manner as adults participating in everyday life activities and chores with no distinctive practices. This perspective of not recognising children as a distinct social group was criticised by romantic philosophers such as Rousseau and Locke (Jans, 2004). Their view was that children had a right to their own social environment which included being protected from unhealthy labour and were entitled to care and education.

With the eighteenth century came a number of authoritative constructions of the child and the need for children to be regulated to be productive moral individuals (Hendrick, 1990). Part of this regulation came in the form of compulsory education which was introduced in 1880 for children aged 5-10 years. Consequently, children were removed from the labour force resulting in a realization of the separation between the environment of children and that of adults emerging alongside new ideas such as the vulnerability of children (James, 1993).

Through restricting children's labour and generalizing compulsory education the government was concerned with more than teaching children to read and write and aimed to dictate to children on how to be moral and patriotic individuals in society (Jans, 2004). These radical

changes led the way for a monumental change in childhood experience and how it was understood (Cunningham, 1995). No longer part of the labour force and as a distinct social entity the position of children shifted from being significant social (professional) participants with the slightest protection during the 18th and 19th centuries to becoming minimal social participants with protection becoming a focus and priority for children in the 20th century (Jans, 2004). Categorizing children gained importance in the 20th century (Jans, 2004). The meaning of childhood evolved in the USA from children being perceived ‘economically useless’, by not being part of the labour force, parents found new reasons to appreciate them beginning to respect them mainly for emotional reasons and thus they became ‘emotionally priceless’ to their parents (Zelizer, 1985).

1.4.2 Constructions of childhood

Before the 1990’s children, apart from being future adults received nominal interest from sociologists (Ambert, 1986). In sociology, children were generally understood in terms of socialization (Handel et al., 2007). In describing this socialization process Knapp (1999) argues that:

“The child is conceptualized as a lump of clay in need of being molded to fit the requirements of a social system” (Knapp, 1999:55).

This perspective has been criticised for portraying children as passive recipients of their social environment and the claim that they could be full competent members of society was rather radical (Waksler, 1991). In the late 1980’s and early 1990’s however, sociologists began to recognise that childhood research required more attention (Ambert, 1986; James and Prout, 1990; Jenks, 1992; Qvortrup et al., 1994; Thorne, 1987). As a direct result the sociology of childhood developed (sometimes referred to as the new childhood studies) and proposed a different interpretation of childhood. It addressed children ‘*as beings not becomings*’ (Qvortrup et al., 1994:2). The new approach examined children as an independent social group with their own meanings, characteristics, and culture furthermore a fundamental part of this research is the focus on children’s perspectives on their everyday

lives. They are depicted as social actors that have an active role in the construction and determination of their everyday social lives (James and Prout, 1990).

Modern day childhood in Western societies is characterised by ambivalence (James et al., 1998; Percy-Smith, 1999; Prout, 2000). With children now positioned in society as cherished individuals that need protection alongside calls to become autonomous individuals this has led to confusion to both children and adults (Jans, 2004). There is an inherent tension between the paternalistic model of protecting the child and the notion of them as active participants in society who have comprehensive rights, Jans (2004) poses the question:

“To what extent can children and young people be expected to be autonomous, independent and responsible, while their living situation also supposes dependency and inequality?” (Jans, 2004:34).

James et al. (1998) argue that the existence of regulation and increased autonomy do not necessarily cancel each other out and instead should understand their characteristic ambivalence as a social concept appropriate to the growing up of children. According to Jans (2004), it is learning how to deal with this ambivalence in real everyday practice which is challenging and that both children and adults are interdependent in the process of learning how to do so.

1.4.3 Children and agency

The concept of children as social actors was then further refined by Mayall (2002) arguing that they should be considered as social agents and pointed to children’s agency in that they had to some degree the power to affect social change. This approach using the concept of agency may be problematic if not contextualised, if children are viewed as social agents this implies that they enjoy the same level of independence as adults without addressing their biological and psychological immaturity (Lee, 2001). Lee emphasises the need to investigate the manner in which children are enabled to be social actors as this recognises that they are positioned in a network of interdependencies in a particular social context. Their interdependencies with others are very significant to their ability to be social actors

particularly with adults who control institutions that justify and support the form of dependency that children experience.

Children's agency has been described as a complex interaction in which children simultaneously are shaped by their environment and shape their environment. Corsaro (1997) refers in this case to 'interpretive reproduction'. It's been argued that agency develops early in childhood (Alderson, 2005) and the process of socialisation plays a pivotal role in its development in children such as the attainment of knowledge and personal skills (James and James, 2004). Therefore, we can suggest that different settings that a child occupies such as the home, neighbourhood, or school may all have an effect on the agency of a child. If we extend this thinking then a more dominant conceptualisation of children's agency within the academic literature is active participation and the ability to act independently in a particular context and make choices on their own (Corsaro, 2006).

Children's agency is expressed in different forms and has different meanings in different contexts. For example, research suggests that children can exercise their agency in contributing to the organisation of their daily school timetable (Bourdieu and Passeron, 1990), negotiation in public places (Smart et al., 2001), living with illness (Bluebond-Langner, 1980) and making decisions for medical treatment (Alderson and Montgomery, 1996). Whilst Simovska (2012) argues that children cannot learn to be social actors in a school context unless,

"...schools and teachers create democratic classrooms and school communities that are inclusive in meaningful ways and where control is shared ...genuine participation allows for pupil ownership of the learning process" (Simovska, 2012:2).

Hart reinforces this argument regarding western schools in that *"they teach the principles of democracy in a pedantic way in classrooms which are themselves models of autocracy. This is unacceptable"* (Hart, 1992:5).

Both Hart and Simovska appear to be suggesting that especially within schools there is a need to rearrange social circumstances to ensure an environment that enables children to exercise

their agency. How far this rights based position may extend and what the realities are when there are state pressures on schools to perform to set standards remains to be seen.

1.4.4 UNCRC and child rights movements

The United Nations Convention on the Rights of the Child and the children's rights movement have significantly brought due attention to a marginalised group that has been invisible for a long time. The United Nations Convention on the Rights of the Child (UNCRC, 1989) ratified by the UK government in 1991 (Newell, 1993), has been ratified by every country in the world, except the USA and Somalia (Morrow, 2011). The UNCRC acknowledges the particular needs of children as a result of their unique position which arises from the inherent tension between their rights as human being and their inherent need for protection. It declares the civil, social, cultural, economic and political rights of children. Article 12 of the convention encourages and calls for the participation of children in matters that concern them.

“State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child” (UNCRC,1989:5).

Article 12 has been significant not only for what it says, but because it recognizes the child as a full human being with integrity and personality and the ability to participate freely in society. It also states in Article 13:

“The child shall have the right to freedom of expression; this right shall include freedom to seek, receive and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any media of the child's choice” (UNCRC,1989:5).

The UNCRC recognises the vulnerable situation that children may be in by calling for participation rights alongside the need for protection (Lansdown, 1995). Hart (1992) notes that the UNCRC fails to point out the implicit responsibilities with rights and argues that children need to learn the rights and responsibilities of citizenship, even though these

responsibilities are shaped by the society and environment and their complexity may not be immediately apparent. He goes on to argue that through engaging in collaborative activities with others, including individuals who are older and with more experience, children are in a position to learn about their responsibilities and it is for this reason that children's participation is so important.

It appears that in many children's rights initiatives in the West and the UNCRC, priority is given to the rights and responsibilities of governments and carers towards children, with less attention given to children's responsibilities towards others (Morgan, 2013). Hart (1992) criticises this emphasis arguing that it stems from Western ideals surrounding individualism and thus is not universally applicable. The manner in which children's rights are conceptualised differs; for example in Africa it was recognised that the UNCRC was not culturally sensitive and therefore it was adapted and resulted in the Africa Charter that addressed the many cultural and social aspects that are particular to Africa (Morgan, 2013).

Children's rights in general have been categorised into two main groups; welfare rights and liberty rights (Franklin and Franklin, 1996). Welfare rights relate to the right to protection for example, from exploitation, and the right to provision such as education (Franklin and Franklin, 1996) whereas, liberty rights relate to notions of empowerment and participation. Welfare rights are normally provided by adults for children and are readily accepted by adults unlike liberty rights which are more controversial (Morgan, 2013). In Africa for instance the majority of countries have concentrated on welfare rights rather than liberty rights, this however is due to the situation of children in Africa that are faced with hunger, armed conflict, and widespread disease (Murray, 2004). Woodhead (2009) argues the tendency for Western child rights initiatives, which have secured protection and provision for their children, to place the main emphasis on liberty rights may allow welfare rights to be overlooked.

The UNCRC however have clearly stated that children's rights are not solely concerned with issues of empowerment and participation but that welfare and liberty rights have a symbiotic relationship which is mutually beneficial as the realisation of welfare rights can lead to liberty

rights and vice versa (Morgan, 2013). This brings us to the UNCRC's view of children's participation.

1.4.5 Children and participation

The UNCRC brings together in one document various commitments to children's rights, and be seen through its overarching principles of welfare, non-discrimination and participation can be seen as providing a framework that envisages children's citizenship (Roche, 1999). Similar to the original argument that participation is directly linked to citizenship made by Arnstein (1969), DeWinter (1997) describes participation as a form of children's expression of citizenship.

The term child has been defined by the UNCRC as any person up to eighteen years. As this includes a wide range of ages, older children particularly teenagers may not be comfortable with the lack of distinction made between them and their younger counterparts. Hart (1992) has suggested that the term 'child' be used for individuals in their pre-teenage years and 'youth' or 'teenagers' to individuals who are of the ages thirteen and eighteen, and the term 'young people' to refer to both age groups.

Children's experiences, familial, socioeconomic and cultural circumstances have increasingly been accepted as part of the pathways involved in health and illness in adulthood (Graham, 2001; Wadsworth, 1997). Moreover, there have been studies in the UK that have implied a relationship between the socioeconomic status of children and their following pattern of mortality (Blane and Montgomery, 2000; Brunner et al., 1999; Davey-Smith et al., 1998). In spite of this, data collected on the health and illness of children continues to be predominantly defined by adults and children's own voices are not heard. Due to this there is a lack of understanding of the social and cultural processes that occur in children's very different childhoods, which underpin and ultimately constitute these epidemiological findings.

One argument for the development of children's participation is that it is unrealistic to expect children to suddenly take on responsibilities and be participating adult citizens without having previous exposure to what is required of them (Hart, 1992). Hart goes on to suggest that children need to be meaningfully involved in activities with peers and adults to gain the

necessary skills and better understanding of responsibility (Hart, 1992). As previously mentioned, the UNCRC has been criticised for its lack of emphasis on responsibilities of children and focusing mainly on the rights of children (Hart, 1992). Instead, it is through collaborative activities with peers and older persons that children and young people are given the opportunity to begin to learn those responsibilities and build the skills they need to fulfil those responsibilities making them more prepared as adults.

From the academic literature, it appears that participation is multidimensional and Sinclair (2004) suggests four fundamental dimensions for understanding participation:

- The nature of the participatory activity
- The focus of the decision-making
- The children and young people involved
- The level of participation.

In relation to children and young people, ‘participation’ is often used to refer to the *interactivity* of approaches used to enhance young people’s motivation to be involved in school and/or community actions in different areas, including health (Simovska and Jensen, 2009). Many reasons have been suggested for children and young people’s participation. These are summarised by Sinclair and Franklin (2000):

1. To uphold children’s rights,
2. To fulfil legal responsibilities,
3. To improve services,
4. To improve decision-making,
5. To enhance democratic processes,
6. To promote children’s protection,
7. To enhance children’s skills,
8. To empower and enhance self-esteem

(Sinclair and Franklin, 2000 cited in Sinclair 2004:108)

What Sinclair and Franklin do not comment on in detail are the ways in which this list may be fulfilled and Sinclair herself acknowledges that “*the ways participation has grown there is some danger of over-simplification of what is a complex activity*” (Sinclair 2004:111). This again underlines the varying ways and lack of clarity in which the term participation is used, although there is an attempt to link it to a rights based approach.

The literature on the children’s rights discourse since the acceptance of the UNCRC has concentrated on illustrating a new childhood image that of a competent child. This is in contrast to the previously held view of children as incompetent and consequently limiting them to the role of objects that are in need of protection. The image of the incompetent child has portrayed children as ‘adults in waiting’ (Matthews and Limb, 1998:67) ‘not-yet-being’ and thus children seen as passive recipients that lack adult competencies. Naturally, being viewed from this perspective meant children were not given opportunities to experience responsibility (Such and Walker, 2005). The children’s rights movement has significantly brought due attention to a marginalised group in society that has been treated as inferior on the base of age (Freeman, 2007; Therborn, 1996; Vandebroek and Bouverne-De Bie, 2006).

There has been a swift increase in activities that involve the participation of children however there remains a lot of uncertainty around ‘how’ to involve them particularly in an effective manner one that would lead to meaningful and sustainable improvements. It has been suggested that there have been three main factors that have served as the impetus for child participation the UNCRC, the consumer movement, and a shift towards recognising children as social actors (Sinclair, 2004). The UNCRC has been discussed previously so the following section will discuss consumer movement and children as social actors.

Consumer movement

As a result of the consumer movement consumers have become more influential regarding the nature and quality of goods and services they desire to use. This movement is now commonly referred to as ‘user involvement’ and is no longer solely focused on the preferences of individuals but also directed towards resource allocation, policy making and the resulting effects on users as a group (Braye, 2000). Children comprise up to a quarter of

general practitioner consultations and a third of cases in accident and emergency departments (Hart and Chesson, 1998) and as a result have increasingly been identified as ‘users’ of public services (Sinclair, 2004).

It has been debated however, that although this has led to more participation this consumerist approach has confined individuals to being ‘users’ this debate has stemmed from Foucault’s theory of ‘governmentality’ (Foucault, 1991) which reflects on the differentiation of the ‘active citizen’ and the citizen as a consumer. Indeed, Taylor (2007) argues that many participatory activities are tokenistic and that rather than accepting citizens as having equal value and decision-making abilities they are constructed as consumers, subjects or clients. Whereas, ‘active citizens’, *“are defined, not through consumerist power ... but as democratic agents, empowering themselves through their challenges to the activities of institutions and organisations which shape their everyday lives”* (Raco and Imrie, 2000:2187).

Patient passivity begins early in life (Pittman, 1992) thus it is important that children be involved and consulted and sufficient priority be given to their needs by health professionals and policy makers. Therefore, a shift away from the predominant ‘child as service-user’ approach in the UK towards children’s autonomous and proactive engagement has been encouraged (Shier, 2001). This shift has been discussed by Cornwall and Gaventia (2000) who highlight the importance of the ‘repositioning’ of participation in social policy and transforming individuals. In the publication ‘From Users and Choosers to Makers and Shapers’, Shier (2001) argues that although the work of Cornwall and Gaventia (2000) concerned adults this may also apply to children, however no examples are provided to explain how this may be done.

Children as social actors

Another argument for the participation of children stems from the (as previously discussed) shift in our understanding towards children with respect to their capacity to influence their environment, illustrated by the concept of children as social actors (James et al., 1998). This has been amplified by the documentation that children including very young children are competent in expressing themselves and in their involvement in decision-making

(Alderson,1993;Clark, 2001). The implicit argument here is that if children are competent then by default they are autonomous agents.

1.4.6 Children's evolving capacities

To promote autonomy, the competency of the child must first be acknowledged. The notion of competence is basically the ability to 'do' something and does not in this performative sense indicate the quality of a given performance. It encompasses a variety of qualities such as cognitive, physical, emotional, social, and moral capacities. It has been suggested that what is viewed as competent differs depending on the cultural context. Competence is dynamic and has the potential to increase and develop through greater opportunities for participation; children learn by experience and in turn competence develops through experience as opposed to simply with age. James and James (2008) propose that naturally, as one grows older one acquires more experience and thus the assumption is made that age is linked directly to competence even though the literature maintains that there is no necessary link between them. Children who are given more responsibilities have shown to be more competent and develop personal skills better than their counterparts that have not been given such responsibilities (Lansdown, 2005).

The presumption that children, particularly young children, are incompetent has been the main reason for their non-active participation in research, the level of competence has often been thought to be linked to age (Morrow and Richards, 1996). Childhood researchers have begun to recognise that age is not a direct indicator of competence and view it as irrelevant and that even young children have the ability to understand their experiences and express themselves (Alderson, 2000, Melton, 2000, Alderson and Montgomery, 1996, Davie, 1996, Pugh and Selleck, 1996, Solberg, 1996). The child's experience has been recognised to be more relevant than age and their ability to formulate and express their views to be strongly influenced by the context particularly the degree to which adults are able to understand their opinion and allow for a supportive framework that facilitates their communication. Smith (2002) has highlighted the need to develop effective ways of eliciting children's voices and one place that children's voices are more frequently heard appears to be in settings such as schools.

1.5 Nurseries

1.5.1 History of nurseries

In an advertisement by a nursery on their website states “*We all take pre-schools or nurseries for granted in this day and age. Without them the wheels of the economy would have the brakes applied dramatically so their worth must not be under estimated.*” Indeed, they must not be underestimated, but notably they have solely focused on their impact on the economy. Is the main purpose of a nursery to serve simply as a child-care institution? There was a time in the UK when nurseries didn’t exist.

In the early 19th century, elementary schools were the only option many families had. Following the Education Act (1870), provision for the very young was integrated with elementary schools as part of the national system and an infant department was introduced. Many of these schools had classes that were crammed with children and lacked proper ventilation. These very young children were expected to sit with the older children for long periods of time and were given the same curriculum. By 1900, 43.1% of children aged three to five in England and Wales were attending elementary schools (Board of Education Statistics, 1912). Concern began to grow regarding the conditions that these younger children experienced and in 1904 an enquiry was set up by the Board of Education to investigate the educational environment of these children. The report concluded that many issues were not age-appropriate and notably described the environment as unhealthy.

“It was clear that health care was not considered a necessary part of the curriculum.” (Straw, 1990:110)

Rather than make appropriate provisions for children aged 3-5 the Board of Education encouraged the exclusion of under-fives from schools (Straw, 1990). This did not do much as many young children had no one to take care of them, their parents were at work and their older siblings at school and work so children aged 3-5 were still attending elementary school. The Board of Education in its report (Straw, 1990) did make recommendations regarding age appropriate curriculum and improving the standard of the environment of the nursery however, they were not materialized due to lack of state grants for nurseries. The only

difference is they were separated from the elementary school children in a separate classroom, everything else remained the same.

The majority of the children aged 3-5 who attended school were from poor families living in squalid conditions in which disease thrived. Concern regarding their health and that of all school children and a desire for better educational conditions was the driver that led two sisters, Rachael and Margaret McMillan to dedicate their lives to improving the conditions for these children (Liebovich, 2014). They strongly believed that health care was an integral part of the education service; children needed to be healthy before education could begin. They tirelessly campaigned for a state system of school meals to be introduced and regular medical inspections in schools. They argued that hungry and ill children posed a significant challenge to learning. Their efforts are believed to have led to many improvements; in 1906, the government subsidised school dinners for poor children and in 1907, passed an Act that necessitated the medical inspection of all school children.

The McMillans began to experiment with different efforts in improving the health of children. One of which was the setting up of a night camp where girls aged 6-14 years were given a good wash and were allowed to sleep in the fresh air. They noticed that the health of the girls had improved, but they also began to realise that their efforts were reaching these children too late and that in order to significantly make a difference in children's lives they needed to help them earlier in their lives.

“They had become convinced that they and the schools were dealing with the children too late; they only encountered them after cruel conditions had laid a heavy burden on their young lives” (Bradburn, 1976, cited in Straw, 1990:111).

They decided to set up a school garden for children younger than the compulsory school age of 5, and in 1914 the first open-air nursery in the UK was opened. This open-air nursery was very different to traditional schools. For example, the garden was designed to be the main area of learning and not the building. The sisters believed that the design of traditional school buildings was not at all favourable to the learning of young children. They designed a school which was basically a garden with shelters in it rather than a building with a garden. The garden, they argued was an attractive learning environment for all children and could provide

different learning opportunities depending on the child. The nursery was thoughtfully and meticulously designed with the young children's needs in mind, as opposed to designing the building and allowing the children to adapt, in essence, it was a child-centred design in which education could take place.

The McMillan sisters strongly believed that children learned through play, movement and their senses. The nursery garden was a complete learning environment that could provide for all this. It was divided into different sections for various play activities.

“There was a gymnasium, an area for scientific and environmental discovery, a horticultural section and a play and building area. The children could follow their various interests without being interrupted. They learnt that certain sections could only be used in a certain way. For example, the kitchen garden could not be used as a digging plot, where one could just dig to study the minibeasts. The kitchen garden had to be very carefully tended and seedlings had to be protected. The garden was arranged on different levels, on grass and hard surfaces. There were paths, steps, open spaces, logs, climbing apparatus, slides, banks, ropes, swings, shrubberies, sheds and playhouses. There was a horticultural section consisting of a herb garden, kitchen garden, wild garden and rock garden. The vegetables, fruits and herbs were used in the cooking at the nursery. Other sections provided nature study ponds, stones, bark and twigs — left for the children to turn over, examine, observe. The digging plot, already mentioned, provided for the study of minibeasts. Bird boxes, tables and baths attracted many birds. Children learnt to care not only for the wild birds and animals but also for pets, including tortoises, hedgehogs, guinea pigs, rabbits, pigeons and fish. The building area consisted of planks, ladders, bricks, stones, boxes, blocks, barrels, ropes — all of which could be used to construct and build with” (Straw, 1990:112).

They believed that in addition to the variety of learning experiences the nursery provided, its value was also in that it used the natural environment thus allowing the learning experiences to be from real life and the children had the freedom to engage with whatever they wanted and learn at their own pace. This was in stark contrast to the mode of education provided in elementary schools which was based on rote learning and there were no opportunities for

interaction with the environment and children were expected to accomplish the same tasks at the same time.

This nursery was founded with the belief that this was a place, where the main objective was not confined to that of the child's education, but took on a much broader approach it focused on child development including physical and emotional aspects as well. Thus, a focus on children's health became an integral part of the nursery agenda. A film of the nursery, its' activities and focus on health is still available from British Pathe (<http://www.britishpathe.com/video/nursery-days>). They asserted that children who had vision problems would not be able to read, those with nasal defects would have problems in speech development and hungry children would be too tired to learn. Therefore, the nursery was a place that these problems could be recognised and medical inspectors could be notified and children with health issues could be attended to in a controlled environment. Through attending nursery, children of whom many lived in poverty and for whom food was scarce were able to have one nutritious meal a day. The outdoors of the nursery provided the much needed fresh air and sunshine for the children, unlike the crowded, ill-ventilated classrooms of the elementary school buildings.

A main concern for nursery education was 'that a child needed to be healthy before education could begin; that a healthy body and a healthy mind went hand in hand'. Their holistic approach to health follows the ethos of today's WHO directives. The nursery pioneers had suggested that with fresh air, fresh food, exercise and rest that the health of children could be improved. The improvement in health of the children in the McMillan's care was so significant, however that it led to the educational attainment of the children to be side-lined by public officials. The importance of the educational development that these children had gained and its role in preparing them for school was ignored by policy makers. It has been suggested (Straw, 1990) that this was a deliberate political decision. For if the government had acknowledged the success of the educational development they would have had to provide it to all children, whereas highlighting the health improvements which were aimed at and offered to poor children meant it would not have to provide for the whole child population aged 3-5 and thus cost less money. Thus it was more convenient for politicians for the nursery to no longer be seen as a learning environment for the very young but 'became

the means by which young children's health was promoted' and although this was part of the McMillan's vision for the nursery their vision was to promote health and educational development in tandem. It is interesting to note that nurseries flourished during the First and Second World Wars, but that they were set up to serve as child-care institutions to enable women to take on various jobs that were greatly needed during the war effort, however with the ending of each war and with less demand for women to take on jobs, the majority of the nurseries were closed due to lack of government funding. This highlights how the nursery was perceived to serve a purpose; it primarily served the interests of the economy and not necessarily the interests of the child. This was a far cry from what the McMillan sisters had envisioned.

The McMillan sisters also appreciated the importance of having appropriately trained nursery teachers and believed that the success of the garden relied on the teachers' capabilities. They argued that these teachers needed particular training one that differed from the teachers that educated older children with an emphasis on their need to be educated on the aspects of child development. It is worth noting that the ethos of the nursery was one of an enabling environment and teachers were encouraged to be facilitators rather than provide didactic modes of learning.

“For it is not the business of such a teacher to prescribe occupations continually and to direct activities; rather must she watch and follow the playing children, give help when called upon and answer questions. Her main duty is to secure for the children more and more opportunities for the exercise of their natural powers and to put them in touch with ample material which will stir them to activity and so promote growth in thought and feeling” (Wheeler and Earl, 1939 as cited in Straw, 1990:114).

1.5.2 Contemporary nurseries

According to Ball (2013) the level of governmental action in the field of education over the last 20 years is unprecedented. Throughout this time there has been a significant increase of social policy both in education and various other fields. Ball (2013) argues that this was not incidental but rather a planned political tactic part of what he describes as the '*dynamism of*

government, *'about being seen to be doing something, tackling problems'* and *'transforming systems'* (Ball, 2013:3). Education in England became a major political and media focus in 1988 which saw the first statutory state control of the primary curriculum. The Education Act 1988 introduced the national curriculum in addition to a statutory assessment system. Prior to this, schools alongside Local Education Authorities, decided on and implemented a curriculum that they thought served the needs of their students.

The Education Act addressed the perceived need for government control over education voiced by government ministers, particularly control over funding in terms of gaining value for money, and the introduction of a national curriculum and a national assessment system were two important tools to enhance their control. Delpit (1988) discusses the different ways power is enacted in the classroom these include for example, the power relationship between teachers and students, the power owned by textbook publishers and curriculum developers with their resulting influence on how world views are presented. In addition to the power that a group of people or organisation have in determining and setting what is and what is not considered to be 'normal' regarding individual capabilities such as intelligence. Delpit (1988:238) goes on to argue that if schooling provides individuals with the qualifications for future jobs and this in turn determines their economic status and therefore power, *"then schooling is intimately related to that power"*. A new agenda was introduced and centred on enforcing a 'command and control' model of change, and introduced a culture of competitive 'performativity' (Ball, 2013) which focused on children reaching pre-determined learning goals. This was considered important to policy makers as education not only determined the economic status of the individual but was also linked to the economic success of the country. Education is widely believed to be a vital element in ensuring economic productivity through preparing future generations to participate and contribute to the economic growth of the country. This is a global perspective and education policy is heavily influenced by the pressures and demands of globalisation (Ball, 2013). Thus government policies are informed by a range of economic, educational and social factors working on both a national and international stage and schooling was now primarily a means by which to improve the economy.

1.5.3 Pre-school education

As a result of domestic and global socio-economic and educational factors, as well as influential research studies government policies began to include pre-school education. These studies have shown that there is a link between high-quality nursery education with positive educational, social and economic trajectories (Schweinhart and Weikart, 1997; Sylva, 1994) The Perry Pre-school Study was a very influential longitudinal study conducted in the USA in 1962 involving African-American children born into poverty it followed the children to adulthood (Schweinhart and Weikart, 1997) This study involved 123 children who were randomly assigned into two groups; one group participated in the programme and the other did not. The children were aged 3 and were in the programme for two years. The Perry pre-school project later known as High/Scope is considered to be the most carefully controlled study out of the 11 reviewed by Lazar and Darlington (1982) Data was collected annually from ages 3 to 11 and then at age 14,15,19,27 and lastly at age 40 (Schweinhart et al., 2005).

An interesting finding of this study is that as adults the group that was in the High/Scope programme had better economic and educational outcomes and greater social responsibility than their peers. The authors do not claim that the programme took the children out of poverty and gave them a 'good life' but that they were better off than their peers in areas such as employment and earnings, criminal records, and even relationship stability. The study at first was hailed for its findings as the new solution to tackling inequalities however many politicians were sceptical and commissioned a study to test children's IQ's after 2 years of finishing the programme and found that their IQ's had dropped and so the study was in the eyes of politicians a failure, for if it didn't make children 'smarter' then it was not working.

The authors of the study were not convinced and decided to continue following up the children. They found consistent results that the High/ Scope group were achieving better than their peers in school but yet they were not necessarily scoring higher than them in IQ tests. This is when they realised there was more to achievement than intellectual capabilities. Upon enquiry they found out that many of the students in the non-intervention group didn't even attempt many of the questions and usually didn't finish the test to the end. They concluded that it was the differences in their emotional and social development that were key to their

achievement and that those in the intervention were more motivated either by having more of a desire to succeed or more of the belief that they could succeed. They suggest that this is a result of the care and nurturing they received in the programme. This was a comprehensive programme it focused on empowering the child, the parent and the teacher.

Initially when the programme began there were no frameworks or curriculum guides to follow; but the Perry Preschool teachers believed that the children's learning should be done through exploring their own ideas and interests. It was set in a framework of active learning which was done through play and an emphasis on listening. One of their main priorities was to enable these children to be heard; they encouraged them to talk, talk and talk.

The idea that children should be seen and not heard is an old and powerful belief (Heywood, 2001) and even parents who do not necessarily support this view, may apply it because it can be a useful parenting tool, often times a quiet child is considered a disciplined child (Cunningham, 2005). Parents from differing social classes may have various views on talking to children for example, regarding the value attached to talking to a child or the appeal about having a talkative child and they may act accordingly based on their beliefs (Heath, 1983). Hoff et al. (2003) focusing on the specificity of environmental influence have argued that the level of a parents' socioeconomic status (SES) may affect their interactions with their child; for example, parents with a low level of SES may have less time to spend on parent child communication and interactions and the extent of other stressful factors on parents will influence their interactions (Hoff et al., 2003). So the opportunity for children to talk and be listened to was considered important as these children were all from disadvantaged backgrounds, for example a struggling single mother living in a cramped flat with lots of children may find it unfeasible to 'talk and listen' to each of her children. Thus, we find studies that show particularly disadvantaged children to be behind in their language development such as vocabulary when compared to children from a higher SES. There are other factors involved for why children from low SES are behind their counterparts (Hoff et al., 2003) but this is beyond the scope of this study. It appears however that children enjoy different levels of engagement at home depending upon their socio-economic status.

Through talking and listening, the teachers had many goals they wanted to accomplish; they believed it would help the children develop cognitively, socially and emotionally. They wanted the children to build their vocabulary but this came second to a more important goal they had on mind; they wanted these children to talk about their ideas and with the teacher's facilitation to extend their ideas and develop them, they wanted to enable their creativity. In order to do so the children were also taken on field trips to places they normally wouldn't go, to see things they normally wouldn't see; the teachers wanted to open up the children's eyes to the world and wanted them to know it was their right to be part of it.

Through providing an enabling environment in which the children could be active learners the teachers wanted to give the children an opportunity to seize a measure of control over their environment and generate a conviction that they did have some control over their lives. They wanted them to develop a sense of empowerment through having some control of their learning environment. To support the children to be active learners the children were allowed to plan their learning activities which were set in a resource-rich environment. Afterwards, the children had the opportunity to talk about their experiences to staff and other children. It was a learning process of '*plan-do-review*' which the teachers felt facilitated the development of the children's abilities and appreciation of having control over their environment. This plan-do-review process is now known as the High/Scope method of learning.

This approach is rooted in Vygotsky's (1962) influence with his theory of learning within the zone of proximal development which advocated that children achieve their learning potential through interactional support and through the mediation of a knowledgeable peer or instructor. However the High/Scope plan-do-review called for the instructor to not only mediate the child's learning by leading them to the outer bounds of their capacity but also to facilitate representation and the development of motivation and self-efficacy (Sylva, 1994). According to Bandura (1997) self-efficacy is essential for personal agency, nothing is more fundamental than a person's belief in their ability to affect and control matters and events in their life. Bandura (1997) goes on to argue that without the conviction that their personal choices and actions can bring about positive experiences and help avoid undesired experiences; people will undoubtedly lack the motivation to be proactive or persevere in difficult situations. Although he acknowledges there may be other factors involved in

personal motivation, he points out that they are anchored in the central belief that one has some control over their environment. A similar concept to self-efficacy is sense of coherence (SOC) (Antonovsky, 1979). It appears that the teachers' efforts were also helping the children develop a sense of coherence (SOC) (Antonovsky, 1979) through focusing on its' three components: comprehensibility, manageability and meaningfulness. This is quite significant considering that sense of coherence (Antonovsky, 1979) and self-efficacy (Bandura, 1997), develop at an early age.

The programme was not limited to the children; the teachers visited the parents each week at home extending it beyond the setting of the school into a wider setting. With the child's presence the teacher would discuss with the parent the child's activities in the nursery. The teachers understood that to be accepted they needed to build a relationship with the parents and on occasions where they felt that they were unwanted or the parent was just too busy, they would put aside classroom issues and just have a friendly chat with them while the parent went on doing what they needed to do for example making dinner or household chores. After rapport was established between the teacher and parent the visits became focused on the relationship between the parent and child. The visits were aimed at helping the parents understand the methods of learning in the nursery but more importantly to illustrate their children as active learners able to learn. Moreover, the teachers believed that involving the parents showed the parents how much they cared and believed in their children. The study suggests that this empowered the parents to be more supportive of their child's development through a better appreciation of their child's potential. The study goes on to emphasise that for the teachers to be able to support the children and parents they themselves needed be supported. Thus they were provided with regular in-service training.

1.5.3.1 Recent developments

The academic literature has provided a plethora of evidence of the positive effects of early childcare on child development and child equality (Parker, 2013). In a report by the Institute for Public Policy Research on the evidence and policy regarding early years education it highlights how the debate has shifted focus from childcare provision for economic interests to childcare provision for child developmental reasons (Parker, 2013). It is interesting to note

that the report uses the word childcare as an umbrella term that includes education and stresses the importance of learning through play. They talk of the improvement in levels of numeracy and literacy of children who had early years childcare. So although the term is childcare they are referring to it as a form of nursery education.

The report discusses the significant role early years childcare has on a child's cognitive and intellectual development but warns against the 'schoolification' of the curriculum and settings. Despite the fact that early years education is able to improve children's readiness for school the report states that it can be detrimental to young children's development to experience school practice learning; and that it is crucial that learning be age-appropriate and play-based. Many findings of the report appear to provide evidence and support the initial efforts of the nursery pioneers. The report also makes a distinction between low-quality and high quality childcare and that the evidence for positive developmental improvements is regarding high quality childcare. Assessing quality is not without its challenges, however there are tools that have been established and are used such as the Early Childhood Environment Rating Scales which are based on the children's development level and social and cognitive outcomes. It has been argued that what is considered as 'high-quality' differs depending on the age group and that is why OFSTED on its own may not be the best assessment method for early years education (Mathers et al., 2007).

It is worth noting at this point that the historical development of nurseries appears to have gone full circle; from the early days of the promotion of health and educational development of very young children in an enabling environment through the support of adult facilitators to a culture of performativity and then a return back to the same principles that existed a century ago.

1.5.4 The early years curriculum

The introduction of statutory national curriculum policies in primary and secondary schools subsequently led to their implementation in pre-school settings and in 1997 with the publication of the White Paper 'Excellence in Schools' (DfEE, 1997) 'early years' education became the remit of government policies. The curriculum went through different

developmental stages which resulted in the current Early Years Foundation Stage (EYFS) framework (DfEE, 2014). This is a statutory framework for the learning, development and welfare of children aged 0-5. It lays out what is legally required by all schools and Ofsted-registered early years providers, including school reception classes, preschools, nurseries and childminders. It is basically the curriculum for children aged 0-5, however the term 'curriculum' has not been used as it has been argued that the use of the term may lead to prescriptive teaching and introduce early expectations that create pressure for children to meet developmental targets (Abbott and Langston, 2005). On the other hand, Duffy (2010) challenges this argument and explains that through the use of the term 'curriculum' for this age group their learning gains more status and becomes equal with that of older children. Semantics aside, the significance of a curriculum or an equivalent framework is highlighted by Wood and Attfield, "*all curriculum models reflect a set of beliefs and values about what is considered to be educationally and developmentally worthwhile in terms of children's immediate needs, their future needs and the wider society*" (Wood and Attfield, 2005:138). According to this statement a curriculum is thus shaped by what is believed by policy makers to be important for very young children.

Modern early childhood education has heavily been influenced by research on learning within the field of developmental psychology particularly Piaget's theory of cognitive development (Piaget, 1952) which views children as active learners and that their development occurs in stages. His influence can be seen today in the EYFS with its emphasis on active learning and papers such as *Development Matters* (Education, 2012) which provides guidance for the EYFS framework. Outlined within this paper is a linear, progressive construction of children's development through distinct stages with evidence of an appreciation of the significance of the surrounding environment for learning. Another significant influence has been Vygotsky's socio-cultural theories of learning (Vygotsky, 1978) which suggest that all cognitive development happens through social learning. Piaget and Vygotsky proposed differing cognitive theories of play. In Piaget's opinion, changes in cognitive development provides the basis for changes in play. Specific types of play in which children participate require a certain level of cognitive ability, therefore different types of play are appropriate for different stages of cognitive development. Piaget argued that play does not lead to further

cognitive development because it merely illustrated the child's cognitive developmental stage. Vygotsky held a significantly different opinion on the relationship between play and development in that it was an activity that directly impacts on the development of children's cognitive abilities. Within the EYFS framework Vygotsky's influence is seen through the theme of learning through play with an emphasis on a resource rich environment and mediated learning.

The current curriculum is underpinned by four themes.

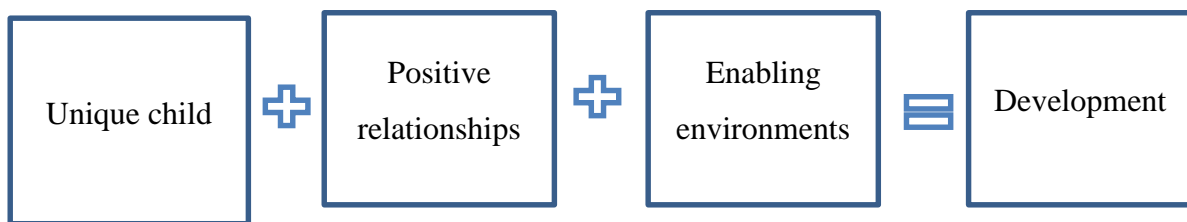


Figure 4. Themes of EYFS (Education, 2012)

The framework emphasises that children are different and each child is unique in capabilities, needs and development. Keeping that in mind, it describes the need for children to have positive relationships with adults and their peers. The staff are encouraged to facilitate the children's learning experience through providing a caring environment and facilitating their learning through prompting their thinking and mediating rather than directing with the aim of providing an enabling environment.

The EYFS focuses on 7 areas of learning and development; 3 prime areas and 4 specific areas. The Prime areas are communication and language, physical development and personal, social and emotional development. The 4 specific areas are literacy, mathematics, understanding the world and expressive arts and design. Each of these sections has an early learning goal children are expected to achieve.

In addition to mandating the standards for learning and development the framework also states requirements for safeguarding. This would require the children to be surrounded by the appropriate individuals and in a safe environment this would include such things as the layout of the setting, equipment, documentation and the daily organisation of the setting. Thus legal

requirements then become institutional rules and regulations which then shape the framework that in turn shapes the nursery environment.

Another issue that is important to acknowledge is that the subtleties and complexities of empirical research have not been addressed in national policies; furthermore, the research evidence regarding the effectiveness of primary schooling has been transferred to early years education without an appropriate understanding of the differences between them (Wood, 2004). Although it is important to develop an effective curriculum it is important to remember that it is brought alive by practitioners in local contexts and not acknowledging their role leads to an over-simplified model of the complexities of early years learning. As Duffy argues,

“The curriculum is only as good as the people who offer it to the children. Practitioners are a key element in the curriculum and the experience of the child will depend on them. Each child and setting is unique, and the curriculum offered needs to reflect this” (Duffy, 2010:105).

Moss (2007) compares the national curricula of England to that of the Nordic countries and notes that the Nordic curricula is concise in outlining the general principles and goals with an emphasis on democracy and entrusts the early years professionals to interpret them and implement them in the way they see most suitable for their setting. This again refers directly to the knowledge and experience of early years practitioners (EYPs) and is reliant on their skills.

In comparison, the English curriculum is longer and does not explicitly refer to democracy as a value. It is also more prescriptive and didactic in nature and as Moss (2007:10) states does not create ‘democratic space’ nor encourage democratic practices. An interesting argument made by (Moss, 2007) is that there are a number of ways to view a nursery and the Anglo-American discourse predominately considers them of either technical or consumerist value. From a technical point of view, they have been described as an *“internationally rampant vision of schooling, teaching and learning based solely on systemic efficacy at the measurable technical production of human capital”* (Luke et al., 2005:12). Another perspective is that it provides a commodity to consumers, in this case the parents. Moss

argues that nurseries should not be limited to being a commodity, but should be recognised as a possible setting for democratic practices with participation being an integral concept.

Participation is based on the idea that reality is not objective, that culture is a constantly evolving product of society, that individual knowledge is only partial; and that in order to construct a project, everyone's point of view is relevant in dialogue with those of others, within a framework of shared values. The idea of participation is founded on these concepts: and in our opinion, so, too, is democracy itself (Cagliari et al., 2004:29).

Cagliari supports Moss but also appears to be saying that human systems are constantly evolving and complex, therefore collaboration and sharing of knowledge becomes essential for the promotion of participation. The nursery setting can be defined in terms of bricks and mortar, but the people within it deliver the service it is supposed to provide. The role of EYPs in children's participation and promoting oral health will be discussed further in section 1.5.6.

1.5.4.1 The early years curriculum and play

Play is an integral theme in the current curriculum guidance across the UK and is considered invaluable to early years development and education (e.g. Department for Education and Skills 2014; Learning and Teaching Scotland 2010). Although a pedagogy for early years practitioners that enables learning through play has been encouraged, studies have shown that some practitioners have different understandings of play (McInnes et al., 2011) and in some instances unclear understandings of how to implement this in practice (Bennett et al., 1997; Moyles et al., 2002). Whilst practitioners understand and agree with this, many admit to a lack of knowledge regarding play and how play relates to pedagogy and therefore the reality of practice is somewhat different, with a mismatch between what practitioners say and what they do.

Play has also been highlighted to be important for health promotion (Alexander et al., 2012). An obvious benefit is physical activity but Ginsburg (2007) warns of neglecting the other key benefits of play such as adventure, creativity, pleasure, freedom, and risk taking. These characteristics of play have been recognised as important for the children's psychosocial health (Ginsburg, 2007; Gordon, 2009). We can see that the wider health benefits of playing

are indeed in line with the Ottawa Charters conception of health which gave value to experiences of pleasure and enjoyment as critical contributors to health. Both the UNCRC and UK policies on play have presented choice as a typical feature of play. Research has shown that children appreciate making choices and not having to adhere to a static structure (Kapasi and Gleave, 2009). There is nevertheless an increasing tension between the prescriptive national curriculum and play-based pedagogy. The challenges that early years professionals experience in enacting a structured curriculum yet providing children with space and freedom have been highlighted by many studies (Bodrova, 2008; Broadhead et al., 2010; File et al., 2012; Hedges and Cullen, 2012; Walsh et al., 2011). Some studies have explained the limitations on children's freedom from a structural perspective, pointing out that national policy, institutional policy, adult's roles, space, time and cultural expectations all work as constraints and shape the freedom that is afforded to children. Other studies, show that factors such as approaches to curriculum implementation (Wood, 2010) teachers' beliefs and values (Sherwood and Reifel, 2010) and approaches to discipline play a more significant role in allowing or limiting children's free choice (Millei, 2012).

1.5.4.1.1 Play and agency

Studies have shown an important distinction to play as compared to other activities children may take part in, for example fundamental to exercising their agency through play is the children's desire for play. Research has shown children want to play for the sake of playing and enjoying themselves (Søbstad 2004) this motivates them to learn and develop strategies of play and enactment of agency that are not available to them in other contexts (Markström and Halldén, 2009; Skånfors et al., 2009).

Recently, a complex conceptualisation of children's agency has been suggested through the combination of contemporary sociocultural and post-structural theories (Wood, 2014). This perspective takes into account the social, material and individual factors that affect children's understanding of the dynamics of power. Interestingly, although Wood and Corsaro conceptualise children's agency differently they both argue that children's play is a form of agency. Play displays them as social actors capable of shaping and interpreting their cultural

and social environment and social networks thus presenting themselves as meaning-givers (Corsaro, 2012; Wood, 2014).

When children play in groups it's been described as a "*complex orchestration of social, physical, cognitive, cultural, temporal and relational processes*"(Wood, 2014:14). Throughout these processes children practice individual and collective agency through shaping social power dynamics as well as relationships with their peers and adults. The process in which children understand how to apply and challenge modes of power is evident through the means in which they understand the regulation of play through understanding the value of rules, self-control, self-regulation and at times negotiation for play to happen. Other researchers have supported the link between play and agency; for example, Jans (2004) describes play as an extensive space for active agency, and points out its value in terms of children's citizenship. Markstrom and Hallden,(2009) illustrate how children exercise agency through negotiating with peers and with adults through challenging rules and/or boundaries. Other examples of children's expression of agency is through role play (Broadhead et al., 2010) playground games (Jarvis, 2007) and children's drawings. These studies argued that these particular forms of play activities allowed children to exercise imaginary power.

This is also in line with the argument made by Henricks (2010) who argues that through pretence children attempt to take some measure of control by constructing imaginary scenarios in which they decide their own roles and rules and in this constructed world of pretence they create their own logic and challenge adult defined limitations.

1.5.5 Early year practitioners

1.5.5.1 Pedagogy

Pedagogy may be defined as the 'the art of teaching' (McInnes et al., 2011), or simply 'any activity that promotes learning' (Stephen, 2006). Pedagogy in early years settings may be observed through the direct efforts of practitioners to promote learning and development which may vary from didactic interactions, interactions with children that support learning, such as, questioning, stimulating exploration, scaffolding and enriching a child's attitude towards learning. It also includes indirect efforts such as planning, observing and reflecting.

Some practitioners however, find it difficult to explain the ways in which they act to facilitate learning and it's been suggested that discussion about pedagogy is lacking amongst EYP's (Moyles et al., 2002; Stephen, 2010b). Furthermore, research suggest that a 'productive ambiguity' exists amongst teachers regarding what they need to accomplish which makes early childhood teaching not an easy task but on the other promotes a degree of flexibility (Blank, 2009; McInnes et al., 2011; Wood, 2004).

This lack of clarity also affects EYP's effectiveness in promoting health. As EYP's are in a unique position to promote the health and well-being of young children they are in effect part of the wider public health workforce. Therefore, it's essential that they are equipped with the knowledge, awareness, and skills required enabling them to be effective health promoters. However, there is little evidence of appropriate training being given that is required to enhance their contribution to promoting children's health (Dewhirst et al., 2013).

1.5.5.2 EYP skillset

Early years practitioners in the UK are in an exclusive position; there has traditionally been a divide between care and education and this can be seen in the various early years qualifications and forms of training. This has led to EYPs as neither belonging to the teacher community nor the social worker community; although they require a unique mix of the knowledge and skills of both professions in addition to others and as a result have been referred to as "*professional boundary crossers*" (Manning-Morton, 2006:50). The professional identity of EYP's is an ongoing disputed debate due to the differentiation between care and education; this has resulted in a concept of professionalism in which some areas of practitioner's expertise are valued more than others. Saks (1983) points out that this concept of professionalism is one in which knowledge is superior to skills, for instance a practitioner that is more knowledgeable in children's learning is valued more than one that is skilful in toilet training.

Manning-Morton (2006) argues however that this concept is problematic as it fails to recognise the importance of the skills required by EYPs. Education and knowledge are important but the art of care giving which is fundamental in the early years context should not take second place (Lally et al., 1995). According to Manning-Morton (2006) the professional

identity of EYPs should be promoted as ‘critically reflexive theoretical boundary crosser’ one who views children as autonomous active learners while appreciating their unique dependency and vulnerability. Acquiring the appropriate level of knowledge and skills to provide good practice requires more than training that is simply concerned with content and focuses on applying externally imposed frameworks. Manning-Morton (2006) emphasise that a training environment that is focused on processes as well as content is required for effective early years practice; she refers to this as a model of relationship-based learning in which self-knowledge and knowledge of the child develop over time in an environment of mutual respect. This is also relevant to promoting health in the nursery because EYP’s require both knowledge and skill to be motivated and confident in their ability in promoting health.

The Effective Provision of Pre-school Education (EPPE) is a longitudinal study (Sylva et al., 2004) which looked into early years education in England and found that settings that were categorised as high quality settings, defined through observational standard ratings scales, had practitioners with higher qualifications and that children’s progress was higher in these settings. Furthermore, it was found that children’s learning progress was enhanced in settings in which practitioners were responsive to the individual needs of children. Interestingly, the study also found that the most effective settings were those in which there was an equal balance of child initiated and adult initiated activities. Differences may exist not only from setting to setting but even within the setting, the nature of the adult-child interaction may differ greatly from one adult to another due to staff having different qualifications, training and levels of experience. We could suggest here that knowing the qualifications of staff within a nursery setting may be a vital starting point for health and oral health promotion teams in order to build more effective interventions.

It’s been argued that the role of the practitioner may be more important than the curriculum itself in children’s learning experience (Bowman et al., 2000). According to Bowman there are many important and significant factors that play a role in the child’s learning experience, such as adult-child relationships, socio-economic and cultural factors as well as the child’s own individual disposition. He argues that focusing solely on curriculum for a more effective setting is not the answer.

Parker (2013) in a report by the Institute for Public Policy Research on the evidence and policy regarding early years education describes how for research purposes the variables related to quality are normally defined as ‘structural’ and ‘process’ variables. Most research is based on examining structural variables as they are more readily measured. Examples of structural variables in childcare settings are: qualifications, group size, setting size and equipment, staff turnover, management and child-to-adult ratios. Process factors on the other hand are difficult to measure and focus on the manner in which the children experience the care provided to them. Examples of process variables: quality and nature of interactions and conversations, the variety of stimulating materials, and the manner in which activities are set up. It is however not a clean cut distinction between the two for example structural factors can serve as proxies for process factors. For example, Parker (2013) notes that children in settings with highly qualified staff are more likely to participate in developmental activities. Structural factors may also serve as a means of promoting quality process factors for example having a smaller adult-child ratio offers the opportunity for the adult to engage the children in conversation and responsive interactions and a smaller group size may encourage and allow a child to initiate their activity. The report concludes that high quality care is a mixture of both structural and process variables for instance; decreasing the number of children in the care of a low-performing practitioner does not guarantee an improvement in the child’s experience.

Another example is that despite children’s participation being eminent on the educational policy agenda, one study found that this was not necessarily translated into practice and that children’s participation was understood differently according to practitioner’s qualifications (Østrem et al., 2009). Considering children’s participation separate from other aspects of education and learning could lead to a skewed form of participation. This results in routines that actualise a narrow interpretation with a focus on self-determination and individual choice. Although there were exceptions, the study showed that some practitioners lacked the holistic and relational understanding of children’s participation as described in both international and national policy documents. This mismatch between actual practice and policy plays against the realisation of children’s participation that was envisioned in the UNCRC (Bae, 2010).

1.5.6 Participation from the early years education perspective

According to Penn (2009) the articles in the UNCRC must be contextualised in order to be realised in practice go through a constant process of interpretation which takes into account cultural, temporal, local and age-related factors. Within the UNCRC, articles 12 and 13 focus on the rights of children to participate in all matters of concern to them, both within the family and society. These articles state children's entitlement to expressing their own views on issues that concern them and impact on their daily lives, and that children's voices should be heard and respected. It does not however, allow children a general right to decide and/or have their decisions prevail. Children are to be given the necessary support and guidance by the adults in their lives when exercising their rights and decisions are to be made in a democratic way. This is important for child-health promotion as participation that enables children to voice their opinions and facilitates their development of social responsibility is an important factor in preventing psychosocial difficulties and in promoting child health and well-being and should thus be considered as a basic right and a prerequisite for promoting the health and well-being of children (DeWinter,1997). Thus, it is essential opportunities are made available for children to practice democratic principles (Lansdown, 1995). According to Sheridan and Samuelsson (2001) early years practitioners find facilitating children's participation through decision-making challenging as they do not fully understand what the limits of the child's right to participation in decision-making are, and the consequences of allowing young children decision-making roles and involving them in the process. Lansdown, explains however that it is through the process of being consulted that children can begin to understand how their decisions affect them and others, and it is through participation that children learn the skills required for democratic decision-making (Lansdown, 1995). This form of participation is considered to empower the child since it develops problem-defining and decision-making skills (Kalnins et al., 1992). This is viewed as a major source of child-health promotion as these skills are fundamental to making choices regarding their health (DeWinter, 1997).

In *Implementing child rights in early childhood (CRC/C/GC/7/Rev.1)* the UN Committee on the Rights of the Child provides a guide on the implementation of the articles of the UNCRC with a focus on young children. Within this document is an emphasis for,

“a shift away from traditional beliefs that regard early childhood mainly as a period for the socialization of the immature human being towards mature adult status is required. The Convention requires that children, including the very youngest children, be respected as persons in their own right” CRC/C/GC/7/rev1:3).

It offers an alternative view in understanding young children’s capacities and states that young children can,

“make choices and communicate their feelings, ideas, and wishes in numerous ways, long before they are able to communicate through the conventions of spoken or written language” (CRC/C/GC/7/rev1:7).

The UN committee points out that children have nonverbal forms of communication which must be respected such as, play, drawing, facial expressions and body language which very young children use to communicate their choices, desires and understanding.

1.5.6.1 Relational approach to participation

Bae (2010) describes the UN guidance as taking a relational approach in understanding children’s right to participation for it describes young children to be aware of and responsive to their social environment and that it is the nature of their interpersonal interactions which creates opportunities for their participation. This relational perspective of children’s participation has been supported by several researchers (Mannion, 2010, Kjørholt, 2008, Woodhead, 2008, Smith, 2007). The guidance document also highlights the need for the interpretation of the UNCRC to be holistic and have a broad perspective and caution against understanding children’s participation in isolation from other relevant rights mentioned in the UNCRC. Although the UN committee state that all provisions are related to Article 12 (respect for the views of the child) they make the distinction that some have particular relevance.

“Article 12, as a general principle, is linked to the other general principles of the Convention, such as article 2 (the right to non-discrimination), article 6 (the right to life, survival and development) and, in particular, is interdependent with article 3 (primary consideration of the best interests of the child). The article is also closely

linked with the articles related to civil rights and freedoms, particularly article 13 (their right to freedom of expression) and article 17 (the right to information)” (CRC/C/GC/12:15).

In addition to the above articles, article 31 ‘the right to play and leisure’ has been described by researchers as central to realising very young children’s participatory rights, (Alderson, 2008; Bae, 2010; Jans, 2004; Kjørholt, 2008; Smith, 2007) as studies have shown play as an important medium for children to exercise their right to participation and freedom of expression (Jans, 2004; Markström and Halldén, 2009; Wood, 2014). Alderson, (2008) describes article 31 as the most significant in relation to article 12 and 13 in the early years since play is a recognised medium through which children can freely show intentions and enjoy experiences and is what children value most in their preschool setting (Søbstad 2004). Not surprisingly, children have expressed play to be the part of their daily lives they most have influence over (Sheridan and Samuelsson, 2001). Based on these research findings play has been seen as an enactment of article 13-the right to freedom of expression (Bae, 2010) and thus play is considered an integral part for the realisation of children’s participation in the early years setting. As mentioned earlier, play is incorporated within the EYFS framework through the theme of learning through play with an emphasis on a resource rich environment and mediated learning.

Bae (2010) explains that taking on a holistic approach means working towards a balance of the different rights to serve in the best interests of the child. This relational and holistic approach to children’s participation values children as both group/community members and individuals and suggests that for meaningful participation to occur adults need to not only rethink how they view children but how they view themselves and their roles in children’s lives.

This approach differs however to a rights-based or political approach to children’s participation which considers participation predominantly in personal decision making processes and thus leads to more individualistic and narrow conceptualisations of child agency and child autonomy that focus on independence (Ghirotto and Mazzoni, 2013). Waldron (1988) highlights the importance of context when considering the rights based

approach to participation as this approach rejects forms of affection which are integral to the provision of care, for example in early years education. Furthermore, Ghirotto and Mazzoni (2013) adopt a 'social perspective approach' to participation (Thomas, 2007) which values inclusion, building networks, adult-child relationships and social connections. They argue that if children's participation is interpreted solely with an individualist bias this may lead to the loss of forming different social relationships that mediate the development of important social competences for example, cooperation, sense of belonging and sense of community. Thus, for contexts such as education where many relationships are based on trust and the provision of care careful consideration to the appropriateness of this approach must be given. For instance, from a rights based perspective, children's autonomy and agency conflict with adult protection and power (Masschelein and Quaghebeur, 2005; Roose and Bie, 2007).

In an education context however, where relationships are characterised by trust and kindness adults are seen to play a pivotal role in supporting the development of children's agency and autonomy through the care they provide (Ghirotto and Mazzoni, 2013). The debate between rights and care stems from the well-known scholarly debate, between Kohlberg and Gilligan who held different views on the role adult relationships played in a child's development (Gilligan, 1982) and proposed two opposing orientations to a child's development particularly their moral development, the 'justice orientation' and the 'care orientation'. The justice orientation views individuals as separate and relationships as either hierarchical or contractual in contrast to the care orientation which views the self and others as interdependent with relationships created and maintained by recognition and response (Gilligan, 1982). It is Gilligan's theory of care which supports the notion that children develop skills and capabilities as well as autonomy and agency within relational interactions with the adults in their lives such as parents and teachers. Psychological theories in child development such as Vygotsky's theory of 'zone of proximal development' and Corsaro's theory of 'interpretive reproduction' where "*children are not simply internalizing society and culture, but are also actively contributing to cultural production and change*" (Corsaro, 2000:92) have also emphasised the importance of taking a relational perspective in an educational context which values relationships as resources rather than hindrances.

The metaphors of narrow and spacious interactional patterns have been suggested as analytical tools in an attempt to unfold the processional flow and reciprocal nature of the interaction (Bae, 2012). Within spacious patterns of interaction a relational space is created in which the child's experiential world is recognised it provides opportunities for the child to share their thoughts, feelings and actions with the adult who actively participates for example either playfully and/or through the sharing of knowledge. The adult also accepts children's playful initiatives. Within narrow patterns of interaction the possibilities for the child's world to be recognised are limited for example due to an over emphasis on rules or asking closed questions and not being responsive. According to Bae (2009) adults can contribute to the opportunities available for young children to meaningfully participate through providing the following:

- following up on the child's initiative
- emotional responsiveness and expressivity
- an attitude of playfulness
- ability to shift perspective and take the child's point of view (Bae,2009: 400)

The adult therefore is a significant potential facilitator of children's participation and if children are to experience a genuine form of participation at a very early age, adults need to understand the value and impact of child-adult interactions; adults need to be willing to re-evaluate and reflect on their own views towards children's participation rights and be able to interpret and translate those rights in local settings (Bae, 2010).

As we can see the view of participation that exists in early years education is one that values relational interactions and places emphasis on the adult as the enabler of participation. This is important for health promotion as it places emphasis on the significant role of EYPs and recognises the child as a competent active agent and this has been argued to be an essential starting point for child health promotion (Kalnins et al., 1992).

1.5.6.2 Participation and reciprocal relationships in the nursery setting

In the previous section we have seen that there is an emphasis on the role of EYP's in enabling children's participation however how does that fit within the context of a nursery?

The characteristics of early years settings display tensions between the setting as an institution in which the children are part of a collective and the emphasis on children's individuality with an appreciation for free time, play and space. As members of the collective, children are expected to take part in pre-planned group activities that are scheduled on a highly organised timetable. The daily timetable lays out the pre-planned activities that will take place, at what specific time and at what specific place. According to, Markstrom and Hallden, "*routines and rules are part of the social and temporal order that characterises the institution, and also function as self-regulating*" (Markstrom and Hallden, 2009:115).

The day is mainly planned with the collective in mind and this significantly defines children's time and space. This focus on being part of the collective has been argued to have a restricting effect on children's individuality (Markstrom and Hallden, 2009) and thus nurseries have been described to offer a particular form of individualisation, referred to as institutionalised individualisation (Kampmann, 2004). This takes on the perspective that children's childhoods are shaped within institutions in addition to the child's individuality being advocated by the institution.

Previously, mentioned in section 1.4.2 scholarly discussions on children's participation within the sociology literature on childhood studies highlight differing views regarding the ambivalent nature of contemporary childhood. For example, some argue that it results in a tension between the increasing call for the need to be autonomous individuals and the protective environments in which children live their lives (Jans, 2004) whereas others argue that this ambivalence should be understood as a social concept appropriate to children growing up (James et al., 1998). Within the educational literature this understanding, of viewing care and autonomy as two polar factions has been seen as limiting (Ghirotto and Mazzoni, 2013) and the argument made by James et al. (1998) that they should be considered concurrently as a unique feature of children's experiences has been supported by Mortari (2009). According to Kj rholt (2008) children should be understood as being *both* competent and vulnerable and that only by acknowledging both as simultaneous experiences of children's lives can one begin to develop practice that is in their best interest.

Some researchers discussing children's participation within the education literature have highlighted the interdependent and reciprocal nature of adult-child relationships (Kjørholt, 2008; Mannion, 2010; Smith, 2007). Thus, from a care orientated perspective children's autonomy and agency is developed through relationships with adults using their power to support rather than hinder, and it is this relational perspective that conceptualises a form of child participation where child agency and autonomy are interdependent with adult power and protection (Ghirotto and Mazzoni, 2013). Therefore, the implementation of children's participatory rights, particularly articles 12 and 13 in practice challenges conventional schools of thought regarding adult-child relationships and requires redefining the role of adults who take care of children (Woodhead, 2005).

The national Norwegian policy for early childhood education depicts preschool as a space where children should be respected as individuals in their own right and express themselves freely. Their preschool experience should allow for the development of democratic relations, and provide possibilities for quality play-time. These are the values that Norwegian early year practitioners are expected to understand. Many Nordic qualitative studies have explored the relationship between practitioners and children within the nursery and have shown that the quality of relationships and interactions that children experienced was not consistent amongst institutions and practitioners (Emilson and Folkesson, 2006; Johansson, 2004; Sheridan and Samuelsson, 2001) The findings show that the relationships varied from those with sensitive and respectful interactions to those that had more unresponsive and dominating interactions. The variation in the type of relationships children experience with the adult practitioner suggests that there will be an unequal realisation of children's participation in daily practice (Bae, 2009).

Another Norwegian study evaluating the implementation of the national early years curriculum found that EYPs tended to take an individualistic approach in understanding children's participation and described it in terms of self-determination and individual choice (Østrem et al., 2009). This interpretation is however incomplete as it neglects the relational and collective dimensions conveyed by the UNCRC.

In a qualitative study which explored the quality aspects of pedagogical encounters through focusing on early years practitioners views of children and their learning, Johansson (2004) identified three themes:

- Atmosphere
- View of child
- View of learning

Atmosphere refers to the manner in which teachers interacted with children and the communication between them. It was also related to the effort the practitioner made to appreciate the child’s perspective. The view of the child represents how the practitioners regard children as human beings. The view of learning considered how the child’s learning was defined and structured. Each theme had 3 sub-themes which are illustrated in the following table.

Table 1. Early years practitioners views of children and learning

Atmosphere	View of child	View of learning
Interactive	Child as a fellow-being	Confidence in child’s capacity
Unstable	Adults know better	Awaiting child’s maturity
Controlling	Child is irrational	Punishment/reward

(Adapted from Johnasson, 2004)

Johansson found that each view of the child had a complementary view on a child’s learning. For those practitioners who viewed the child as a fellow being their view on learning was characterised by ‘*confidence in the child’s capacity*’, those that thought that adults know better interacted with children depending on their maturity in what Johansson describes as ‘*awaiting the child’s maturity*’. The third theme the child is irrational shows practitioner’s view of learning to be dominated by encouraging conformity from the child through various efforts and is described as ‘*punishment and reward*’ (Johansson, 2004:13). It could be argued

that for the purpose of promoting health the practitioner's view of learning depends on the practitioner's view of the competence of each child.

For example, the interactive atmosphere is accompanied by the theme 'child is a fellow-being' representing the practitioners personal view of the child and the theme 'confidence in the child's capacity' representing their view on the child's learning. The interactive atmosphere is characterised by practitioners having an active engagement with the child's experiences through sensitivity and proximity to their life-world. They make an effort to understand the child's intentions, needs and individuality. They also believe and treat the child as a competent individual and learner.

During the unstable atmosphere the practitioner may move back and forth from having a close interaction and a distant one, having positive and negative emotional expressions and varying levels of friendliness. The view of the child is based on the view that adults are superior and that they alone know what's best and the view of learning is related to beliefs on maturity. The controlling atmosphere is described as an atmosphere that hinders the child's experience; the child is viewed as irrational and that their behaviour can be moulded in ways that promote their learning. Johansson's findings provide empirical evidence that the manner in which practitioners understand childhood itself has an impact on children's daily affordances to participate on their own terms and thus has an impact on child health promotion. If we consider that the concept of childhood is undergoing a paradigmatic shift (James et al., 1998), where there is a growing recognition of children as agents rather than objects that can be shaped and formed according to planned agendas, the variations that exist amongst practitioners is regarded to be reasonable as both understandings of children and adult roles are in transition (Bae, 2009).

Although Johansson (2004) has argued that an adult will never truly have a child's perspective they must attempt to come close to it and this depends on the adult's capacity to understand a child's world. A distinction has been made by Sommer et al. (2010) in that a *child perspective* is the adults' outside perspective regarding children's perceptions, actions and conditions while keeping in mind what's best for the child. Child perspectives evolve from adults who purposely explore children's worlds to reconstruct children's perspectives as

realistically as possible. Whereas a *child's perspective* is the child's own perspective or understanding of their experiences and culture. This is what adults strive to understand through their construction of the child perspective. It's been suggested that a child's perspective is important for genuine participation (Ingrid, 2003). We could argue that without valuing children for who they are in the here and now whilst simultaneously appreciating that children are competent social actors then their perspectives cannot be analysed and represented. Emilson (2007) argued that the concepts of participation and a child's perspective are interdependent and in order to enable a child's participation they must come close to the child's perspective.

1.6 Oral health promotion

As discussed previously health promotion involves various complementary actions to promote health and well-being. Founded on these principles, oral health promotion has developed as the approach to managing oral diseases. The overarching principle of oral health promotion is to achieve sustainable improvements in oral health and reduce inequalities through a range of actions including targeted and population approaches to prevention.

One of the main concerns of oral health promotion is the prevention of dental caries. Although dental decay is largely preventable it remains a significant problem including young children; national figures revealed that 25% of 5 year olds had dental caries with an average of 3-4 teeth being decayed (PHE, 2016). The latest data for 3 year olds from 2013 found that 12% had dental caries with an average of 3 teeth being decayed (PHE, 2014).

The oral health of an individual affects them on many levels. This can be both physical and psychological for example, chewing, tasting, speaking, sleeping, aesthetic appearance and may influence how they grow, socialise and their feelings of well-being (Locker, 1997).

Poor oral health may lead to pain, discomfort, disfigurement, infections, and eating and sleep disruption as well as higher risk of hospitalisation, and in the case of children may lessen their capacity to learn as well as lead to loss of school days. This has a detrimental effect on the quality of life of the child and their family (Sheiham, 2005).

Despite being largely preventable, treating dental disease cost the NHS £3.4 billion in 2014 alone. Tooth extractions alone for children aged 5 and under cost the NHS approximately £7.8 million (PHE, 2017). Tackling dental decay in children also fits in with the wider public health agenda of reducing health inequalities and increasing social justice.

In order to improve children's oral health a whole systems approach as discussed previously in section 1.2.4 has been recommended in the latest national guidance (PHE, 2017). This emphasised the need for action at different levels across the sector such as national and local policy, in addition to working with other sectors and engaging stakeholders.

1.6.1 Promoting oral health in the nursery setting

Schools have long been seen as effective settings for accessing children and influencing their health choices (Hubley et al., 2013) and the World Health Organisation advocates using Health Promoting Schools to promote general and oral health (Kwan et al., 2005). This has been further extended to nursery and pre-school settings as research has shown that an early start to developing a healthy lifestyle is conducive to adult health (Wadsworth, 1997). Children develop patterns of behaviour through the process of socialisation that significantly shape their adult behaviour (Blinkhorn, 1980) and the pre-school years are a critical period for setting foundations for good oral health (Watt et al., 2001).

1.6.1.1 Toothbrushing clubs

The incidence and severity of tooth decay is reduced by daily application of fluoride toothpaste to teeth and it's been found that children living in deprived areas are less likely to brush their teeth the twice daily recommendation (PHE, 2017). Consequently, the NICE oral health guidance (National Institute for Health and Care Excellence, 2014) and Public Health England guidance (PHE, 2017) recommend targeted supervised tooth brushing schemes for nurseries and primary schools in deprived areas.

Across the UK, targeted supervised tooth brushing schemes have been introduced (PHE, 2016) these are often referred to as tooth-brushing clubs. Brushing each day at school or nursery over a 2 year period has been found to be effective in preventing caries and can help

establish life-long behaviours conducive to good oral health (PHE, 2017). However, the intervention should not be limited to the nursery or school setting but should promote and support tooth brushing in the home as well.

A study evaluating toothbrushing clubs found that the toothbrushing club was more successful when the members of staff involved embraced the concept of improving children's health alongside educational attainment (Woodall et al., 2014). This study also found that the nurseries had not formed strong partnerships with parents and this was something which should be improved. This was considered important so that oral health messages provided in the nursery setting may be reinforced in the home (ibid).

Currently, toothbrushing clubs within England are mainly targeted at high-risk populations such as those living in deprived areas. In Scotland however the toothbrushing scheme is part of a wider oral health promotion programme called Childsmile and operates on a national level (Macpherson, 2013).

1.6.1.2 Childsmile

Childsmile, a comprehensive nationwide programme in Scotland uses universal and targeted strategies to reduce inequalities and improve the oral health of children in Scotland (Macpherson et al., 2010). The programme has been designed with four components, Childsmile Core, Childsmile Practice Childsmile School and Childsmile Nursery. Childsmile Core distributes free toothbrush/toothpaste packs at least six times during the child's first five years. It also includes daily supervised toothbrushing by EYP's to all 3-4 year olds attending nursery. This is extended in disadvantaged areas for children attending Year 1 and Year 2.

Childsmile Practice has three main agendas, to establish and strengthen partnerships between primary care services and health visitor services; raise parental awareness; and to provide an enhanced programme of care within Primary Care Dental Services. Through health visitors, infants identified as high-risk for dental decay are referred to dental health support workers who then provide individual support for families, regarding oral health messages, dental services and accessing community activities that promote oral health. Childsmile nursery and Childsmile school delivers clinical preventive activities through primary care services within

nursery and primary schools in disadvantaged areas. Activities are focused on applying fluoride varnish twice a year and facilitating registration with a dentist. The programme has proved successful in reducing dental decay and oral health inequalities (Gibson et al., 2016; Anopa et al., 2014; Macpherson et al., 2013) as well as claiming to be cost effective (Anopa, 2015).

The literature explored in this chapter has demonstrated that public health and health promotion have historically been and continue to be inherently political. The different conceptual models of health have been discussed and critiqued. We have seen that health promotion advocates participation as a key tool for the implementation of the five components of the Ottawa Charter and the literature on participation highlights the need for children's participation. Despite this children's participation in oral health promotion remains unclear.

1.7 Rationale, aim and objectives

1.7.1 Rationale

The Ottawa Charter (1986) stressed the necessity for participation for health promotion and outlined it as a key guiding principle in enabling people in matters concerning their health (Rootman et al. 2001). Therefore, participation as a new perspective of child-health promotion is important. Helping children to articulate their opinions on their environment and stimulating them to develop social responsibility would appear to be crucial in the promotion of health and well-being.

Participation is also a key element the International CRC and should be at the core of every child health promotion programme allowing a bottom-up instead of a top-down approach. There is a growing body of work in dental research that has sought to increase the voices of children. This body of work seems to follow the broader agenda of increasing participation of citizens in issues to do with their health both in public health, health promotion and the research literature on children. But as we can see from the health and educational literature within this review there are different perspectives as to what participation means.

Toothbrushing clubs are a relatively new oral health intervention and very few studies exist, despite the pre-school years being recognised to be a critical period for setting the foundations for good oral health (Watt et al., 2001).

1.7.2 Aim

The aim of this study is to explore the dynamics and meaning of children's participation in oral health promotion (OHP) implemented in nurseries

1.7.3 Objectives

- Explore the ways in which children participate in the selected intervention
- Explore how the setting has an impact on participation
- Observe children's perspectives of the oral health promotion intervention

Chapter 2 Methodology

2.1 Overview

The aim of this study is to explore the dynamics and meaning of children's participation in oral health promotion (OHP). This section outlines why an ethnographic case study approach was adopted for exploring participation as a new perspective for children's oral health promotion. This is an exploratory study. An inherent characteristic of exploratory research is that the focus is initially broad and becomes progressively narrower as the research progresses (Adams and Schvaneveldt, 1991). A qualitative approach was chosen as it was the aim of this study to have a child-centred approach in understanding issues such as oral health, oral health promotion and participation to provide information from their perspective from within their world. This depth of exploration would not have been possible with quantitative methods.

Moreover, a qualitative approach allows for more flexibility and adaptation to a changing setting. This is particularly important for health promotion research which Eakin and Maclean (1992) argue involves the study of complex human behaviour in natural settings that cannot be controlled for scientific investigation. Raeburn (1992) argues that qualitative research gives value and scientific legitimacy to the subjective experiences of individuals. As the focus of this study will be on the perceptions and meanings attached to children's experience of participation regarding issues that concern their oral health a broad set of ethnographic principles are relevant. This includes the incorporation of unexpected information or events and analysing critical issues and events as they arise such as children not wanting to participate in the research, children who refuse or children who participate but seem to be bored of the relevant activity and may have lost interest. This includes the methods employed by relevant staff in the settings being explored that may be used to resolve possible challenging situations.

2.2 Research approaches

Although there are a range of methods available for working with children in oral health research (Marshman and Hall, 2008) these methods and techniques can only be applied within a broader methodological framework. Methodology is the study of the logic of scientific enquiry. It prepares the researcher's expectation of what they might see when they adopt a particular perspective. It is therefore important to consider in advance of undertaking a study the methodological stance that will be adopted and why.

There are several qualitative approaches which could be proposed for this study such as grounded theory, narrative, phenomenology, ethnography and case study. The grounded theory approach focuses on developing a theory based on data from the field; as it is not the aim of this study to develop a new theory regarding participation this approach will not be used. A narrative study explores the lived experiences of one or more individuals and a phenomenological study focuses on understanding the essence of a lived experience within a group of individuals and aims to describe the essence of that shared phenomena. This study is interested in exploring the dynamics of participation in a group of individuals rather than their past life experiences and thus neither of these approaches were considered as suitable. Furthermore, both the narrative and phenomenological approaches rely primarily on individual in-depth interviews for data collection and this was not deemed a suitable method of data collection for the target group in this study (Punch, 2002; Christensen and James, 2008).

2.3 Ethnography

Ethnography has proved to be vital in social research of children (James, 2001). Its main strength *"lies in the way in which, through close attention to the everyday and familiar through which the social world is both created and sustained, it has enabled the voices of those who would otherwise be silent to be heard."* (James, 2001: 255).

Ethnography draws from the disciplines of anthropology and sociology. Because ethnography originates in the discipline of anthropology, the concept of culture is of central importance.

Ethnography focuses on describing and interpreting a culture-sharing group, exploring their beliefs, behaviours and issues of social interaction (Creswell, 2007). The ethnographer participates and immerses themselves in the natural context rather than under specified conditions, staying with them in their own environment for a long time and uses primarily the research techniques of observation, field notes and interviews to collect data (ibid). The aim is to understand the particular group or culture through observer immersion into the group.

By observing things as they occur, a more accurate picture can be acquired and subtleties and things that the participants themselves are not aware of may be revealed which other methodologies may not be able to unveil. This is a particular strength of ethnographic research because it allows the researcher to explore in-depth the contextual dimensions that influence a social phenomenon. Ethnography focuses on natural, ordinary events therefore it is eminently suitable to study participation and allow a better understanding of the factors that enable or disable participation, providing a comprehensive perspective for the dynamics of participation as a process and for children’s behaviour. Miles and Huberman (1994:10) argue that ethnography “[...] is well suited for locating the meanings people place on the events, processes, and patterns of their lives”. Ethnography focuses on natural, ordinary events therefore it is suitable to study participation and facilitates insights into the factors that enable or disable participation; providing a comprehensive perspective for the dynamics of participation as a process.

2.3.1 Conducting ethnography

Ethnography is a social science research methodology that relies on fieldwork using multiple data collection methods (see figure 5).



Figure 5. Multiple data collection methods of ethnography

According to Wolcott (1999) the process of ethnographic research entails three aspects; description, themes and interpretation:

- An in-depth description of a culture-sharing group
- An analysis of identified themes
- An interpretation made by the researcher regarding the themes and their meaning and its applicability for generalisation regarding people's social life.

A case study develops an in-depth description and analysis and focuses on the exploration of a bounded system or a case or multiple cases over time through in-depth data collection. This is the preferred method when the researcher wants to include the contextual factors that may be relevant to the subject of study (Yin, 2003). Mason (2002) argues that case studies should and can result in explanations which are generalizable in some way and Yin (2009) supports that argument.

“...case studies, like experiments, are generalizable to theoretical propositions and not to populations or universes. In this sense, the case study, like the experiment, does not represent a sample, and, in doing a case study, your goal will be to expand and generalize theories (analytic generalization) and not to enumerate frequencies (statistical generalization)” (Yin, 2009:15).

As both the ethnographic and case study approaches appear to be valid for this study an ethnographic case study would appear to be the most appropriate methodology. An ethnographic case study is defined as *“prolonged observations over time in a natural setting within a bounded system”* (Angers and Machtmes, 2005:777). The reason behind combining these two approaches is that the observational method is useful in adding knowledge of another culture and the case study contributes to understanding the individual, group, organizational, social, political and related phenomena (Yin, 2003). This approach would therefore potentially allow for the exploration of actions and events for groups of children as they occur in their natural setting therefore providing a deeper understanding of the dynamics and meaning of children's participation in the specific oral health promotion programme.

2.4 Sampling

Qualitative research differs from quantitative research where generalisations are normally based on statistical sampling. Representativeness is a property of a sample and generalisability concerns the findings of the study. Silverman (2014) argues that statistical sampling allows for:

- confidence regarding the representativeness of the sample
- broader inferences about the whole population to be made

In qualitative research however, statistical sampling is generally unavailable. For example, if you were to increase the sample size for it to be representative it would prevent the intensive analysis that is desired in qualitative studies (Mason, 2002:91) Gobo (2008) points out the concerns regarding qualitative methods:

“Even though qualitative methods are now recognized in the methodological literature, they are still regarded with scepticism by some methodologists, mainly those with statistical training. One reason for this scepticism concerns whether qualitative research results can be generalized, which is doubted not only because they are derived from only a few cases, but also because even where a larger number is studied these are generally selected without observing the rigorous criteria of statistical sampling theory” (Gobo, 2007: 193).

Random sampling is also usually inappropriate in qualitative studies and instead non-random alternative sampling methods are used; such as theoretical, purposive and convenience sampling (Abrams, 2010; Marshall, 1996).

Theoretical sampling is more commonly used with grounded theory, in which sampling strategies are developed continuously according to the categories that arise during the process of data collection and analysis (Charmaz, 2006).

Through purposive sampling cases can be chosen because they demonstrate a process or characteristics that the researcher is interested in, this does not however, mean any sample case can be chosen. The parameters of the population of interest must be considered carefully and critically thought through before the case is chosen (Morse et al., 1994).

Convenience sampling is where cases are selected based on accessibility within the required time and cost limits set for the study.

A distinguishing feature of qualitative samples is its emergent nature meaning that strategies may change according to the researcher's reflections and data analysis during the study this then requires a level of flexibility in the research design. Also qualitative sampling is difficult to predetermine, as usually the researcher does not know when the data will reach theoretical saturation; in other words, further data collection does not add any further theoretical understanding (Abrams, 2010).

2.5 Participant observation

Participant observation is a type of data collection method used in qualitative research, particularly ethnographic studies. It is commonly associated with explanatory and exploratory research. It has been argued that it is more than just a method but rather a basic resource of all social research *"in a sense all social research is a form of participant observation, because we cannot study the social world without being part of it. From this point of view, participant observation is not a particular research technique but a model of being-in-the-world characteristic of researchers"* (Atkinson and Hammersley, 1994:249). It has been described as a natural feature of our daily lives; in various ways we observe the world around us and participate in it (Guest et al., 2012) the challenge however as a researcher is to, as much as possible, systemise and organise an inherently fluid process. This means in addition to being a social actor within a certain social scene to focus on the research objectives through selectively observing what is relevant to the research question, taking notes, and asking questions that help explain the hows and whys of human behaviour in a particular context. As a researcher, the participant observer is attempting to discover, understand and analyse aspects of social settings and how they operate. In any particular setting participants are bound by intrinsic rules and norms that they may be so familiar with that they act automatically and thus it is something that is difficult to articulate but may be observed (Guest et al., 2012).

As the research aim of this study is to explore the dynamics and meaning of children's participation in an oral health promotion programme, participant observation is a well suited method of data collection. By immersing oneself within a natural setting; a health promotion programme aimed at improving children's oral health, and observing the children's interactions with one another and staff would enable this research question to be explored. It also sensitises us to the fact that the setting within which the programme takes place will have an impact on how that programme will occur and that there will be underlying rules and norms to explore when making these observations. The process of teasing these out is often not very straightforward however, as we shall see.

2.5.1 Planning for participant observation

Before beginning participant observation, the researcher should consider a few points such as self-presentation both in terms of appearance and how the purpose of the study will be explained and to whom. Also, the researcher should decide what type of participant observer they will be.

Self-presentation

As a participant observer a choice must be made as how to present oneself and to whom. The degrees of self-revelation have been categorised into three degrees (Guest et al., 2012):

1. All participants know you are a researcher
2. Only some participants know you are a researcher
3. None of the participants know you are a researcher

Each degree of self-revelation has issues regarding ethics, consent and building rapport. For example, when all participants are aware and you are an overt researcher ethical issues are usually not problematic however, it may mean that building rapport will take longer or more difficult. Whereas, when none of the participants are aware there are likely to be many ethical issues although building rapport will be much more feasible.

Types of participant observation

Spradley, (1980:58) describes five types of participant observation:

1. Non-participatory: the researcher has no direct involvement with the actors for example in the study by Collet and Marsh (1974), who positioned a video recorder on a building overlooking Oxford Circus, London to observe pedestrians.
2. Passive participation: the researcher maintains a distance and is only a bystander.
3. Moderate participation: the majority of ethnographic studies are based on moderate participation where the researcher keeps a balance between assuming an outsider and insider role.
4. Active participation: the researcher becomes a member of the group and is not limited to participating marginally in the daily activities of the participants and becomes more involved and may learn or acquire skills from the group they are studying.
5. Complete participation: the researcher assumes a pre-established role prior to the study. This type has been criticised for having a high risk of losing all levels of objectivity (Schwartz and Schwartz, 1955).

2.6 Interviews

Interviews are a widely used research method in social research and there are many different types of interviews. An interview is basically a directed conversation (Lofland and Lofland, 2006). They are most commonly classified into three main categories based on the depth of the response that is desired by the researcher; these are structured, semi-structured, and unstructured interviews. A structured interview is usually in the form of a questionnaire or survey where the respondent is asked fixed questions and chooses from a choice of pre-selected answers. This method does not allow the researcher any space to probe deeper and explore the respondent's answers in contrast to the more flexible semi-structured and

unstructured interviews. These more flexible interviews have been referred to as qualitative, depth, in-depth interviews (Robson, 2002), intensive interviews (Charmaz and Belgrave, 2002). These allow for an in-depth exploration of the research question; the respondent has the freedom to express whatever they want about the topic with minimal prompting by the interviewer. The interviewer prompts the respondent in a manner that elicits their interpretation of their relevant experiences this insight into their personal experiences helps the researcher better understand the research topic. Although an interview is basically a conversation in the more flexible interviews it is the respondent who does most of the talking.

2.7 Documentary analysis

A further kind of data that is often looked at by ethnographers are documentary sources Hammersley and Atkinson (2007) suggest that within any given setting there are often sources of relevant documentation and for this reason they stress the importance of viewing contexts as having “*documentary constructions of reality*” (Hammersley and Atkinson, 2007:121). This means that the documentations that settings consume have a direct impact on the construction of social activities within that setting. Therefore, ethnographers need to consider relevant documents as part of the social setting under study as they can provide information about the setting or about the wider context.

2.8 Research techniques for research with children

There are a range of techniques that have been recommended for children such as drawing, storyboard, photos, vignettes, activity worksheets, questionnaires, and diaries (Marshman and Hall, 2008; Clark, 2006; Punch, 2002). Christensen and James (2008) have argued that allowing the child to engage in a task allows them to work in a manner that they are familiar with and offers a feeling of being in control; they are more at ease and may respond at their own pace. Punch (2002) also points out that task-based methods allows the child to initially interact with the paper rather than the researcher and thus may make the child more comfortable as the relationship between child and researcher develops. This is a young age group which poses particular challenges such as clarity of language and the power imbalance

must be kept in mind. Within this study, drawing, storyboard, vignettes and activity worksheets have been proposed as possible tools for data collection which have been suggested to be more appropriate for younger age groups (Punch, 2002)

Participant observation has also been suggested for young children (Fargas-Malet 2006; Clark, 2005; Smidt, 2002). However, this technique becomes less suitable for older children, as older children are more aware of the presence of observers and thus interviews become more appropriate (Dunn, 2005). An example of a study using participant observation is the 'Healthy Eating Project, (Mauthner, 1997). In this study, researchers observed children eating during mealtimes. During lunchtime they ate with the children and observed the foods children chose, how they chose them and what was actually eaten.

In addition to participant observation a range of techniques will be incorporated; this is to allow the data collection process to be interesting for the children as well as effective in generating data. Using a variety of techniques has a number of benefits which have been highlighted by Punch (2002) such as minimizing possible bias from focusing on one technique, allows for the triangulation of data, and satisfies varying preferences and competencies of the children. Through activities and reflective dialogue they will be asked to describe what oral health and participation mean to them. They will also be asked on whether they have been consulted regarding the toothbrushing club for example what could make it more appealing to them and what things they don't like about it. The discussions will be lead with a less directive approach by asking 'what' and 'how' do they feel about the objects of discussion avoiding 'why' questions which may make them feel defensive.

2.9 Methods of data analysis and ethnography

2.9.1 Inductive thematic analysis

Thematic Analysis is a type of qualitative analysis that identifies analyses, and reports patterns or themes within the data. It moves beyond focusing on explicit words or phrases and focuses on identifying both implicit and explicit ideas within the data. Data can be in any form including transcription of an interview, field notes, documents, pictures, and videos

(Guest et al., 2011). Similar recurrent ideas are grouped together under a theme. A theme represents important parts of the data in relation to the research question, and has some level of patterned response or meaning within the data set (Creswell, 2013). Adopting an inductive approach means the themes identified are strongly related to the data themselves. This means that the data is coded without attempting to fit it into a pre-existing coding frame and in this sense the analysis is data driven. There are generally six phases of the analysis; *familiarisation, generating initial codes, searching for themes, reviewing themes, defining and naming themes* and *writing up of the report* (Braun and Clarke, 2006).

2.10 Challenges and limitations of ethnography

Reflexivity

Reflexivity can be defined as the process of one constantly analysing and evaluating one's own actions (Abercrombie et al., 2006). It is an important part of ethnography (Hammersley and Atkinson, 2007) that necessitates an acknowledgement of the role of the researchers' particular standpoint plays in shaping the interpretation of events during fieldwork and what is 'selected' as data. A distinction between data and evidence has been made by Hammersley (2010) in which he describes interview transcripts and field notes from observations as data whereas the data selected to be part of the analysis process to address the aims of the research as evidence. Reflexivity involves the researcher being aware throughout the research process that both data and evidence are constructed according to the needs of the researcher, data is always collected for a particular purpose and interpreted from the particular standpoint of the researcher (James, 2012). Therefore the researcher aims to represent reality while acknowledging that their representation will always be from a particular perspective and thus there can be multiple valid representations, this has been referred to as 'subtle realism' (Hammersley, 1992:44).

Chapter 3 Materials and Methods

The aim of this study is to explore the dynamics and meaning of children's participation in an oral health promotion (OHP) programme implemented in nurseries. This chapter describes the process of addressing that aim. This section presents the process of sampling, methods used for data collection, challenges faced and the efforts carried out to overcome them and data analysis.

3.1 Overview

This was an ethnographic case study which involved participant observation of children and EYP's within 2 nursery settings as case studies and 6 semi-structured interviews with professionals. Observations occurred three times a week attending the full morning session over a span of 14 weeks in each nursery. Thus observations were made multiple times before, during and after toothbrushing clubs. Participant observation has traditionally been used for early years education research as a means of understanding young children's interests, abilities and needs (Smidt, 2002) and Elfer and Selleck, (1999) argue that the younger the age of the children the more important observation becomes. Furthermore, as discussed previously ethnography has proved to be vital in social research of children and it has enabled the voices their voices to be heard (James, 2001).

These observations were then followed up with 6 semi-structured interviews. These interviews were conducted for gaining a more in-depth understanding regarding the toothbrushing club and the personal views of the professionals. The interviews were conducted with 3 EYP's; one from each nursery and an additional Senior EYP who had worked in varying contexts and who came from a separate nursery was selected to balance out individual views. In addition, two local oral health promotion professionals and one dental care professional (DCP) involved in setting up toothbrushing clubs were interviewed. In addition to that, documentary analysis was employed as a tool to triangulate data from the interviews and observations. Data analysis was conducted using thematic analysis.

3.2 Sample

I'm going to begin by explaining how sampling developed. I was introduced to the manager of the local oral health promotion team (OHPT), via email, through a member of staff at the department within the dental school. Afterwards, I contacted the manager and a meeting was scheduled. In this meeting I explained the scope of the research to her and she shared with me what the OHPT were currently involved in. With this knowledge I discussed with my supervisors and a staff member who is involved with the OHPT, possible settings that could be explored in order to answer the research question whilst keeping in my mind the criteria suggested for sampling by Miles and Huberman (Miles and Huberman, 1994:34).

- 1. The sampling strategy should be relevant to the conceptual framework and questions addressed by the research;*
- 2. The sample should be likely to generate rich information on the type of phenomena which need to be studied;*
- 3. The sample should enhance the 'generalizability' of the findings (meaning a study's analytic boundaries, not population representation);*
- 4. The sample should produce believable descriptions and explanations;*
- 5. The sample should be ethical; and*
- 6. The sample should be feasible.*

The sample consisted of two nurseries as case-studies and 6 interviewees. As the data will not be collected from the entire population and statistical inferences are not the aim of this study but rather to gain a better understanding of complex human issues that need more personal in-depth analysis.

The nurseries were selected through purposive sampling. As this study is concerned with children's participation in an oral health promotion programme; nursery schools in South Yorkshire that had been running a toothbrushing club for at least a year and agreed to take part were approached.

Six semi-structured interviews were conducted for gaining a more in-depth understanding regarding the toothbrushing club and the personal views of the professionals. The interviewees were selected through purposive sampling which is a form of sampling that occurs throughout an inductive qualitative enquiry where the researcher reflects on settings, events and people contributing to answering the research question. The interviews were all conducted at the individual's place of work. It was decided that further sampling was unnecessary once reaching data saturation.

3.3 Procedure

3.3.1 Recruitment

Having chosen the research design and gained ethical approval from the University of Sheffield, I contacted the director of the OHPT and told her of the plan to use toothbrushing clubs within nurseries as a setting. She agreed and was glad as they themselves wanted to understand more about the toothbrushing clubs and its acceptability from the children's perspective. She advised that I contact a certain OHPT member who directly dealt with the toothbrushing clubs. I contacted her via email along with a copy of my protocol and all relevant information and consent sheets (Please see Appendix B-E) so she could better understand what the study was about. Afterwards, we arranged a meeting to discuss how to gain access to the nurseries. I was given a list of the nurseries that were running the toothbrushing scheme, in total there were 14 nurseries on the list and advised on which nurseries would be more receptive, based on her experience, to allowing a researcher attend and observe the toothbrushing club as well as the children in their care. At the end of the meeting the OHPT member expressed that the majority of the nurseries might not be very enthusiastic about having a researcher observing them and suggested that it may help if she contacted them directly and ask them as opposed to me approaching them.

Based on her experience with the nurseries she chose 5 nurseries to be contacted first. After a couple of days, she contacted me and explained that there were only 12 nurseries rather than 14 running the toothbrushing scheme due to budget cuts. Out of the nurseries contacted, two nurseries declined, one stated the reason being that they had had a recent arson attack; the

other nursery stated they were understaffed and had enough to deal with. The other three nurseries agreed, however one nursery when I contacted them to make arrangements to begin visiting explained that they were unsure if they were staying open as they had been given notice that they may be closing also due to budget cuts. To avoid the uncertainty of whether I would be able to spend the required time at this nursery I decided to leave it after I had finished with the other two nurseries. When I did contact them again they were still open however, I was then met with another challenge when I was told that the majority of the children were from the Roma community and neither they nor their parents understood or spoke English. The interpreter that normally worked for the nursery was on maternity leave and that the nursery was barely managing to communicate with them regarding basic matters. This meant that I had to find a Roma interpreter; this was an obstacle as my research funding did not cover the costs of a professional interpreter. I was also told that even if I did manage to find an interpreter it would be challenging to get the parent's consent, they would be sceptical to someone coming to observe the children due to their particular background they may perceive their children to be targeted. As a result of the above ethical, moral and pragmatic reasons it was considered not feasible to access the toothbrushing club within this nursery. This left two nurseries that agreed to allow me into their toothbrushing club; they will be referred to as Rainbow Ways Nursery and Crayon Town Nursery.

3.3.2 Gaining access

3.3.2.1 Gatekeepers Rainbow Ways nursery

The OHPT member who I was in contact with and had previously contacted the nurseries to ask if they would be willing to allow me in, contacted me to say she was going to visit Rainbow Ways and offered to introduce me personally to the nursery manager. The nursery staff appeared to have an open and trusting relationship with the OHPT member, and I felt that as a result of her introduction I was warmly welcomed into the nursery. I had a chat with the nursery manager about the research what it was about and what it would involve, she was very enthusiastic and eager to know more and expressed that they were happy to help in research that has potential benefits to children's oral health.

3.3.2.2 Gatekeepers Crayon Town nursery

When I phoned to arrange my first visit to the nursery, I explained who I was and who had previously contacted them on my behalf. I explained that I was calling to arrange a date for my first visit based on the understanding that they were willing to allow me in. I was told that the nursery manager was off sick and she would call back upon her return. When a week passed I decided to call again and was told she was back but was busy and to phone again the next day, but the following day she was also busy. I asked many times when would be the best time to call but was told to simply keep trying, and so I did. Each time getting a different response, I started to wonder if they had changed their mind and after some more attempts I finally managed to speak with the nursery manager. After I had introduced myself she asked many questions as to why exactly I was there. She also wanted to understand why I had to make so many visits; she said that she had initially agreed when the OHPT contacted her because she was under the impression that it was merely one visit. I explained to her the aim of the research and the value and need of observing the children over a period of time, although she did in the end agree I couldn't help feel her reluctance in allowing me into the nursery. We set a date and time for my first visit. On that visit the nursery manager came and greeted me at the main entrance door and asked for my Disclosure and Barring certificate as soon as my first foot walked through the door and explained all the security precautions that a visitor had to take, such as signing in and out of the building. As she showed me around the nursery she asked "*What exactly does the OHPT want to know from you being here?*" I explained again that I was an independent research student and this was not in collaboration with the OHPT, she didn't seem convinced and over the days I spent at the nursery I felt that she was suspicious of my presence. On many occasions she would explain things that went on in the nursery in a defensive manner, justifying it by either lack of resources or that it wasn't an OFSTED requirement. Gaining access is a common challenge in ethnography and something that ethnographers should anticipate (Feldman, 2003; Hammersley and Atkinson, 2007).

I couldn't help notice the difference between the two nurseries in their acceptance of me. In Rainbow Ways I felt that the being introduced by the OHPT made them more trusting towards me whereas in Crayon Town I felt it made her feel I was there to report back to the

OHPT and this made her uncomfortable. That being said, I'll never know if she would have even considered speaking to me had she not been contacted by the OHPT.

3.3.3 First visit

Emerson discusses different approaches to participant observation and field-notes (Emerson et al., 2001) and after consideration I decided that I would collect my data from one toothbrushing club at a time and then move on to the next rather than do them simultaneously. This was done in order to allow time between the visits to rewrite field notes in more detail, reflect on what I had observed make notes on my interpretations and initial stages of analysis to be done. My data collection began in Rainbow Ways Nursery. On my first visit I had taken with me the parent information sheets, parent consent forms, child information sheets and child assent forms (See Appendix B-E) placed in an envelope. I was introduced to the children by the nursery manager, who explained to the children who I was and why I was there. After a few minutes, I then left the room with the nursery manager. I then discussed with her what would be the most suitable way of contacting the parents in order to gain consent, as the children would only be approached for their assent once the parents had agreed. She advised that the best time would be at home time. Over three visits I waited for parents at home time, with one of the EYP's by my side, as they were either on their way in or out of the nursery. I introduced myself and asked if I could speak to them. Some parents would stop and give me the opportunity to explain what I was doing there, take the envelope and say bye. Some parents were more interested and began to chat about how they felt about the toothbrushing at nursery, once they knew that I was interested in it. Whereas, some parents appeared to be either in a hurry or didn't seem interested and so I was unable to speak to them. When I mentioned that I'd come back next week to try to speak with the parents that I hadn't managed to, a senior EYP offered to give them the envelopes herself as in her opinion these were the parents that may not be interested or want to be approached. After 2 weeks all of the consent forms had been returned, this did of course require me to remind the staff to remind the parents.

I was now ready to begin observing. Interestingly, I had set out to access the toothbrushing club but on my first day as a participant observer actually, I observed the toothbrushing

activity was over in about five minutes and I thought “is that it?” and I was concerned about how I would achieve the aim of my study if I was to stay and observe for just five minutes. I went away anxious and began to reflect on what I had seen and how the research aim could be addressed. I sought guidance from my supervisors who were experienced qualitative researchers, through discussions with them I was able to take a step back and look at the bigger picture and realised that the social world of the toothbrushing club was embedded within a bigger social world, that of the nursery. This realisation developed my increasing understanding that the sample was now the nursery as a social setting and not just the period of time that I was observing the toothbrushing club. This now meant that my observations would have to be much wider and that I would be required to stay and observe the whole session rather than just the time when children brush. This is an example of the flexibility in design that is sometimes required in ethnography and the required adaptation and responsiveness to the circumstances and issues of real life social settings. As Hammersley and Atkinson point out “*after all, a particular virtue of ethnographic research is that it remain flexible and responsive to local circumstances*” (Hammersley and Atkinson, 2007: x).

3.3.4 Building rapport

While I was in the nursery I would attempt to not stand out, I wore very casual clothes and had nothing in my hands for example a pen or notebook. When the children were sitting around tables I would sit on a table if they were sitting on the floor I would sit on the floor. Initially, I made no attempt to interact with the children giving them time to get used to my presence and giving myself time to observe the setting and chat with staff. As I felt it was equally important for staff to be comfortable with my presence. I also felt it was more likely for the children to accept my presence if they saw and felt that staff were comfortable. After a few visits, some of the children began to smile at me and make eye contact, some of them even began to greet me by name and say “good morning”. It is these children that I would sit next to as they played waiting for them to invite me to play with them, which after a few occasions they did. At this stage the children were happy to play with me but not necessarily chat with me, some of the children would suddenly include me in a game or activity they were doing where others would just take my hand and say “*will you read me a story?*” or

“do you want to play shop? I’m shopkeeper!” While we were playing, I attempted to start a conversation with them for example about what games they liked to play or their favourite toys most of the time I received no response so I gained insight into their world that playing was one thing and chatting was another. I continued to play with those that wanted to play and attempted to involve myself with the children that did not approach me. If I felt in any way, I was making the child uncomfortable I would praise whatever it was they were doing and move somewhere else. Some playtimes however, if a child did not approach me I would not attempt to play with any of them, instead taking the opportunity to observe.

Eventually, I reached a stage where some children were greeting me with hugs; others arguing who would sit next to me and at story time some of the girls would just come and sit in my lap. Yet when I would I ask them a direct question the response would either be a smile that appeared genuine or an answer that had nothing to do with what I had asked, but something they wanted to talk about instead. My insight as to the issues of working with very young children developed rapidly as a result and I began to rethink my data collection methods.

3.4 Data collection

3.4.1 Participant observation

Participant observation has traditionally been used for early years education research as a means of understanding young children’s interests, abilities and needs (Smidt, 2002; Clark, 2005) and Elfer and Selleck (1999) argue that the younger the age of the children the more important observation becomes. Clark (2001) points out that observation can inform other methods. In this study, as a result of my observations I was able to change my method of collecting data from the children to one which suited their interests, capabilities and setting this will be described in section 3.6.

Observations occurred three times a week attending the full morning session over a span of 14 weeks in each nursery. Thus observations were made multiple times before, during and after toothbrushing clubs.

My observations included things such as the physical setting that the toothbrushing club was conducted in, for example what type of room was it, small, large, bland or colourful? What was the lighting like, was it bright and airy, did it feel dark, cramped and oppressive? Did it look clean, were the floors in good condition, did it look tidy or cluttered? I also thought about the outside of the nurseries and noted my first impressions. During my observations I focused on the manner in which the children participate or do not participate in the toothbrushing club, their interactions with each other as well as with those running the club. Other points I looked was whether or not issues of socializing children come up such as teaching children about sharing, consideration for others, possibly even general hygiene? Were the children grouped together or allowed to brush individually? What type of toothpaste and toothbrushes did the children have? Is the toothbrushing club run in an authoritarian manner or is it more playful? Did they have the choice to choose to participate or not? Did they appear to enjoy being part of the toothbrushing club? Did they appear express an interest/ lack of interest in learning about their oral health for example, expressing they were excited or bored. I noted the children's reactions towards objects such as their toothbrush and their toothpaste and what opinions they expressed if any. In this study I assumed different levels of participation depending on the situation, at times I was a passive participant and at times a moderate participant which allowed for a good extent of involvement to build rapport yet maintain a level of detachment (Schwartz and Schwartz, 1955) as discussed in the previous next section on building rapport.

3.4.2 Field notes

Notes from participant observation are called field notes, they are accounts describing experiences and observations made during a session and they are usually written directly into a fieldwork journal. In order to improve reliability and help systemise field notes as suggested by Spradley (1980) separate sets of notes were made.

These were in the form of:

- Short notes made at the time
- Notes later elaborated as soon as possible after each observation session

- Notes taken regarding any ideas or problems that arise during each stage of fieldwork
- Preliminary notes on any interpretation and analysis

While I was at the nursery I would quickly jot notes down in shorthand on a piece of paper I kept in my pocket. I would do this at times I felt neither the staff nor children would notice so as to not make either of them uncomfortable or give them the feeling that their actions or conversations were being scrutinized. In addition to taking these short notes I would record my observations on a tape recorder as soon as I left the nursery. I used this tactic to record any observations I did not have the chance to write down and also to explain in more detail what I had observed and any interpretations I had. Also if I had overheard a conversation I would try and find somewhere that I would not be seen or heard and record it as soon as I could, which was usually the playground or toilets. In addition to recording events and informal conversations, I paid attention to other information that was relevant such as the general environment, interactions among participants and the atmosphere (Mack et al., 2005).

The notes together with the audio recordings were then expanded into a written descriptive narrative of objective observations, usually the next day. These descriptive notes included the physical setting, accounts of particular events as well as demographic information regarding the time, date and place of the setting. In addition to that a diary of my own reflective process, experiences, ideas and process of analysis throughout the study was kept. Any personal comments and interpretations were written in a separate section so as to not confuse one with the other and to enable a later reflection on my interpretations regarding what had been observed. As part of expanding my field notes I also wrote down questions about participant responses that needed follow-up as well as issues that arose that may need further consideration.

Hammersley and Atkinson (2007) argue that field notes are always selective; this is a result of the participant observer not being able to capture everything and having to make decisions about what to focus on. A nursery room full of children is a busy place and many interactions are going on at once and I found on many occasions that I had to decide on where to look and what to listen to, this was often frustrating as I wanted to see everything and hear all the conversations that were going on but this of course was not possible and I felt that there was a

constant trade-off between breadth of focus and detail which has been described to be an inherent characteristic of ethnography (Hammersley and Atkinson, 2007).

The field notes also included accounts of **informal conversations** that I had directly with the children and staff or conversations that I had overheard as suggested by Spradley, (1980). This did not pose an ethical issue as the children and staff were fully aware that I could hear them.

3.4.3 Interviews

Understanding the EYP's and OHP professionals' perspectives was integral to understanding the context of the toothbrushing club. This allowed the voices of the professionals that worked directly with the children to be heard as they were a key element in children's experience of participation in the toothbrushing club. Therefore, in order to overcome the challenge of not fully understanding the context or why things are done in a certain way, interviews and documentary analysis were also conducted to add more depth in an attempt to overcome this challenge.

I contacted the nursery practitioners and oral health professionals to arrange interviews. I contacted each individual by phone and asked if they would be interested and if I could email them an interviewee information sheet and consent form to which they all agreed, however the nursery manager of Crayon Town once again was difficult to get a hold of and convince to take part. After many attempts to reach her I left a message and asked if she could give me no more than five minutes in which I would explain to her the importance of her contribution. Upon calling back, I was finally put through to her and on making clear the intentions of the interview and that it was *her* voice, *her* opinion of the toothbrushing club that I was interested in all the while emphasising that I wasn't there to judge, just to understand she finally agreed.

Six semi-structured interviews were conducted for gaining a more in-depth understanding regarding the toothbrushing club and the personal views of the professionals. This was chosen to enable a focused and in-depth exploration of topics. An interview guide was prepared before the interviews with some possible open-ended questions around the topic

area, this provided some focus allowing a degree of freedom and adaptability in getting the information from the interviewee.

Three EYP's were interviewed; one from each nursery and an additional Senior EYP who had worked in varying contexts and who came from a separate nursery was selected to balance out individual views. In addition, two oral health promotion professionals and one dental care professional (DCP) involved in setting up toothbrushing clubs were interviewed. Each interview lasted between 45-60 minutes and they were all conducted on an individual basis. The EYP's were interviewed at the nursery whereas because of time limitations and geographical constraints, the additional EYP was interviewed over the phone. As for the OHP professionals and DCP they were all interviewed at their place of work. The interviews were recorded and then transcribed verbatim and stored securely. Recordings were deleted after transcription was completed.

3.4.4 Documentary analysis

Any documents that appeared potentially relevant from either observations or interviews were searched for or requested. These included the oral health promotion strategy for the local area, the guidance that was provided to the nursery by the OHPT, and the national early years curriculum.

3.5 Data analysis

Inductive thematic analysis was used to make sense of the data. A rigorous and systematic reading and coding of the transcripts, field notes of the observations and relevant documents allowed themes to emerge. Each stage of this process was discussed with 2 experienced qualitative research academics JO and BJ.

The analysis involved the following stages:

1. Familiarisation: I spent several weeks reading and re-reading through all of my field notes, interview transcripts and documents. This process included taking notes of my first impressions while reading through the data.

2. **Generating initial codes:** Once I felt I was familiar with the data I began to search for meanings and features of the data that appeared relevant to the research question. Several codes were developed and used to provide an indication of the context of the data extract (see Appendix H). All data extracts with the same code were then collated together. The data was thus reduced and organised into meaningful sections.
3. **Searching for themes:** This process began after all the data was initially coded and collated with a resulting list of codes identified across the data sets. Collated codes were then analysed to form overarching themes. Different codes were sorted, either combined or separated, into potential themes (for further examples see Appendix I).
4. **Reviewing themes:** Themes were reviewed to ascertain whether the data within each theme was meaningful and that the themes were distinct from one another. Themes were also reviewed to check if any of the themes should be combined, separated, refined or removed. This was done in 2 stages. In the first stage themes were checked in relation to the coded extracts. In the second stage the entire data set was re-read and themes were checked. This was done for 2 reasons. To ensure the themes matched the data extracts and to code any additional data within themes that may have been missed in earlier coding stages.
5. **Defining and naming themes:** Up until this stage themes were given working titles. This stage involved refining the theme names to accurately represent the essence of each theme. These refined theme names were then used in the final write up of the analysis.
6. **Writing-up of the report:** Data analysis within ethnography is an iterative process. Data collection was considered to be sufficient as a result of reaching data saturation (no new themes emerged from the data) and no further interviews or observations were conducted. I then began to write an analytic narrative of the story of the data in relation to children's participation in the toothbrushing club.

3.6 Ethics

3.6.1 Ethical considerations for research with children

Ethical considerations are part of all aspects of research but are particularly salient in research involving children and young people (Punch, 2002). As this study concerned very young children any ethical issues were given top priority and thus anyone involved was informed that I was a researcher; including the oral health professionals, nursery staff, carers/parents of the children and children. They were all made aware of my purpose of being there. Considering the children may not fully grasp what being a researcher meant this was broken down in simpler terms and they were told I was there to watch them brush their teeth. This was done through the information sheet given to them along with their assent forms, by nursery staff when introducing me and when I introduced myself to them (see Appendix B, C). Even then there were children who came up to me and directly asked “*why are you here?*” I would explain to them that I wanted to watch their toothbrushing club as not all nurseries had toothbrushing clubs.

The important areas outlined by Alderson and Morrow (2004) in research with children, were considered. These include the purpose and risks of the research, confidentiality, recruitment, information to children and parents, consent, and dissemination.

- Purpose: The purpose of the research is to translate what child participation may look like in an OHP initiative.
- Risks of the research: This study was not concerned with sensitive issues that may harm or embarrass the child and they were not in any way obliged to participate. The children were given information and assent sheets and the purpose of my presence was explained to them verbally and that by choosing to not participate this will not be held against them in any way, or it did not matter if they said they did not want to take part. If they did decide to take part they were free to change their mind and withdraw at any time they pleased and this would not have any repercussions (or no-one would be cross if they changed their mind). As I was observing the whole nursery class, children who did not agree were not going to be approached to take part in any

activities or talked to unless they decided to talk to me. I was aware of the power imbalance in the relationship with the children and that they may find it difficult to disagree or say things which they perceive as unacceptable, therefore I avoided putting the child in any situation that they may find uncomfortable. This was done based on taking the advice of staff members and having what has been referred to as an ‘ethical radar’ (Skånfors, 2009) who argues that simply applying the research-ethical principles is not enough and having an ‘ethical radar’ is also important in research with children. This concept places value to ethical conduct during the research process and that researchers have to be attentive to children’s actions and reactions towards the researcher, whether explicit or implicit for example facial expressions and body gestures that may indicate that the child is uncomfortable.

- Confidentiality: Confidentiality is ensured through anonymity. All individuals mentioned were given a pseudonym
- Recruitment: Children and their parents had the option to opt-in rather than opt-out
- Information for children, parents/carers: Information sheets were provided that were age appropriate using lay language that described in detail the purpose of the study and what the potential participants would be involved in.
- Consent: Consent forms were given to the parents/carers to sign if they agreed to their child being involved in the study.
- Dissemination: At the end of the study, I plan on contacting the nurseries to explain the findings of the study to them, discuss what they think about the findings, say goodbye and thank them for participating.

3.6.2 Ethical considerations with ethnography

In addition to reflexivity, which has been previously discussed, an ethnographer must also consider issues of representation. A common unfounded assumption is that the resulting research text should present an objective, value-free, and accurate representation of the participants whereby excluding the researcher’s involvement in the study (Mantzoukas, 2004). Guba and Lincoln (1994) point out that what is in fact represented by the research text

is the way in which the researcher has conceptualised the production of knowledge based on their beliefs and understanding of truth and knowledge. From my own experience from this study, I must admit that although I had read the literature extensively to prepare me for qualitative research and the issues involved it hadn't prepared me for the following example that I will now share with you.

When it came time to write about Crayon Town nursery, my field notes described a rather chaotic scene and my personal notes described how I felt while I was there and the overall atmosphere that I sensed. After writing my description of the nursery based on my field notes and personal notes, I remembered that I had asked for permission from the nursery manager to take a photo of the room when no one was inside it and she had agreed. I explained that it was not going to be used in any way as to avoid identifying the nursery. When I looked at the photo it seemed different. It appeared slightly brighter and a bit more cheerful than the visual image that existed in my mind. I saw coloured alphabets high on the wall and some colourful animal photos that I had not seen before and was not in my notes. I found the difference in the two images the one in the photo and the one that existed in my head rather puzzling and began to carefully reflect on why. I came to the conclusion that the photo was a representation of physical matter; however my image was constructed as a result of the existing physical objects in addition to the atmosphere and my feelings while I was there. The photo was not able to represent or describe what only I could describe by being physically there, nonetheless it was my perception. The photo also proves that as an observer it is difficult to observe and document everything particularly in a busy setting, as I had never seen the room empty except in the few seconds in which I took the photo. This highlighted to me the importance of accurate representation in ethnography and the responsibility of the researcher to acknowledge their role in presenting the findings of the study and representing the social world of the participants with care and sensitivity.

3.7 Challenges and limitations of research with children

Previously the importance of reflexivity in ethnography has been discussed in section chapter 2, it is also essential for research with children. In this study children were viewed as active

agents rather than passive subjects. At the onset of this study I had read the literature and understood that frequently when working with children one had to be creative in the methods one used to obtain data from them and that the younger the child the more challenging the research situation became (Christensen and James, 2008; Clark, 2005; Marshman and Hall, 2008; Punch, 2002).

I was aware that this was a young age group and they posed particular challenges such as clarity of language and that the power imbalance between myself and the child must be kept at the front of my mind. Therefore, I had proposed for the sake of this study a plurality of methods; drawing, storyboard, vignettes and activity worksheets as possible tools for data collection which have been suggested to be more appropriate for younger age groups (Punch, 2002) mentioned previously in section 2.8. To my frustration, I began to realise that none of these would be possible, for a number of reasons which I will proceed to explain.

As I observed the children's daily activities in the nursery I noticed that any learning was based on playing and story-telling. There were no activity worksheets or even individual task-based activities that required the child to draw or colour. The children were given the choice of what to do and play during playtime and when it wasn't playtime they would recite numbers and/or alphabets out loud as a group. This was done verbally and not in writing. I felt that if I were to introduce a method that they were not accustomed to they may not want to take part. There was also the issue of getting staff to help in something that they didn't normally do. I decided to ask staff members for their advice on how best I could obtain the information I needed; they were not keen on drawings or individual task-based activities saying that the children would find it awkward. They thought many of the children were comfortable with me and maybe with a little more time I could try to talk to a group of the more vocal ones. So I decided to continue with my efforts of talking to the children about their teeth and how they felt about toothbrushing club while we played, although I felt that this approach wasn't working.

I realized it was time to thoroughly think this through and reflect on what the best method was in this situation to hear what the children had to say. From my observations, I recalled that the most discussion from the children regarding things outside of nursery was when they

all sat as a group and a staff member would begin talking to them and asking questions. For example, after half-term the nursery leader asked if anyone had been on holiday, at first there wasn't that much response, but once one or two children started speaking and interacting with the staff members the majority seemed to want to talk. Before long, they all had their hands up in the air or were shouting in order to be heard. The other time that children were vocal was during story time. I frequently observed that in many instances, children would hear a certain part of a story and say "oh, that's just like when ..." or "yeah that happened to me once" or "our neighbour's dog looks just like that.". I realized that the children were far more comfortable speaking when they were part of a group and this had a snowball effect encouraging others to speak. I witnessed how the stories helped them identify with each other and share their experiences. I discussed this observation with the staff members and we decided to choose stories that allowed the topic of teeth and toothbrushing to be brought up. We hoped that this would allow the children to talk about 'the story' while I and members of staff would ask questions that would encourage them to talk a little more. I hoped that I would hear their opinions of tooth brushes, toothpaste and how they felt about brushing in general. I also wanted to find out more of what they knew regarding taking care of their teeth. An EYP suggested the book *Dirty Bertie*. It was a story that they used as a tool to discuss issues of personal hygiene with the children and the children enjoyed it as they liked to shout out a repetitive phrase that occurred in the book "No Bertie, that's dirty!" The book presented different acts that Bertie would do such as eat off the floor, pick his nose, lick the dog or wee on the garden bed each time being told by a family member "No Bertie, that's dirty!" The EYP and I had agreed that as she read the story to the children that when she reached the part of where the family member scolded Bertie that I ask the children for example "so what did dad say?" or "what did gran think of that?" to which they all excitedly and shouted the same phrase "No Bertie, that's dirty!". This was a way for the children to get used to me being part of some their activities and be able to ask them questions *through* the story rather than directly. After the story was over I asked the children what they thought Bertie did in the morning after waking up. The following is a recollection of the conversation written down immediately afterwards.

Lucas: I bet he doesn't wash his hands!

Billy: (laughing) Wees in the bathtub!

Kate: (laughing) Stinky feet

Carla: (laughing) has smelly breath

Me: Why do you think that?

Lily: Cause it's Bertie!

Joshua: Smelly breath cause he eats worms!

Sophie: doesn't brush his teeth!

Me: Do you think Bertie should brush his teeth?

Many of the children shout: Yes!

Me: Why?

Megan: Then his teeth won't fall out

Sophie: Or have stinky mouth

Ian: His teeth will be ugly

Me: What would help Bertie to brush his teeth?

Ellie: Tell him "No Bertie, that's dirty!"

Ian: His mum

Lisa: Bertie doesn't listen to his mum (laughing)

Ian: If she stays with him like mine does he'd like it

Me: So you like brushing at home, do you like brushing here at nursery?

Children shout: Yes!

Kylie: Oh yeah they could get Bertie to brush at nursery like we do!

This approach was successful because finally the children were talking and once they got started the majority of them wanted to join in and share their views.

Being a mother of young children I feel this worked to my advantage in being able to communicate and understand some of the children's non-verbal expressions it also helped in understanding some of the demands on the EYP's. I feel that my experience as a mother made me more appreciative of the efforts of the EYP's. I am also a dentist and thus have my own values of oral health.

3.8 Validity and reliability

Most of the criteria developed for evaluating the quality of research are rooted in the quantitative tradition (Bryman, 2001). Unlike quantitative research where validity may simply be described as 'does it measure what it says it does?' and reliability as 'are the results repeatable?' Within qualitative research validity has been defined as "the extent to which an account accurately represents the social phenomena to which it refers" (Hammersley, 1990:57). Whereas reliability refers to the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions (Hammersley, 1992:67).

Verification in qualitative research helps further to ensure rigour, this refers to the strategies employed throughout the process of research of checking and making sure that the research question, literature, sample, data collection methods and analysis are in harmony; thus going through an iterative process of moving between research design and implementation to incrementally contribute to ensuring reliability and validity and rigor of a study (Morse et al., 2002). Data was checked repeatedly and systematically maintaining a focus of the research question, and analysis and interpretation were checked and confirmed continually throughout the study.

In addition to verification the following strategies were applied to ensure validity and reliability:

- Spending a prolonged time in the field. Allowing time for the researcher to better understand the setting and social context and an opportunity to build a relationship

with the individuals involved potentially facilitating more in-depth understanding and better interpretation of the phenomenon being studied (Creswell, 2013).

- Member checking: Interviewees were asked to verify if the researcher's interpretation of their perceptions and meanings are accurate (Creswell, 2013)
- Provision of a rich, thick, detailed description (Geertz, 1973)
- Data triangulation: examining data related to the same concept from participant observation, interviewing and documents (Hammersley and Atkinson, 2007)
- Peer debriefing: the research process was reviewed by two experienced qualitative researchers in order to involve interpretations beyond the researcher
- Acknowledgement of any bias the researcher may bring to the research process for example how the researcher's background may affect the interpretation of results.

Chapter 4 Context

The aim of this study is to explore children's participation in an OHP programme implemented in nurseries. In order to address this aim and to ensure rigour it is necessary to provide a detailed description of the setting within which the oral health promotion initiative occurs. This chapter will present a detailed description of each nursery. This is necessary in ethnography as it provides the thick description described by Geertz, (1973) who argues that in order to understand peoples' actions we must consider the context in which they are acting.

4.1 Rainbow Ways nursery

Rainbow Ways Nursery is in an area of South Yorkshire. It opened in 2012 and is run by a partnership between a charitable company which has lead responsibility and the local city council. Recently, Rainbow Ways Nursery announced it would be closing due to cuts in government spending. There was a resulting community backlash due to the announcement of the nursery's closure and parents met with the nursery operator and started a petition and contacted local politicians to reconsider. The efforts of the community were successful and local politicians agreed to keep it open. A parent nursery partnership was formed through the setting up of a parent board for the nursery in order to continue to support the nursery and other parents. This partnership allowed more direct community involvement to support the daily running of the nursery. Ofsted report (2012) rates the overall quality of the nursery's provision as good.

Area

A deprivation report was accessed to better understand the level of deprivation of the area in which the nursery was located. It used the Index of Multiple Deprivation and the report mainly used data at the lower super output area (LSOA) level but it also referred to neighbourhoods. Lower super output areas have an average of roughly 1,500 residents and 650 households. Neighbourhood geography differs in size and population much more than individual LSOAs do. For example, Area 1 consists of 6 LSOAs with a population of around 9,000 whereas Area 2 is comprised of a single LSOA and around 1,700 people. Analysis on

the level of neighbourhoods provides a more generalised view of deprivation within the city and helps portray the spatial pattern of deprivation.

Out of 29 neighbourhoods considered to be the most deprived in the city, the local neighbourhood of the nursery is ranked at 11, none of the 20 most deprived LSOAs however are located within the local area. The local area is one of the areas considered to be in the 20% most deprived in the country.

Building

The nursery building is located in a quiet residential area and surrounded all around with houses. As you walk towards the nursery building you can see a high green fence that stretches across the building. The fence encloses part of the outdoor playground but not the building. The purpose built building is a prefabricated structure with a brick exterior. It is a rather small building which is well maintained both inside and out. From the outside it is not obvious that it is a childcare centre, as there are no signs above the nursery and the playground cannot be seen. The building inside is split into several rooms which serve different functions. They are all carpeted, except the nursery room and the entire childcare centre is bright and well-lit. There is a small office which is in a glass enclosed space, a small staff room, a smaller room which is used for the various activities the children's centre provides and a large room which serves as the nursery room. Outside there is a secure, enclosed outdoor play area. The staff room is clean and clutter free it provides a comfortable and relaxing area for staff to rest. There is a small sofa and chair and a small wardrobe where members of staff can keep their belongings. This is where they have their lunch break; normally they do a rota; only one member of staff at a time takes their lunch break, so they will often eat alone. This room is also used for meetings between staff and parents or meetings between staff and other professionals visiting the childcare centre. The other room is used for various activities, such as 'stay and play' sessions where mothers can bring their babies to play with other babies, other sessions are scheduled for health visitors and health and oral health promoters to meet up with parents and give them advice and answer any questions or concerns they may have regarding their children. This room is also clean and inviting and does not have anything other than some toy boxes for storing away the toys.

The outdoor enclosed playgrounds are connected but separated by a small gate they are both surfaced with areas of concrete and areas of grass. They are enclosed with very high green wired fences.

Staff

There are six members of staff (all female), including the manager, who work directly with the children. Of these, two hold Early Years Professional status, one holds a degree in Early Childhood Studies, one holds a foundation degree in early years and two hold a qualification at level 3 in early years. The staff members have worked with many of these children for almost two years and have established a friendly and what appears to be a trusting relationship with the children, parents, or carers.

Children

A maximum of 32 children may attend the nursery at any one time. The nursery cares for children aged two to five years old. On the days I visited there were no more than 25 children in a session. There is only one nursery room and so all the children are in one group.

Nursery

To gain access into the childcare centre one must ring the buzzer on the intercom that is mounted on the wall. A member of staff has to come and physically open the door to let you in; the door is not opened by simply pressing a button from the inside. The nursery feels safe and secure due to the security precautions involved. The main door is a thick laminated glass door with a metallic frame that gives the visitor a view of the nursery hall and enables staff to see who is at the door before they answer it. If the receptionist is in the office the visitor does not have long to wait; however, if all members of staff are in the nursery, as is usually the case, then the visitor is left waiting for a short while until the door is opened. As you look through the main glass door you can see a brightly lit area and in front of you a solid light-colored wooden door that looks like birch wood; this is the door to the nursery. Frequently, this is the door that staff will exit from to open the main door to visitors. I found that as I waited, I tended to get into the habit of fixating my gaze on that door. As staff come out of the nursery to open the door I found they were always very friendly and greeted me with a

smile and were usually apologetic about my wait. As you walk in you can see office of the nursery located on your left hand side, it is enclosed with glass. The office looks onto the hall of the nursery and is next to the only entrance and exit for visitors. The glass enclosure enables the person in the office to have a clear view of the door and the hall.

The wooden door to the only nursery room is secured at all times and has an electronic security system installed which can only be opened using staff swipe cards. There is a clear protocol on security both externally and internally. Upon entering the nursery room, you immediately notice that it is bright and colorful and the hustle and bustle of the children in comparison to the peace and quiet on the opposite side of the door at once gripped my attention. Once I went through the door I felt as though I had crossed into a completely different space. Everything is different on this side of the door from the colours, the sounds, the level of excitement and the level of warmth. On the other side of the door even the staff appeared in a different manner, more formal, more composed whereas, on this side their tone of voice changes to a softer, more playful one and at many times a more affectionate one. After becoming accustomed to the stark contrast my attention drifted to the room. I observed that the nursery room was well- lit, spacious, clean and airy. On the right hand side as you walk in, there are coat pegs mounted on the wall for the children to hang their coats and bags. The pegs are barely visible as they are full of colorful coats, jackets, umbrellas and character backpacks and underneath are an array of popular children's character wellies. There is an open plan area that has 4 cabin toilets and has 4 white wash up sinks that are easily accessible to the children. Both the toilets and sinks are at a level that the children can reach without the help of staff. This area is distinctly plain and bland, compared to the rest of the nursery room, as it is simply all white however, it is the plain white walls, white sinks white cabin doors and no clutter that give it such a polished hygienic appearance. Next to that area, there is a small room which is used as a baby change area and where soiled clothes are kept.

The walls of the nursery room are full of paintings and artwork the children have made, this helps them feel that this is their own personal space. As they look around they can see their drawings and their artwork, which has been clearly labelled with their names, displayed across the room. One of the walls is the birthday wall on which there are 12 laminated photos of cakes, each cake is labelled as a particular month of the year. The children's' names are

attached to the month that corresponds with their birthday. The walls have been used not only to decorate the nursery but to enable the children to visually see and feel their presence in the nursery. As I walk around children would point and proudly say “*that’s mine!*” or “*that’s my name!*”

Underneath that wall there is a sink which is used mainly to wash items that have been used for painting; and is easily accessible to the children so they can wash their hands independently. There is a holder for them to put away their brushes once they are done and a rack which they can place their paintings on to dry. Nearby are shelves that have items the children may use for coloring; crayons, coloured pencils and white sheets of paper. In this area there are two tables the children use when they are playing. Opposite to this area there is another table with two chairs and a computer on it, this table is situated next to the nursery kitchen. The kitchen is designed with a half wall, this allows the member of staff in the kitchen to easily communicate with other members of staff while they are preparing snacks, so they are still interacting with the others and not isolated in the kitchen. The kitchen with its open design maintains its place as part of the nursery gives it a warm homelike atmosphere. When the snacks are ready they are placed on the countertop of the half wall which overlooks the area where the children’s tables are situated. There are three tables for the children to sit on and there are two tables used as play stations and one table for the computer. All the tables the children sit on are colored; a bright red table, a yellow table and a green table that have various colored chairs including red, yellow, blue and green. Part of the flooring is carpeted and this area is divided into two sections; a reading area and a playing area. The reading area is surrounded by shelves which are made of birch wood, like the shelves in the rest of the nursery and contain many books. There is an armchair in the corner and during story-time a member of staff sits on the armchair with the children surrounding her seated on the floor. There is also a whiteboard hanging on the wall.

The staff appear to genuinely enjoy being with the children, with one particular member of staff standing out from the rest. Kath while on her way to change a nappy and happily talking to one of the children says:

“Nice to have a chat during nappy time, most time you can get the most out of some of them (laughs)”

Many times when children come to her she responds with

“Yes dear....”

She waits for their reply if they remain quiet she says

“Do you want a cuddle?!”

To which the child normally responds by hugging her straight away.

The staff generally appears to be very interactive with the children; they constantly engage the children in activities and conversation. If a child mentions something they have done outside nursery they tend to encourage the child to share their experience with the other children. The following example occurred when children were seated at carpet time getting ready for story-time.

Oliver: *“Kath, I went on holiday”*

Ben (Oliver’s younger brother, as he excitedly goes up and down while seated):
“yeah, yeah, me too”

Kath: *“You did?! Oh wow sweetie, do you want to tell us a little about your holiday?”*

Oliver nods yes while Ben blushes and smiles at Kath.

Kath: *“Well, it is story time and I was going to read you a story, but I tell you what, how about you tell us the story of your holiday first and then Gill will read you all a story.”*

Then Kath begins to enthusiastically facilitate Oliver’s account of their trip by asking him open questions, she also engages the other children by asking them where they have travelled to, what they like best about holidays and if there was somewhere in particular that they have heard of that they would like to go to. Many children begin to join in and they take turns sharing their personal experiences. As the children mention different places and after they have talked about it a little Kath asks the children who have remained quiet if they have remembered all the places that have been mentioned.

“Amy and Holly you’ve been doing some brilliant listening as we haven’t heard a word out of you! Can you help Kath remember all the places that the children have said they visited or would like to visit?”

This was one of the many situations where I observed the facilitation of the children’s participation by staff. They would take notice of the children who were quiet for long periods of time or seemed disengaged and encourage them to join in. There was one particular girl however, that they seemed to not encourage as much as the other children. I was curious as to why and Kath explained that they have come to understand, after her being in their care for over a year, that this particular girl was very quiet by nature and she would sometimes participate but was also happy to play alone or listen attentively without speaking a word.

Playtime

Playtime is either indoors, outdoors or a mix of both depending on the weather. There are two enclosed outdoor play-areas, a smaller play area and a bigger play area and are connected to each other by a locked gate. The smaller play area is partly covered like a shed. This play area has play stations such as sand, water, big wooden building blocks and a craft-making station unlike the one inside here the children use the grass and flowers to make things. There is not a lot of space for the children to run around here so mainly they play at the different stations or take buckets and try to collect worms and insects from the grass and flowers that line the edge of the nursery playground.

There is a locked gate which connects to the bigger outdoor play area. Sometimes after allowing the children to play in the small play area, a member of staff will ask them if they would like to go play in the other one. She asks the children that would like to go to line up at the gate. Some children will normally quickly run to the gate while others finish off what they are playing and some are so absorbed in what they are doing they don’t even notice. She normally will keep asking and wait a few minutes until all the children line up, they do not split the children into groups between the outdoor play areas.

They all play together in either one; this makes supervision more manageable. It causes the staff less confusion to have them all together than to get confused as to where the child is. After the children are all lined up the gate is opened and the children excitedly and hastily run to the other play area. This one is much larger and has scooters, bikes and 2 Little Tikes ride-on cars. There are also two outdoor playhouses one is a light brown wooden house the other is a pink and purple plastic playhouse. In the middle of the play area there is a covered space that is open from all sides. Around the edges are green areas and on the side is a big green space for the children to play in. The members of staff mainly supervise during playtime and occasionally will interact with them as they play.

In one instance, Cindy called out to the children to gather round and asked them what game they would like to play together. One boy suggested a game that she seemed to know and she cheerfully went off to get the items they needed. She brought back a play tunnel and placed it on the grass. As she is doing this 3 boys are huddled together discussing something then they suddenly run off and begin to bring the big wooden blocks, they begin to build small steps in front of the tube.

“Cindy, Cindy!” they shout. “Whoever wants to crawl through the tunnel has to climb up the steps, jump down and crawl through!”

“Oh Ok, that’s a good idea. Let me go get something for you to jump on so you don’t hurt yourselves.” Cindy replies as she goes and brings a mat and places it under the steps.

The children begin to play while Megan stands at the steps to make sure no one falls and Cindy plays with the children. Some of the children begin to make suggestions:

“Let’s pretend it’s a secret tunnel.....that ends in....uh...uh...” (Max)

“ends in the ocean!” (Dylan)

“No that’s just silly....you’ll drown!”(Oliver)

“No, I won’t! I can swim.” (Dylan)

“It takes you to a castle” (Max)

“Oh yeah, a castle! Let’s go to the castle!” shout the boys as they run towards the steps. All the while Cindy is standing smiling and amused at the children’s conversation. She joins in and says

“Off we go to the castle boys and girls!” as she walks alongside the steps and alongside the tunnel *“Oh dear I’m afraid if I try to go through I’ll get stuck so I’ll just meet you all at the castle!”*

Cindy keeps playing with the children while Megan supervises; both the children and Cindy seem to be thoroughly enjoying themselves.

Although the thought of children playing during playtime may bring about images of spontaneous chaos from what I observed at playtime this was a very ‘organised chaos’; children running about here and there, shouting and screaming, playing with toys, and playing games with each other yet appear very aware of playtime rules that have to me as an observer clearly played a role in structuring playtime with resulting minimal conflict among the children. We also, notice in this example that the children have decided which game to play, and direct how it is played. Cindy plays along rather than directing the game.

Tidy up

After playtime the children are asked to tidy up. If the play time was outdoors than the children are asked to tidy up just a bit. If the playtime was indoors however, staff are very determined that the children do their own tidying up. A child is nominated to notify the other children that tidy up time is in 5 minutes and the child is given a laminated card that has a clock with a 5-minute sign on it. The nominated child will go around telling the other children, *“It’s tidy up time, it’s tidy up time, five minutes, tidy up time.”*

Staff members then begin to encourage the children to put everything away including the younger ones, reminding them of where things belong and praising those children who were tidying. They are also encouraged to clean their areas for example if they have spilled sand on the floor to sweep it up with a dustpan and brush. *“Ryan, that’s good tidying; Lily that’s good tidying; I’m looking to see who’s doing good tidying”*.

For those children not tidying for example, “*Adam, I don’t see you tidying and you need to be tidying. Now can you please go and help the others tidy.*” It was clear that the staff were unrelenting in their efforts to encourage and support the children to tidy up and would not tidy up for the children. After tidy up time there is always a “reward ritual”. The children are asked to sit down at the carpet, normally Charlotte would lead this.

Charlotte: Now, I had my good looking glasses on. I was looking to see who’s doing good tidying. I saw some really good tidying and some not so good tidying. I’m going to give out stickers now to those who did good tidying and those that did not do good tidying you won’t be getting stickers today but you can try another day.

Although most of the children tidied up it was the children that needed no or minimal encouragement, or did more than their share that were rewarded with stickers. Charlotte would call each child out to come get their sticker and afterwards together with the other children give them a round of applause. This was done with each individual child.

The children who had been rewarded were then told to go wash their hands and sit at the tables before the other children. Then the other children were asked to go wash their hands except those children that did not tidy or did not finish. These children were told to remain seated on the carpet where they were then spoke to and reminded of the importance of tidying up. Firstly, that it meant each child had to do their share and it wasn’t fair to the other children or to staff for them to make a mess and not put things away. Secondly, the importance of having a tidy room meant that it was a safer room for them to play in, otherwise they would be stepping on toys hurting their feet and tripping over things. Lastly, it meant that when they wanted to play with something they would always be able to find it. After this discussion was over, Charlotte would go around the room bringing toys that had already been put away and handing them out to the group of children that were with her. She would ask them one by one to get up and put the toys away and afterwards they could go and wash their hands and be seated at the tables with the other children. This action that Charlotte normally takes with the children of asking them to put the toys away is not for the intention of tidying up as the toys are already in their designated places, but it appears she does this to reinforce to the children that they have to tidy up and do their share. In addition to the

personalisation of the nursery space through using their labelled arts and crafts being displayed on the walls, the responsibility given to the children of tidying up helps give the child ownership of the nursery space.

4.2 Crayon Town nursery

The 2011 OFSTED report on Crayon Town Nursery rates the overall quality of nursery provision as satisfactory. Most children enter early education with skills and knowledge lower than that is usually expected, particularly in their personal and social development and speech and language skills.

Area

This area has 5 lower super output areas (LSOAs) in the list of the 20 most deprived in the city and is ranked the number 1 most deprived neighbourhood in the city, as mentioned earlier, lower super output areas have an average of roughly 1,500 residents and 650 households. It is also in the 10% most deprived neighbourhoods in the country.

Some areas are more deprived in a relative sense on individual domains than they are on the combined Index of Multiple Deprivation (IMD), though some are also less deprived. The nursery is within the most deprived LSOA in Education, Skills and Training Deprivation and Crime.

Building

The building is a purpose built childcare centre. It is a large red brick building with a large spacious enclosed outdoor play area that is secured by an all-around high green fence. To reach the nursery you need to walk down a street and cross through the car park and so the outside appearance is mainly of the outdoor area as it is facing the street. The entrance to the building is on the side, after reaching the end of the car park there is a path on the side of the building and at the end of that path is the main entrance.

Staff

There are 20 members of staff in total throughout the nursery of whom 16 (all female) work directly with the children in the nursery. The EYPs' that worked with the children I was observing had the following qualifications; the nursery manager who works directly with the children holds an Early Years Professional status now referred to as Early Years Teacher and the other two EYPs' hold a qualification at level 3 in early years.

Children

A maximum of 73 children may attend the nursery at any one time. The nursery cares for children aged two to five years old. There are 5 nursery rooms each with a different group of children. I only visited one room which had on average 16 children a session.

Nursery

At the main entrance of the building there is a door that is usually left unlocked, after walking through this door there is an enclosed space with another door in front of you which is always locked for security reasons. On the right hand side there is a big bulletin board and an intercom and buzzer on the wall, the intercom and buzzer has different buttons for visitors to ring for access depending on which nursery room you want to go to. Each button is labelled with the corresponding nursery room. The door in front leads to the nursery and is made of thick glass within a metallic frame. In this area there is also a camera allowing staff inside the office to see the individual at the door, there is also a visible screen where you can see the footage. As I wait for someone to answer and open the door I can see myself clearly on the screen. After buzzing the nursery class, I am visiting a member of staff answers and I introduce myself, she then lets me in. No one physically comes to the door to open it; they press a button from inside the nursery room to unlock the door.

This childcare centre has many different rooms; I personally did not see the entire nursery. Once inside I noticed that the inside of the building is quite different from the outside appearance. Indoors the building is rather gloomy and the lighting is dim. It isn't very cheerful the walls are painted a white colour but due to the lighting they appear almost grey. It is also quite stuffy and almost humid. To reach the nursery class, I was visiting I walked through a hallway which led to a big nursery room, at the end of this nursery room there was

a white wooden door with a small vertical window in it, this door leads to the 'pre-school room', which contained the group of children I was visiting. The class comprised of the oldest children in the childcare centre and they were all approximately four to five years old. This was the only class currently taking part in the toothbrushing club.

The nursery room I was visiting was a bit small, smaller than the room I had to walk through, it was rather crowded with all the different play areas and there was little free space left. It tended to appear messy at times even when the children were not playing, possibly due to its small size. The room is not very inviting, as the lighting is dim, it is crowded, and a bit messy. As I walk through the door, on the right hand side there are pegs mounted on the wall for the children to hang their coats and bags on and on my left hand side a blue 3-tiered rack for the children to place their lunch bags on. Within the room there are different play areas which include an area that is used to play house. This area has a wooden kitchen, bed and desk. Other play stations include playdough, sand, colouring, blocks, and various toys. Within the room there is a small enclosed toilet area that has two toilets and two sinks. This is where the children come to brush their teeth. Also, within the room is another small enclosed area which is used to prepare the children's snacks. In between these two enclosed areas is a big sink, next to the sink there are a few plastic cups. The children use this sink for drinking water and to rinse off their paint brushes. When staff want to have a chat with the children or they want to encourage the children to have a chat with each other this is done in the carpet area it is also often used for learning activities. In one corner of the room and there is a small carpet area where the children sit on. There is one big piece which is blue and three other smaller square pieces of different shades blue and grey placed next to it. Every morning after the children have had their first playtime they are all asked to come and have a seat on the carpet; they are asked to sit in a circle. Susan (pseudonym) tells the children that it is time for them to all say good morning to each other. Susan turns to the child next to her on her left and says, "*Good morning, Josh*". Josh replies to Susan and says "good morning" however she explains to him that this is like a game and that in this game children pass the good morning on to their friends sitting next to them.

"Josh, could you please say good morning to whoever is sitting next to you now?"

"Good morning, Ellie"

Ellie then turns to the child next to her and says good morning.

“Good morning, Rachael”

This is done until all the children have said good morning to the child sitting next to them. After this is done Susan asks the children the date, as the children shout out the date some correct and some incorrect, she asks individual children if they know the date.

Kevin, do you what is the date today?

It's Tuesday

Do you know which month?

June

Good that's right, now can you tell me what day in June it is? Say 16, 17?

Dunno

Who can tell me the date today?

17 cause yesterday was 16!

That's right! It's Tuesday, June the 17th.

Now who can tell me what comes before and after Tuesday?

The children begin to answer with some answers correct and some incorrect. Susan suggests that children say the days of the week with her. They then go over the months of the year and then she asks a child to volunteer to write the numbers of the date in this instance 17, they are asked to write the number 1 and the number 7 on a piece of paper and show it to the other children. This is done every morning.

On one of the walls above the carpet area, in the corner is a picture of a rocket. The rocket is divided into three colours; the bottom half of the rocket is divided into a bottom quarter which is red, and an upper quarter which is yellow and the upper half of the rocket is green. On the rocket there are laminated cards with the children's names on them and their photos, the name cards were scattered all over the rocket with one name card clearly at the tip of the rocket. Initially, I did not know what the rocket and the name cards were meant to represent however, I then observed it used as a behaviour chart. Having your name in the red area

meant you had been behaving badly for most of the week, yellow meant sometimes good and sometimes bad and green meant good behaviour with the tip representing the star of the week. The following is an excerpt from a conversation where Susan refers to the rocket to motivate the children to behave better.

Jason, if I have to ask you to sit on your bottom one more time I will move you from your green spot to a yellow spot on the rocket. Look at the rocket there so many good girls and boys on the green spot do you want to leave and be in the yellow spot?

I' m in green! shouts Nikki

Yes you are, and Kylie was the star of the week can you all see Kylie's name all the way at the top. I know that all of you can be at the top if you try. This week I want to see how many of you will move up from yellow to green.

But I'm in red! shouts Ryan angrily

Yes, that's because you have not been behaving nicely with the other children. I bet you could make it to green too if you wanted.

Ryan stays quiet and gives Susan a defiant stare.

Often Susan would ask the children if she could see their "school sitting".

Many of you are going to school next year and in school you have to be ready to sit and learn. You will no longer be in nursery; your teachers will want to see good sitting, school sitting. Can you all show me your school sitting?

The children sit up with their backs straight and their hands and legs crossed, two boys don't seem to be bothered. One starts rolling on the floor and the other just watches the other children, Susan ignores them.

At the end of carpet time Susan brings over her "necklace basket" inside this basket are "job necklaces". The necklaces are made of yarn that goes through a round laminated piece of paper. There are 4 different types of necklaces representing the different 'jobs'. Three of them are differentiated by the colour and one of them is white with a coloured toothbrush image on it; these are the toothbrush job necklaces and there are only four. Susan hands out the necklaces to the children and then designates each colour to a different play station for

example, purple is playdough, red is sand and yellow is for playing house. She asks the children to go to the different play stations according to the colour of their necklace. As for the children who are given the toothbrush necklace Susan asks them to come with her to the sinks.

Playtime

The playtime after carpet time is a designated play area playtime where each child is told to do a 'job' according to the necklace they were given. The 'job' represented which play area to play in, unlike the playtime session before carpet time where each child chooses what they want to play. Although they are told which play area to go to, the staff does not enforce them to stay in that one play area. It is a system that they have devised in order to take away the children that are to brush their teeth that day; they are going to do a job just like all the other children. Rather than telling all the children it's playtime you can all go and play now but selecting a few and telling them you have to come now and brush your teeth.

Playtime is generally quite chaotic there are usually only two staff members to supervise the children and on many occasions one of them is busy preparing snacks. Often times the children keep running back and forth from different play stations. Children seem to quickly lose interest in playing with the stations the way they were intended. The boys rarely use the blocks for building anything but tend to build a tower and kick it to topple it over or jump into it to knock it down. The boys frequently play fight which sometimes turns into a less play and more fight situation. On many occasions staff did not notice from the beginning as they were busy, as mentioned earlier, either with the preparing of snacks which is done in an area that does not enable them to see the children, or were with the children brushing their teeth or simply playing with other children. At the play-dough station some particular children enjoy making balls of dough and throwing it at the walls or other children rather than attempting to make something. The children appear to have difficulty resolving their own conflicts peacefully. I observed on many occasions their first reaction is to defend themselves by fighting back rather than asking staff for help. The following is one example,

Billy threw some play dough at Ellie

"Stop it!"

He did it again

“Stop it!”

He did it again. This time she kicked him in the leg and gave him an angry stare and said *“Stop it!”* Billy went away.

The children appear to be quite disruptive, in one instance a boy threw seashells in the toilet, noticeably the boy was not reprimanded and the consequences of what he had done were not explained to him, Susan called to everyone and asked them not use that particular toilet until the shells were removed. In another situation three boys were playing with the sink after they had come for some drinking water, they turned the tap water on and started splashing water everywhere and on each other. Susan saw them and calmly told them to turn it off, no one responded. Two girls realised what they were doing and decided to join in, by now there was quite a puddle on the floor underneath the sink. Again Susan with a slightly firmer voice this time told them to turn it off and that they were behaving very silly, no one responded.

Susan now went to the sink, turned the water off and led the children to different play areas. *“I was talking to you and none of you listened, that was not very nice”* she said. The children did not say anything upon her commenting but ran off to play.

The one play area that seemed to stand out from the others where the children played together with minimal conflict and seemed to be thoroughly involved and interested was role play. This was the area that had the kitchen, desk and bed. They would sometimes play house, doctor’s office and shops. It is this area that often even the more disruptive children would play along with the other children without conflict and play continuously for longer periods of time. There were different scenarios, and sometimes different children playing different scenarios at the same time. A group would pretend they were in the kitchen baking and send someone off to the shops for ingredients, the child at the desk would play shopkeeper and sometimes say *‘I don’t have that in stock do you want me to order it?’* As they pick up the phone and pretend to make an order, magically the order appears in a minute and they are given their ingredients to go and bake. On the other end of this play area is a boy lying in the bed pretending to be poorly with another boy pretending to be doctor and having a look at

him. The children who were baking then suggest that they take their cookies over to Josh who is poorly so that he may get better. It is this area that most clearly illustrates the childrens' imagination and their ability to participate with one another to play as a group.

Near to this play area on the wall is a large poster that states "we are learning about emotions" this displayed magazine clippings of people with particular facial expressions and next to each group was a label with the corresponding emotion; for example, angry, sad, happy. In addition to the clippings are drawings made by the children and with their interpretation of which emotion it represents.

Tidy up

After play time is over the children are told by staff that they need to tidy up. As a sign that tidy up time has begun the James Bond theme song is played, which actually makes it rather difficult for staff to communicate with the children while it is tidy up time. Susan has to shout to remind the children that they should be tidying. The music is loud and the quality of the sound is bad and for me as an observer it merely appeared to take the chaos of the room to another level. Normally, during tidy up time few children tidy up and the staff do most of the tidying. Susan does not normally enforce that the children tidy up; she seems to have accepted that she will do the tidying. One day though Susan decided she would have a talk with the children. Throughout the day she expressed her frustration and disappointment.

"I did all the tidying today and on many other days as well so I'm not getting out my stickers" (the giving out of stickers for tidying up was not a common occurrence) as she was talking a boy interrupted her and she snapped at him saying *"Don't talk when I'm talking it's rude! You are the older children in this nursery and the younger children tidy up better than you!"*

She made comparisons to the class next door that had a younger group of children, how she felt that they behaved better and caused less trouble for their teacher. She stressed that this kind of behaviour would not be acceptable when they went to school and it was very important to listen to their teachers at school. Some children appeared to be more attentive

when Susan began addressing them as ‘the older children’, ‘the big boys and girls’. As an observer I cannot explain the difference in Susan’s behaviour. I considered various options:

- Was she tired and did not have the energy to be her more tolerant self or was it completely the opposite?
- Did she have a burst of energy and motivation and felt that she needed to be more assertive with the children?
- Did my presence have something to do with her change in behaviour?

Whatever the reasons, the children appeared to understand that Susan was genuinely upset today and for the rest of the day they were distinctly calmer.

Chapter 5 Findings

This chapter begins with a short description of each toothbrushing club within the context of the nursery setting. The names of staff and the nurseries have been altered to protect staff and children. This is then followed by the cross-cutting themes that emerged across the data collection approaches presented using a public health system framework (Handler et al., 2001). This framework is based on Donabedian's work which showcases the relationship between structure, processes, and outcomes in relation to quality assessment. Using this framework was found to be useful in understanding the dynamics of the toothbrushing club as part of a settings-based health promotion initiative and in understanding the dynamics and role of participation within that initiative.

5.1 The toothbrushing clubs in the nursery setting

5.1.1 Rainbow Ways toothbrushing club

Rainbow Ways nursery had been running the toothbrushing club for about 2 years at the time I had visited. To prepare them for the club they received a one-day training course from the oral health promotion team. An oral health promoter visited the nursery staff and discussed with them the concepts and basics of tooth decay. The basic process of tooth decay was explained to them; that sugars turn into acid and eat away at the enamel surface, the most outer surface of the tooth. If this continues it will reach the underlying layers of the enamel and will lead to a cavity.

The aim of the toothbrushing club is to expose the children to fluoride at least once a day. Members of staff were given guidelines on cross-contamination, the type and amount of toothpaste, when to brush, the method of brushing and for how long. They were also informed of the basic principles of cross-contamination and were given a checklist. Other than being advised to allow the children to brush before they had their snacks, they were not informed or advised on the actual operationalization of the toothbrushing scheme; this was left up to the nursery staff. So they decided that after all the children were seated and ready

for snack time, but before they have their snacks, they would have them brush their teeth. The oral health promotion team supplies the childcare centre with toothpaste, a toothbrush holder and coloured toothbrushes which are replaced each term. Both the toothbrushes and toothpaste are non-branded. They were also given learning and teaching resources such as a model mouth and toothbrush.

The toothbrushes are stored in a toothbrush holder with each child having their individual labelled toothbrush. Normally 4 members of staff stand around the tables during toothbrushing time. One of them hands out the toothbrushes to the children. The toothbrushes are placed in the middle of a plate that has previously been prepared with pea-sized amounts of toothpaste all around its edges, she takes a random toothbrush scrapes up one of the prepared amounts of toothpaste then looks at the label and hands it to the child.

The established daily schedule for the children is to have snacks after morning playtime. The children wash their hands and are seated around the coloured tables and are then handed out their snacks. After snacks, the toothbrushes are handed out and as soon as a few children have their toothbrushes, Kath begins to energetically and cheerfully sing a song they appear to use to encourage the children to brush and make it fun. Once she begins singing the rest of the staff join in and all sing together. I noticed that they begin to sing the song as soon as the first 2-3 children have their brush the song appears to also serve the purpose of engaging the children so they do not get restless or wander off from the table while they are waiting. The song also appears to be used as a method of keeping their attention. The song is based on the theme of “The wheels on the bus”.

The children continue to brush until countdown. Normally, the younger children need constant encouragement. Many of the younger children struggle to hold their brushes correctly in a way that allows to them to brush however, the nursery staff do not physically help them with holding the brush or brushing their teeth but support them to participate through encouragement. To finish the toothbrushing session, the members of staff begin to count from 1-20 and clap; it is now that the children get very excited and even those who were previously not brushing begin to brush. During the counting many of the children brush rather vigorously.

After the countdown a staff member goes around the tables with a plate and collects all the toothbrushes together on it, takes them to the kitchen and washes them together. This practice shows that the EYP's have not fully understood the cross-contamination guidelines. The current manner in which the toothbrushing club is managed is based on trial and error. The members of staff attempted different methods and chose the one they felt worked best for the cohort of children they had and fit in best with the established daily schedule of the nursery. The majority of the children took part and were engaged with the staff while a few sometimes wandered off particularly the very young children which the staff often ignored because the feeling was that they would engage when they were ready. This nursery took a collective approach to the toothbrushing task.

Initially, the staff attempted to take an individualistic approach in implementing the toothbrushing club, taking a few children at a time, however they found that it was not practical and the children were not happy with being taken out of the group and so they tried the collective approach. For example, staff had attempted to have the children brush in small groups where they would stand by the sinks and brush their teeth. They chose this method thinking they could provide better supervision for those children brushing and seemed like the natural thing to do. After a few attempts at this method they began to realize it was disruptive and sometimes difficult to gain the children's cooperation. According to the staff this was due to the children feeling they were being taken away from the rest of the group while the others were playing. They went to on explain that the children would be watching the others play and were distracted and not focused on the brushing. This led them to do the toothbrushing as a whole group. If looked at from the perspective of achieving the aim of the OHP intervention which was to have the children exposed to fluoride everyday then the toothbrushing club has achieved this.

During toothbrushing time the nature of the interactions of the children, on an individual level, with the staff were narrow particularly in comparison to the nature of their interactions outside of the toothbrushing club such as in playtime or story time. There was hardly any space for conversation and minimal reciprocal interaction. Staff focused on accomplishing the task, albeit making it as enjoyable as possible.

5.1.2 Crayon Town toothbrushing club

Crayon town nursery has been running the toothbrushing club for the past four years and received a one-day training course from the oral health promotion team. An oral health promoter visited the nursery staff and discussed with them the concepts and basics of tooth decay. The basic process of tooth decay was explained to them; that sugars turn into acid and eat away at the enamel surface, the most outer surface of the tooth. If this continues it will reach the underlying layers of the enamel and will lead to a cavity. They were also informed of the basic principles of cross-contamination; the importance of separating toothbrushes and toothpaste. Other than being advised to have the children brush before they had their snacks they were not informed or advised on the actual operationalization of the toothbrushing scheme; this was left up to the nursery staff.

In contrast to the other nursery, this nursery found the collective approach impractical within their setting and decided on taking a more individualistic approach. The centre had previously attempted to have all the children brush their teeth each day, which was the initial aim of the oral health initiative to expose every child to fluoride at least once a day. They tried the same method of taking a group of four children to the sinks but with all the children; they found that this did not fit in with their nursery schedule as it was too time-consuming. They did not however try a method that allowed the children to brush all at the same time. There did not seem to be a particular reason for them not trying this method but they seemed to be focused on the sinks and that the children would naturally brush by the sinks and since there were only two sinks then they would not be able to do all the children at the same time. They stated that the space did not allow it and they didn't have enough staff to do the children in shifts and still manage their schedule. When the senior member of staff was asked if the nursery was interested in knowing more about different methods of operationalizing the toothbrushing club she did not show much interest and expressed that she did not feel a different method would be applicable in their nursery. She explained how she understood that it was the aim of the oral health promotion initiative to have all the children exposed to fluoride at least once a day and that it was unfortunate that it was not being met however, she had to prioritise and toothbrushing was not an OFSTED objective.

After playtime, children are given necklaces that designate which area to play in and some are given toothbrushing necklaces. I observed that the children who are given the toothbrush necklaces often appear to be pleased that they have been chosen and many times children who have not been chosen ask if they can brush their teeth. Susan explains that everyone needs to be given a turn as she only chooses four children a day. The children stand by the sinks, two at each sink. Susan takes each child's labelled toothbrush from the tooth brush holder which is kept high up on a shelf mounted on the wall and puts a pea-sized amount of toothpaste before she hands it to the child. After each child has their toothbrush she looks at the clock and asks them to begin brushing. While they are brushing she diligently encourages and focuses on them brushing all the teeth surfaces. She will often bend down and get closer to have a better look at how exactly they are brushing. While the children are brushing, Susan constantly reminds them to brush at home and talks to them about their teeth and how to keep them healthy.

After toothbrushing time is over the children are asked to rinse their brushes under the running water and hand them to Susan who takes each brush separately and places them in the toothbrush holder. The children are instructed to spit and wipe their mouths with a paper towel. The children appear to like the brushing and continue to brush until the time is over. As an observer it is difficult to distinguish if they are enjoying their time brushing or they are enjoying the individual attention they are getting from Susan, as she rarely has the time or opportunity to give them the individual attention due to her responsibilities. There does not appear to be a specific toothbrushing technique that the children are encouraged to use. They each brush differently some using a circular motion where as others brush in a back and forth motion. After the children are done brushing their teeth they are told that they can now join the other children.

Throughout the session, Susan engages with the children with a sensitive and responsive approach, sincerely listening and giving the children space to voice their thoughts. This validates the importance of their communication. Through their mutual engagement she is able to see the child's perspectives on issues such as the tooth fairy and brushing at home or in the toothbrushing club. To an observer, these spacious patterns of interactions that encourage and facilitate children to share their life-world are glaringly obvious. Within these

patterns, both adult and child are active agents sharing knowledge with the adult demonstrating an acceptance of children's initiatives.

From the two nurseries we can see the complexity of the setting and how this may alter the format and outcome of the toothbrushing clubs. In the following section the findings of this study will be presented using a public health systems framework linking the components structure, processes and outcomes.

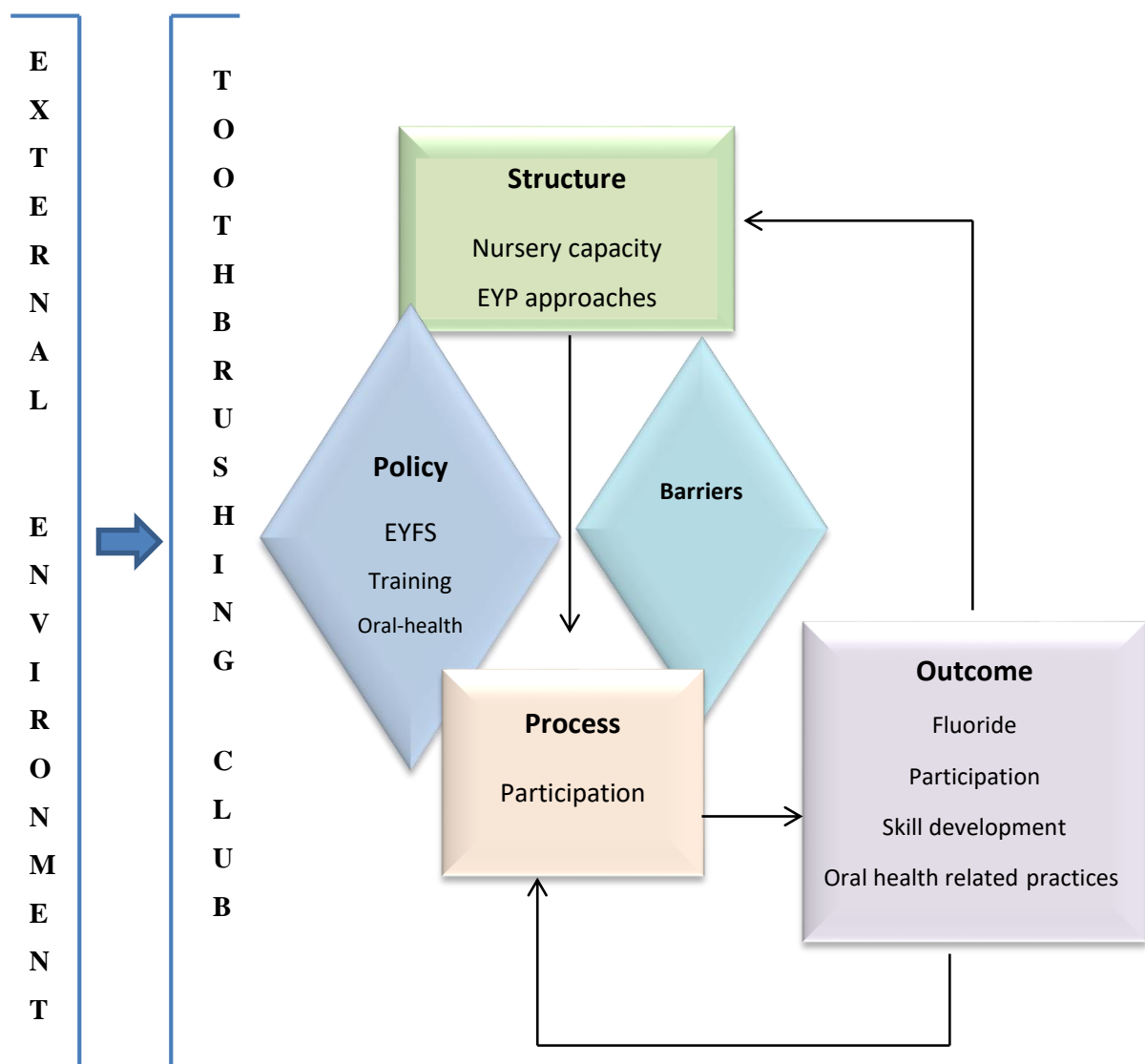
5.2 Structure, process and outcome

In making sense of the data and reviewing the themes it became apparent that the toothbrushing club was shaped by both structural and process variables. Structure refers to the environment in which the oral health intervention is taking place. This includes material resources such as facilities, equipment, human resources such as the number and qualifications of staff. Process encompasses the method in which the intervention is delivered. Outcome refers to the results of the intervention. The link between them has been discussed previously in section 1.5.5 in regards to the quality of care children receive within a particular setting (Parker, 2013). This framework (Handler et al., 2001) was developed for assessing the performance of public health systems and was based on Donabedian's work on quality assessment and systems monitoring (Donabedian, 1988). The following figure illustrates the dynamic relationship between structure, processes, outcomes and external factors such as the social, economic, and political context. This proposed model was found to be useful in making sense of the findings of this study (see figure 6).

This framework illustrates the relationship between structure, process and outcomes and how they are affected by policy and furthermore how the entire system is affected by the wider external environment in which it operates. The social, economic, and political contexts play an overarching role affecting all of the components either directly or indirectly. This includes the social, economic, and political situation at any given point in time and geographic location. It is important to include the external environment as it highlights that dental public health is involved in a dynamic relationship with various forces external to its own remit and thus oral health promotion cannot be considered without considering the social environment.

The economic, political, cultural and organizational factors are the larger factors in any population that shape the everyday lives of individuals on a micro-level. Therefore, the wider context may influence the goals and priorities of interventions, capacity depending on the amount of human and financial resources, processes for example technological or scientific advances may improve efficacy, and outcomes for example the importance placed on certain health outcomes depends on need as well as social values within a population. In the next section, each of these components will be presented with examples from the toothbrushing clubs.

Figure 6. Conceptual framework of the toothbrushing club



(Adapted from Handler et al., 2001)

5.2.1 The socioeconomic impact of the surrounding geographical area on the nurseries

The toothbrushing clubs in this study were within nurseries located in disadvantaged areas. An opinion that was voiced by Ann a senior EYP, was that the nurseries in these disadvantaged areas were already dealing with other issues that concern children with low SES backgrounds and thus the staff in these particular areas are more likely to feel overwhelmed at taking on a new responsibility of having children brush their teeth at nursery.

Ann, Crayon Town Nursery:

“It is difficult for us to fit it in to the routine you know we’ve got so many targets to meet so many sorts of things to provide and it’s not in the curriculum, it could be you know. They could put it in there you know brushing teeth it’d be a benefit to us because then it’d be part of what OFSTED would be looking for..... I think it would help in areas like this,...children from this area already have so many issues going on....these children need stability they need all the things that might not be there at home and that’s why we feel it’s important”

In the previous quote Ann describes how EYPs that care for these children need to provide extra support and extra care to help compensate for what the children may be missing from home.

Ann goes on to explain that because the children were from disadvantaged areas many had never brushed their teeth before the toothbrushing club. This meant that toothbrushing clubs in disadvantaged areas were more challenging for EYPs as the child needs more support in becoming familiar to simply having a brush in their mouth and this was something that they had to learn. This created another task for the EYPs.

Ann, Crayon Town Nursery:

“[...]cause if they’ve never had a brush in their mouth it can be a bit weird. So yeah, we wouldn’t think it’s weird, but some kids would. If they’re three and they’ve never had a toothbrush in their mouth and then you tell ‘em not to put things in the mouth but then ...here, put this in your mouth... so you know it’s a bit backwards isn’t it? They’ve been told don’t put that, don’t eat that, don’t do that, that’s dirty and that’s I

dunno and we're saying put this brush in your mouth every day! We do... do that... some kids if it's been drummed into them you know it makes it a challenge getting them to brush."

These two examples given by Ann point towards the extra support needed by children from disadvantaged areas for their oral health, as well as general issues. Thus one could argue that EYPs working in disadvantaged areas themselves would need more support to provide effective and efficient oral health care.

5.2.2 Policy

Policy is largely affected by social, economic and political factors and as previously discussed in section 1.1.2 public health and health promotion are socio-cultural products that are inherently political. Within a particular intervention there exists the policy or remit of the public health intervention and the policies of the setting itself. The following section presents the findings of this study which show a missed opportunity to integrate the dental public health remit into the policy of the setting which in this case is the nursery curriculum.

5.2.2.1 Aim of the toothbrushing club

The main remit of the oral health intervention for this area of South Yorkshire is that every child has daily fluoride application through brushing their teeth at nursery.

5.2.2.2 The curriculum and oral health

The national curriculum which sets the policy for nurseries does not explicitly mention oral health. In the following quote Ann expresses her lack of understanding as to how the nursery has been asked by the local OHP team to run a toothbrushing club on the basis that toothbrushing is important for young children, and yet there is no mention of it in the national curriculum or guidance notes.

Ann, Crayon Town Nursery:

“....it could be something... an initiative the government could look at and it could be included in the curriculum you know.”

Ann, Crayon Town Nursery:

[.....] There’s no specifics for oral health in there ...we’ve got it in there and it’s a bonus for us but I don’t think everywhere would look at that sort of thing[...]”

The document Ann was referring to in this quote was Development Matters, which provides non-statutory guidance for practitioners in implementing the statutory requirements of the EYFS and in it there is a more detailed breakdown for each developmental age.

In physical development under ‘Moving and handling’ there is a distinction of the targets for each developmental age group in relation to the following Early Learning Goal:

“Children show good control and co-ordination in large and small movements. They move confidently in a range of ways, safely negotiating space. They handle equipment and tools effectively, including pencils for writing.” (DfEE ,2014:24)

Table 2. Moving and handling-Physical development

8-20 months	Holds pen or crayon using a whole hand (palmar) grasp and makes random marks with different strokes
30-50 months	Holds pencil between thumb and two fingers, no longer using whole-hand grasp. Holds pencil near point between first two fingers and thumb and uses it with good control.
40-60+	Uses a pencil and holds it effectively

Education, 2012:22-24

In the physical development section under 'Health and self-care' the early learning goal is Physical development: Health and self-care

“Children know the importance for good health of physical exercise, and a healthy diet, and talk about ways to keep healthy and safe. They manage their own basic hygiene and personal needs successfully, including dressing and going to the toilet independently.” (DfEE ,2014:27)

Referring to the previously mentioned learning goal *“They handle equipment and tools effectively, including pencils for writing.” (DfEE ,2014:24)*

Ann explains how in this section a toothbrush could also be used and that just as there are ways to hold a pencil appropriately there are ways to hold a toothbrush properly and this is all part of physical development.

“you know physical development could beholding a toothbrush appropriately there’s holding a pencil appropriately. There’s lots of ways they could slip it in there”

This can be seen in relation to the early learning goal under Physical development: Health and self-care it states, as mentioned previously, that children should be able to

“.....manage their own basic hygiene and personal needs successfully, including dressing and going to the toilet independently.” (DfEE ,2014:27)

Brushing teeth was seen as a missed opportunity by early year practitioners.

Julie, Starlight Nursery:

“They talk about washing hands, going to the toilet, brushing teeth is as important as those things...It’s part of your personal hygiene so... yeah, it’s in there it does say hygiene but it could be a bit more...when you look at the break down they could say they’re able to wash their hands on their own, can they brush their teeth on their own?”

Julie here describes how she believes that brushing teeth is an important part of person hygiene and equates it with washing hands. Her personal beliefs on personal hygiene and the

values she places on toothbrushing appears to have led to her interpretation that toothbrushing is part of it although it is not explicitly stated within the curriculum.

Both practitioners believed there are opportunities in the existing curriculum to be expanded on to include oral health and brushing teeth. They both hint at the importance of the level of experiential knowledge and how this is then used to interpret the curriculum.

Kath also felt that if promoting oral health was on the curriculum it would be something that OFSTED would be looking for and thus would encourage EYPs to set up toothbrushing within the nursery.

Kath, Rainbow Ways nursery:

"[...] It would encourage more people to do it if OFSTED were looking for it.. yeah, yeah, more people would do it if they know it's expected of them."

Kath then went on to describe how they recently had a visit from OFSTED and although toothbrushing was not something they were looking for but they were very pleased with it.

Kath, Rainbow Ways Nursery:

"Yeah, they loved it, cause it's not seen a lot she said 'oh I've not seen this before'. She said it's obviously promoting good hygiene, good practice so she liked it"

The findings in this section show missed opportunities which could be gained by public health and education policy makers working collaboratively to produce policy that serves the interests of both sectors and thus making it more feasible.

5.2.3 Structural variables

In order to achieve the goals of an oral health intervention, appropriate structural capacity is needed for example, suitable physical, organisational, and human resources. Thus structure refers to the characteristics of the settings in which the toothbrushing club occurs. Structural variables in childcare settings include staff qualifications, group size, setting size and equipment, staff turnover, management structure and child-to-adult ratios. Structural variables are considered to be important prerequisites for the process component (Slot et al., 2015). This is in line with the findings of this study which found that structural resources and

the relationships between them shape the toothbrushing club and its delivery. The following section provides examples from the data.

5.2.3.1 Size of nursery and capacity to host toothbrushing clubs

The size and layout of nurseries may ultimately have an impact on the ease of hosting a toothbrushing club. One nursery suggested that they simply did not have the capacity to have all the children brush every day.

Ann, Crayon Town Nursery:

“...we did it every day, but it took that much time to do that in small groups and that’s why we decided that we rotate it so everyone’s on the list every week but it’s a rotation so it only takes a member of staff out for a shorter period of time just because the way our rooms are set up and there’s only 2 members of staff in each of the rooms, so to take a member of staff out it could leave someone vulnerable. So that’s the way we do it, so it’s just a quick job once a day so that works best for us, I think.”

From the quote above we can see that the toothbrushing club has been shaped by the context as she describes that it was the way the rooms are set up (physical structure) and number of staff (human resources) that dictated the way it was implemented.

The following particular nursery which was approached by Amber from the local oral health promotion team appear to have witnessed some of the children’s poor oral health but nonetheless did not agree to having a toothbrushing club in their nursery.

Amber:

“it’s the staff there they see the rampant tooth decay, days off school because of tooth decay, visits to the dentist, full mouth work. I think it’s just the staff there and there’s nothing that I can say to them that would change that in fact, when I had a meeting and trained the staff atthe staff were very aggressive.... they didn’t want to because of the time, paperwork, all the national curriculum this, this and this and they say well it’s not in the curriculum so.....”.

Again in this example we observe how staff may feel overwhelmed with an additional responsibility and simply do not have the resources to implement what they were being

asked. It again emphasises how the lack of explicitly mentioning oral health in the early years curriculum renders promoting oral health within the nursery more challenging.

For nurseries with inadequate structural capacity, particularly staffing issues, the toothbrushing club is left to compete with other demands and thus it may be pushed down the priority list. A compounding issue is that the OHP team who introduce the toothbrushing clubs are under resourced themselves and do not have the required staffing to provide the extra support needed by the nurseries.

Amber, OHP professional:

“Sometimes I’ve had negative responses to nurseries who’ve had the training, they’ve had the guidelines and then they say ‘oh don’t you come and do it?’No, its staff have to do it every day I said there’s only one of me and I’m only part-time ‘oh we don’t want to do it then’ so it’s a staff thing.”

The structural capacity also includes the managerial expertise of senior EYPs in being able to effectively approach their staff. Ann explains she has a particular way of approaching her staff as she is aware that some may feel it as a burden and she emphasises the need for EYPs to have appropriate support.

Ann Senior EYP and nursery manager:

*“..... I operate sort of a 50/50 relationship really so I’d say look we’ve been approached about this ‘what do **you** feel? Do **you** think it could work?try and make it not a chore for them... I’d just try and support them...suppose depends on the setting as well whether the staff are getting the support they need to put it into practice.”*

An interesting point made by Ann is that even if she agrees to the toothbrushing club, as senior EYP and nursery manager, she is reflective and understands that it is the EYPs that will be delivering the toothbrushing that need to be listened to and supported. And so there is a hierarchy within the nursery itself and managers must be reflective when introducing any new task to be undertaken by the EYPs especially when that task is an optional one and not explicitly required by the curriculum.

The findings emphasise the importance of the need for capacity building through continuous professional development of staff-human resources. The capacity of each nursery may influence the approaches that EYP adopt as will be presented in the following section.

5.2.3.2 EYP oral health beliefs and values

Although the curriculum sets out desired targets Ann, described how the learning goals are interpreted differently by each nursery setting and thus the necessary measures to reach those goals varied. She described how in promoting healthy living and healthy eating nurseries may adopt different approaches.

Ann, Crayon Town Nursery:

“It’s very loose.... the curriculum is very, very loose...it is a self-interpretation. So it’s the settings interpretation of that and what they see as being acceptable because you might go to another nursery and they might take a bottle of juice from a parent and let a child drink it. We would say while they’re with us we’d prefer if you could bring them milk or water.”

Julie also describes how the interpretation for example, of basic hygiene can differ from one practitioner to another based on their own personal knowledge, values and beliefs:

Julie, Starlight Nursery:

“[...] there are lots of things that I might take to indicate that a child has or has not developed aspects of basic hygiene....for example if I see a 3 year old with snot coming down his nose and they’re lickin it, I’m thinking....but if they wipe their nose then that’s an indication of developing basic hygiene.”

Here Ann describes the significance of the EYP qualifications on the quality of the setting and impact that the internal settings policy procedure has.

Ann, Crayon Town Nursery:

“[...] it is internal moderation and the education of the practitioners that you’ve got in the setting that brings the standards up or down so there is a lot of onus on your settings policy procedures, who’s monitoring the curriculum..... every setting sees things differently.”

She explains how it is the senior practitioner(s) within a setting who have the responsibility of interpreting the curriculum and based on their interpretation, layout a settings policy procedure for the staff to follow. She describes how every setting will see things differently depending on their demands, priorities and resources.

Kath, Rainbow Ways Nursery:

“You see little ones walking around upset with their hands on their mouths cause they’re sore....that child isn’t gonna do anything that day...they’re in pain. It’s sad cause you can’t help them and you think he’s not healthy.”

Through experience, Kath came to realise that oral health is part of general health as she has seen many instances of children who are unwell due to toothaches. She expressed how their poor oral health restricts their participation in the nursery activities. Kath’s experiential knowledge influences how she encourages children to think about their oral health.

In the following excerpts Kath and Ann display their experiential knowledge and the link they have made between oral health and general health.

Ann, Crayon Town Nursery:

“They’re unaware how much damage not just to the teeth.... to the health you know because they’re part of each other you know.....it’s not healthy to be eating rubbish like that so we give the healthy lunchbox leaflet when they start nursery so that’s embedded right from the start.”

Kath, Rainbow Ways Nursery:

“Why not promote toothbrushing if we’ve got to promote healthy eating?...we’ve got to promote the need for exercise and physical development, why not promote for your teeth and toothbrushing it all comes part of it... doesn’t it?to promote any part of your health or anything that’s gonna make you fitter, make you better, make you not need any work.”

Here, EYPs view oral health as part of overall health and therefore oral health related practices such as toothbrushing are part of a wider set of practices and thus they are mutually

reinforcing. This is linked to the overall beliefs and values that individual EYPS attached to personal hygiene and indeed to oral health. In addition to viewing oral health as part of overall health the sense of responsibility EYPs feel towards improving children's oral health was also found to play a role in the toothbrushing club.

It is interesting as the EYPs of both nurseries observed in this study, describe how it was when the OHP team showed the statistics and explained to them that the children in their respective areas had the highest levels of decay in the city in addition to witnessing children being in pain and having to miss school due to tooth decay.

EYP, Crayon Town nursery:

"she brought us the statistics so we found out that we were probably, we were the worst area in ...for kids with decay which made it feel even more worthwhileand that's why we felt that it was important and valuable to give it a go really."

This appears to be linked to the oral health beliefs and values of the EYPs and the degree of importance they ascribe to the area. This EYP suggested that when recruiting nurseries that oral health promoters should make nursery staff aware of the local levels of decay in order to persuade them to set up toothbrushing clubs, she did however point out that this depended on the individual settings.

"...I think if they saw the statistics for their local area they were in... an area that needed to improve. I think they'd probably feel really guilty and want to do it so maybe if they sent the statistics for that locality when they introduced it or asked them about it they might change their mind cause then I think they'd feel a duty to do that but then again every setting sees things differently."

Again the issue of beliefs and values creeps into her suggestions because of the 'guilt' EYPs may feel when they see the statistics for the area.

EYP, Rainbow Ways nursery:

"when the lady came to introduce the toothbrushing club she said that this area is ridiculous you know this area is one of the worst in...for dental health for the children's teeth. A lot of the children are having teeth took out you can see it, all rotten and it's awful it's horrible and it must be painful as well"

The notion of responsibility is linked to this EYPs beliefs and values about oral health and caring for children. She draws us in and invites us to align our beliefs with hers with the phrase 'you know'.

Making nursery staff aware of the local levels of decay may not always be enough to encourage them to introduce a toothbrushing club if as discussed previously they do not have adequate structural capacity. It may also be more effective if the beliefs and values of EYPs align with providing oral health promotion because they perceive it as important. Here we have tensions between what is being asked of the nurseries, the beliefs and values of the staff and the resources available. The next section provides some of the findings on possible barriers to the toothbrushing club.

5.2.3.4 Structural barriers

An interesting and important point made by Ann (a senior EYP) is that the toothbrushing club is as dynamic as the nursery. She felt that having a toothbrushing club requires regular evaluation and adaptation to any changes within the nursery setting.

"I think just getting it in there and embedding it into practice and restarting ...that's every year. So you have to restart every year and if you've got a difficult cohort of kids that are really difficult to focus that you know as I've said with the.... if it's taking a member of staff out you're leaving other members of staff quite vulnerable to manage more children. But then you work out which children to put in which groups so you're splitting those children up so that's probably the challenge really so sometimes it takes a little bit of working out which children need to go in which group and things like that."

When I asked Kath (a senior EYP) what she thought could be possible barriers for those nurseries that chose not to have a toothbrushing club, she believed that the most important thing was making sure the staff understood the importance of it and the benefits the children would have from it. She also explained how some nurseries would complain that they didn't have time but she didn't agree. In her opinion any nursery that had an appropriate staff to child ratio should make an effort to find a suitable way to have the toothbrushing club.

Kath EYP:

“Assuming they’ve not got issues with their numbers, I won’t say time really matters there’s always a struggle for time doing everything within a nursery you know.... you’ve got to get snack in, nappy time in, playing out, story time, activity time, there’s so much to fit inso if you use that as an excuse every time you won’t have time to do anything will you? You just got to fit it in and manage it and you just have to find the right way that works for you and your children, our staff have all got it they all know the way to do it. They all make time to do it.... because you get benefits from it....it’s worth it.”

She went on to describe how she was currently helping out in another nursery as they had someone off sick and that they had been previously approached by the OHP team. The nursery had received the training and resources but had not yet started running the toothbrushing club. She said that they were anxious about the toothbrushing club because they were issues with the daily running of the nursery. This indicates that resources have the potential to have an impact on whether the toothbrushing clubs were implemented and sustainable.

Kath EYP:

“...their snack time is quite hectic as it is because their children ...they don’t encourage them to sit, so they kind of run around a bit here, there and everywhere. So I think they need to work on their snack time anyway and when they’ve got that more set then it should be easier but they’re gonna find things hardbecause they’re not organised... if the kids aren’t sitting down and kids running round... but you got to encourage them that’s part of us being there ...they could do with some support you know in managing their daily schedule, they need to sort that out first.”

Kath expresses that this nursery appears to lack the managerial expertise and needs support on how to manage the daily activities of the nursery and thus they would undoubtedly find another task overwhelming although they had good intentions and were willing to do it. This further supports the importance of capacity building.

The OHP team also faced certain challenges gaining access.

Amber, OHP professional:

“....biggest primary school inI had a lot of problems trying to get into that school. A hygiene therapy student contacted me and said she contacted the school and is doing a project inand could I help and I went Yes! So I’ve gone in and spoken to one of the managers there who has dealings with all the health part of the school, lovely lady showed me around the school and because I had been trying to target the nursery, she took me round and she says ‘oh that’s nursery but you’ll not get in there’, so obviously it would have been the staff there that is the problem.”

She described how she was unable to access nursery so set up the toothbrushing club for the 5 year olds. Even though her remit was for under 5’s she felt that since she did not have access to the under 5’s in this particular area then at least the children could have it at 5. This was considered to be important as these children lived in one of the most prioritised oral health action team areas with the worst levels of dental decay in the city for children 5 and under. She described how dental therapy and dental hygiene students interested in setting up toothbrushing clubs have actually helped her gain access into some nurseries that had previously declined. These students had not contacted her prior to starting their projects and contacting the schools. She only became aware of their projects when they contacted her asking if she could provide funding for the toothbrushing club to continue. Regarding the role of the dental therapy and dental hygiene students she believes it’s important that they work together rather than independently from them. This illustrates her ideas around collaborative working, capacity building and reorienting oral health promotion services.

Amber, OHP professional:

“They start it, they do the project and that’s it that’s them done. That’s why I like them to come to me so I think it’s a sustainable project; it’s no good if they’re going to do 1-2 week project nothing good will come out of it you know what I mean? Yes the child might have a free brush and toothpaste but how, what good is that? at least they have made the initial contact which has been good for me to get into some schools that I’ve had problems with.”

The dental hygiene and therapy programme students can be viewed as facilitators of access for the oral health promotion team, but also the work they do needs to be sustainable and not just an example of dropping in to deliver a project with no support for the nurseries afterwards. This raises issues around the ethics of projects which are for the purposes of fulfilling course requirements but which fail to engage with community development.

“...and there’s been a couple of nurseries who have not started it.....that’s to do with the staff themselves and their attitude you know what I mean? ‘oh they’re forcing something else on me’ you know?”

Although Amber may have a point here, she also displays a lack of insight into the everyday life of the nursery and the roles of the EYPs. This leads her to make an assumption that the EYPs are being somehow difficult. One point made by the EYPs and the OHP team is that other nurseries may be more receptive if first approached by other EYPs already involved in toothbrushing clubs. Amber explained how some nurseries she didn’t contact, because they were not in the targeted action areas, have contacted her to ask for resources and her support in setting up a toothbrushing club. These were due to an EYP from another nursery who was involved in toothbrushing clubs telling them about their experiences. Ann also suggested that EYPs may engage with developing skills and communities, simultaneously facilitating the job of OHPs through sharing their experiences with other EYPs. The power differentials between EYPs are less than those between the oral health promotion team and EYPs and this may be a potentially useful facilitator for increasing the reach of the OHP team in the area. Through her experiences, Ann explains how sometimes when the OHP team contact a nursery it may not even reach the necessary individual.

Ann, Crayon Town Nursery:

“.....someone might not pass that message on if she sends an email out it might not get to the right people ...So I suppose people like us sharing what we’re doing is valuable because then they think oh well maybe we need to ring them and get that started in our setting so I think maybe just word of mouth.”

Possible reasons nurseries may refuse may have to do with the personal values that the staff attach to oral health or possibly that they have a more demanding workload than other nurseries, or possibly their personal beliefs on parenting and the responsibilities that come with it (Woodall et al., 2014). I can further suggest that power may play a large part in these interactions because if nurseries are approached by an ‘outsider’ to their social world they may perceive that there is lack of understanding as to the ways in which they operate and the pressures of delivering the everyday curriculum.

It is not my intention to explain why the staff in that particular nursery did not agree to run a toothbrushing club, and why Amber was told by school staff that she was not going to be able to access the nursery but rather to point to the importance of understanding *why* some nurseries agree while others don’t. We can suggest here that an important starting point may be understanding that each nursery is different and they cannot be considered as one homogenous group, but rather have different structural capacity and wider environmental influences that have unique contextual factors which define them as individual settings. This has implications for introducing and implementing supervised toothbrushing programs within nurseries.

5.2.4 Process variables

Process refers to the daily experiences of children in early years settings that are conducive to development, which includes engaging in activities and social interactions. In a nursery setting, process variables include the manner in which the children experience the care provided to them. This includes the quality and nature of interactions and conversations, the variety of stimulating materials, and the manner in which activities are arranged. Therefore the concept of participation is key to the process component and the following sections provide findings from this study which present participation on a micro-level through the everyday experiences of children’s social interactions within the nursery and the toothbrushing club.

5.2.4.1 Oral and general health education

The following is a conversation between Kath an EYP and a 4 year old boy, Oliver from Rainbow Ways nursery.

Kath: Finish off all your fruit, you need to eat your fruit cause it's healthy, eat it for a healthy tummy.

Oliver: I like chocolate for my tummy!

Kath: but that won't give you a happy tummy

Oliver: Oh yes it will! smiling widely

Kath: (laughs) But it won't be a healthy tummy

Oliver: (thinks a while) it makes you fat!

Kath: (laughs) yes it does but it can also make your teeth sore and not nice-looking

Oliver: Eewww!

In this interaction Kath engages with Oliver and takes the opportunity to help Oliver make meaning of what is healthy and help him reach the learning goal 'importance for good health...a healthy diet'. From her perspective, Kath equates healthy to being happy but she then learns that for Oliver being happy and being healthy are not necessarily related. Kath makes the distinction for Oliver that just because he enjoys chocolate and has a 'happy tummy' this does not mean that it is healthy, Kath allows him the time to think about the distinction she has made and then Oliver makes sense of it through the possibility of it making one overweight which he understands is unhealthy. He is now able to make the link between eating chocolate, being overweight and being unhealthy. Kath then explains how it will affect his oral health as well, in a way she believes Oliver will understand and so she highlights pain and appearance.

The EYP's do try to engage the children in conversations about toothbrushing and oral health outside of the toothbrushing club. One example is during storytime.

All the children were sitting down on the carpet and appeared excited that Kath was going to read them a story. As Kath was reading the story one of the pages showed some hippos with their mouths wide open,

Kath: What can you see inside his mouth?

Child shouts: A big tongue!

Kath: What else do you see?

Some children shout: Teeth!

Kath: Good, now can you see anything else? Think really hard. What are these above the teeth (as she points)

Ella: Gums!

Kath: Clever girl Ella! At nursery we brush our teeth and gums to keep them nice and clean and healthy. Are you all taking care of your teeth at home as well? Are you keeping them clean and healthy?

Some children nod yes and some do not respond.

Kath: How many teeth does this hippo have?

Some children shout: 4!

Kath: How many do you have?

Children are quiet many of them sticking their fingers in their mouths trying to feel their teeth.

Kath: Next time you brush I want you to count your teeth and then when you are in nursery come and tell Kath how many you have. Remember if your teeth aren't clean they will get sore and that will make you sad. So keep brushing!

This observation illustrates how Kath seized the opportunity when the story showed a close up picture of a hippos mouth to engage the children in conversation on the health of their mouth and reinforce the oral health messages the nursery was trying to deliver to the children of the need to brush or else they may feel pain. This approach emphasises the creativity of EYPs and the power of storytelling to deliver health related messages.

5.2.4.2 Participation, positive reinforcement and skill development

Positive reinforcement emerges from the field of behavioural psychology and is often used in educational environments. It is often seen as way of encouraging children to acquire new skills or promote desirable behaviours. Alfred Bandura suggested that modelling and/or reward was one way of reinforcing positive behaviour. Reward may be seen as praise or validation.

Susan from Crayon Town Nursery and her instruction in the toothbrushing club:

That's good but don't forget those teeth all the way in the back (as she opens her mouth points to her back teeth)

Got to do your top ones and your bottom ones as she points to each one

Keep brushing it hasn't been 2 minutes

How long do we need to brush for? Yes 2 minutes

Oh ...look you forgot to brush those teeth

Don't forget to brush your tongue at the end

We want those teeth to sparkle!

Susan usually then asks all the children to show her their smiles to which she responds

Oh...fantastic they're sparkling!

Children respond to this praise by flashing their smiles to other children as they appear to be proud of their sparkling smiles.

Carrie (nursery pupil):

Hey, Lora....look ..my teeth...they're sparkling! Says Carrie as she smiles a very wide smile.

Skill development can also be promoted through positive reinforcement and praise was often used during the toothbrushing sessions at the nurseries:

During the singing at Rainbow Ways Nursery, staff are very cheerful and supportive and children who are not brushing are encouraged by staff with comments such as *I can't see you brushing, Where is your good brushing?, Who is doing good brushing?* They also continually praise those children who are brushing well or are trying to brush with comments such as *That is good brushing, I can see some really good brushing.*

Kath sometimes tries to make it more fun and help get the children involved, for example instead of singing *this is how we brush our teeth* she will swap it with *this is how we brush our hair, brush our hair, brush our hair.*

No, it's brush our teeth! the children shout as they laugh

Kath laughing continues to sing altered lyrics

The spoon in your mouth goes round and round, round and round.

No, the toothbrush! (the children shout as they laugh)

The toothpaste in your mouth goes gulp, gulp, gulp

No, goes bubble, bubble, bubble (as they laugh even louder than before)

Ah.... so you were listening!

Kath has managed to get all the children's attention and giggling and laughing and makes the task fun in the process. *Ok now, let's see good brushing.* For example, a young girl who sat sucking on her brush was told, *Good try Isabel, keep brushing. That's it you want to brush round and round.*

This level of encouragement from the EYPs mean that children are developing daily routine toothbrushing practices at the nursery, although these practices may not always be carried out in the home environment.

5.2.4.3 Peer support and oral health promotion

Ann describes how she thinks brushing at nursery allows the children to support each other

Ann:

"....the other kids help out, help us educate at the same time cause they talk about routines at home so I think the kids they love it.... the kids that are used to it, it helps the children that aren't used to it cause they'll say 'well I do mine in the morning when do you do yours' it sparks that conversation."

Peer-to-peer support and learning is often used in the field of education but it is also used in the field of health promotion and viewed as a way of increasing participation (Wong et al., 2010).

5.2.4.4 Complexities of structure and process

Although the routine of the nursery setting is predominantly designed for the collective, children are able and competent in removing themselves and creating alternative spaces. The following vignette illustrates how children may do this.

Cindy had told all the children to go wash their hands as the other staff repeated it around to get all the children's attention. One girl seemed upset and did not respond to the staff calls to go wash her hands. Cindy called out to her and asked her if she could come and wash her hands the girl, Sophie who was new did not respond. Another girl, Layla who was on her way to the sinks, heard Cindy talking to Sophie and turned around she looked awhile at Sophie and then began to walk back to the play area where she was sitting. Cindy saw Layla and called to her and reminded her that she was supposed to be washing her hands like the other children and not playing. Layla ignored Cindy and walked up to Sophie, she looked at her gently and smiled she then took her hand and tilted her head towards the sinks and smiled again. Sophie got up out of the chair and walked with Layla to wash her hands. Afterwards, Layla took her to a table as it was snack time and they needed to be seated with the other children. Layla took out a chair for her and sat down she then took out the chair next to her, looked up at Sophie and smiled. Sophie gave Layla a nod and a little smile and sat down next to her. Although Cindy initially appeared frustrated that Layla had ignored her, when she realised Layla's intentions she stopped calling for her to come back and observed their interactions. She then praised Layla for taking care of Sophie on her first day at nursery.

It appears that although Layla was acting as part of the collective and following the social order of the nursery she then chose to exert her agency by ignoring Cindy for something she felt was more important. She makes the decision to help and support the new girl who has no friends, giving her priority over following the rules. Although there was no verbal communication between the girls the interaction appeared to be affectionate and genuine. Layla was able to comfort Sophie in her own way and Sophie who had chosen to ignore Cindy, chose to trust Layla and follow her lead. Both children were able to make a connection with each other without verbal communication and acted as *active agents*

reshaping the situation into one that was more acceptable and pleasant for both of them. In taking away the constraint around following rules, Cindy enabled the children to participate on their own terms. If we return to the dominant conceptualisation of children's agency as active participation and the ability to act in a particular context and act dependently and make choices on their own (Corsaro, 2006) discussed in section 1.4.3 we can see that children's agency is expressed in different forms and has different meanings in different contexts. I argue that understanding how children exercise their agency and become active participants in different contexts is crucial to understanding how children may, or may not, participate within the toothbrushing club.

5.2.4.5 Participation

Participation as a process involves social interactions the following section will present each nursery with a focus on everyday interactions and what that participation looks like.

5.2.4.5.1 Participation and adult-child interactions in Rainbow Ways Nursery

The following vignettes illustrate some adult-child interactions in the daily routine in Rainbow Ways Nursery. This is important because as we shall see these techniques and approaches have a profound effect on how the toothbrushing club was established and maintained. Today the EYP had a meeting and left the assistants Megan and Charlotte in charge of playtime. There was an observable difference in the children's behaviour; they were much louder and ran about more. When the children were asked to tidy at the end of playtime many of them didn't listen and one of the assistants went to get Charlotte a more experienced EYP to help her with the children. Charlotte came and told the children that she was disappointed that they did not listen to Megan and she began to encourage them to tidy, she stood and watched until they were finished all the while praising those who did and encouraging those who didn't. After tidy-up time was over she called out to the children,

Charlotte: Can you all please come sit down here next to me please? We need to talk. Today at nursery many of you did not tidy-up when you were asked by Megan and Charlotte, and at nursery we have to do good listening.

She explained to them that she was not giving out any stickers today because she was not happy with how the children behaved.

Charlotte: I think we need to practice our good listening, let's read a story. I'm going to have my looking glasses on to see who is doing good listening, okay?

As she read the story she praised those who were doing 'good listening' and began to call out the names of the children one by one in order of those who she thought listened best. By now the children were much calmer and appeared to have understood that they had not followed the rules they also appeared to be engaged in the story.

Charlotte: Thank you boys and girls I saw some very good listening.

After asking the children to tidy up Charlotte rewarded those children who did 'good tidying' with stickers and a round of applause and those that didn't were not given any stickers.

If the following excerpts are considered through the themes suggested by Johansson (2004), it appears that the atmosphere is a 'controlling atmosphere' and Charlotte uses a reward/punishment approach to encourage the children to tidy. However, it is not controlling in a manner that prevents the child from learning from the experience and creating meaning. Charlotte appears to interact with the children as rational beings but the strategy she applies portrays her view of learning as having 'confidence in the child's capacity' in addition to 'punishment and reward' she attaches importance to stressing rules, conditioning the child and using rewards and occasionally punishment as a strategy. She does not solely rely on this strategy for enabling children to learn about respecting rules. She engages the children and guides them through the process of understanding the consequences of their actions promoting critical thinking and appears to have a close relationship with them. This could arguably be seen as a form of democratic 'meaning making' (Moss, 2007:12).

All the children who had stickers for 'good tidying' were asked to wash their hands and sit down at the table. As that group of children went to wash their hands, Charlotte talked to the remaining children of how it was important for them to do good tidying.

Charlotte: I want to tell you why you did not get stickers today, because you did not do good tidying. At nursery we have to do good tidying.

Some children objected saying “*I did tidy*”, “*I put away my toys*” and Charlotte listened to all of them and then said:

Yes you did do some tidying, but Cindy had to keep telling you to tidy and some of you I saw put away only one toy so that’s not good tidying because some of your friends put lots and lots of things away.

Charlotte continued to explain to the children in a firm but affectionate voice,

You see if we don’t put our things away we won’t have room to play and we won’t be able to find anything when you want it, it’s also not very safe because you may trip and fall and get hurt. That’s why it’s important to put things back where they belong. We have rules at nursery, we have to follow those rules and one of them is at the end of playtime we have to tidy up.

Many of the children who were upset before seemed to have calmed down now and nodded their heads in agreement when Charlotte asked if they would do good tidying next time. In this way, Charlotte gently reinforces the rules and gains the children’s agreement to participate in future.

Charlotte told the children it was outdoor playtime and that they should all go put their coats on as she waited by the door and began to sing the theme song for ‘Thomas the Tank Engine’ they were asked to stand in a line and join in the song. They then began to queue at the door and she sang the first half of each line of the song and let them finish it off, the children were excited and enjoyed showing they could finish off Charlotte’s song. She would react with expressions of surprise and astonishment that they knew the lines to which many of the children smiled triumphantly. While Charlotte was waiting for the children one of the boys attempted to cut into the queue in front of another boy.

Charlotte: Oliver, you are not allowed to cut in front of other people. These children were here before you. Your place is at the end of the queue.

Oliver became upset and refused to go back to the end of the line.

Charlotte: It’s your choice Oliver, you either go back to the end or you can stay inside, you need to decide what you want to do.

Oliver takes a few moments and then reluctantly goes back to the end of the queue.

Charlotte: Thank you Oliver for making that decision; at nursery we respect one another and that means we do not cut in front of other people. Is everyone ready? Okay choo....choo..choo (as she opens the door and the children excitedly run outside).

In this observation Charlotte attempts to share the children's world through using a familiar children's song and creates a situation whereby both she and the children can participate together by singing different parts of the song. The children enjoy finishing off the lines of the song and laughing with Charlotte. As an observer it appears that through engaging the children in this manner she has also used the song as a tool for constructing social order in the nursery and thus the atmosphere is one that it is interactive yet controlling.

In her interaction with Oliver she treats him as a competent learner and as a competent fellow-being. She clearly explains to him the rules and consequence of not following them and then enables him to participate by making the decision himself rather than physically taking him by the hand to the end of the line. She then explicitly acknowledges and praises him for his decision.

From my field notes I noticed a similarity in the strategy of using a song, in the previous example in which Charlotte uses the theme song for Thomas the Engine and staff using The Wheels on the Bus for the toothbrushing club. The song in addition to the number of staff involved, creates an atmosphere that is interactive yet controlling facilitating a form of 'controlled participation' within the toothbrushing club to ensure that all the children brush, now while many of them may not have the actual dexterity to brush properly their aim appears to be that the child has the brush in their mouth whether it be brushing, sucking or chewing and that they all get their required daily fluoride exposure.

5.2.4.5.2 Participation and adult-child interactions in Crayon Town Nursery

During playtime, children were running around loud and screaming one of the boys took the bucket from the indoor sand pit, filled it up with water and began to pour water in the bins. Susan upon seeing him told him to stop. The boy continued and now began to pour water on

the toys around him, Susan told him to stop making a mess. Now the boy had filled up the bucket again and poured it over his head. “*Oh! Don’t do that!*” Susan said as she came quickly and took the bucket away and went clearly frustrated to get him a change of clothes. The boy looked at Susan wide-eyed and was quiet, I later approached him after he had his clothes changed and asked what game he was playing with the water. He explained that he was trying to make things grow the way plants grow with water.

In this observation Susan does not explain to the boy why he needs to stop or the consequences of his actions. The interaction between them is a narrow one in which the boy is not enabled to be an active learner of the experience and no attempt was made to understand his intentions. There was a lack of reciprocity and no opportunity for the boy to participate, he was not able to voice or explain to Susan that he was not ‘*making a mess*’ but wanted the toys to grow bigger and himself to grow taller. This is in contrast to Rainbow Ways Nursery who tended to listen to children during playtime in order to understand their perspective and try to gain their participation.

In another instance during playtime a girl put some seashells she was playing with down the toilet. One of the children came and told Susan what the girl had done. Susan came over and scolded “*Oh! What have you done?!*” As she closes the toilet door and tells all the children that this one is closed for the day and to use the other one. She then left and did not directly speak with the girl who was still standing at the toilet door. I then overheard the little girl who was now upset explain to her friend that she only wanted to put them in water as seashells are always next to water on the seaside.

Again Susan does not directly engage the girl in conversation and is quite distant she does not explain to her why she should not put seashells down the toilet and does not attempt to understand from the girl’s perspective why she did so. The girl’s intention was not to break any nursery rules but to put the seashells in a place where she thought they belonged.

During playtime at this nursery the atmosphere is often one of distance where Susan and Louise try to get through the intensive situation as calmly as possible. There is hardly any conversation between them and the children, other than instructing the children to not run, fight, push, or anything else that they may be doing that is against the rules. Although they

attempt at times to play with some of the children this is often interrupted by the actions of other children requiring her attention. The atmosphere is often chaotic and appears stressful. From the observations it appears that Susan has developed a different approach in frantic, stressful situations where the communication between her and the children seems to be suppressed and the children's participation is prevented. She appears to be unresponsive to their world and takes on a view of learning of 'awaiting the child's maturity'. She does not engage with the children in these situations with the view that they are competent fellow-beings. And the children are not enabled to experience and create meaning. These observations are important as they illustrate the nature of the interactions and will be compared to those that occur in the toothbrushing club presented further on.

The children were practising songs for a performance they had and Susan rewarded all those 'who sat on their bottoms' and sang all the songs with stickers. Joshua was unhappy because he did not receive a sticker and begin to stomp his feet and shout.

Joshua: I did sing!

Susan: Not all of them

Joshua: I did! I did sing! I did! (he continued to insist repeatedly about 15 times)

Susan: I'm not going to argue with you (as she turned her attention to the other children and ignored him)

Joshua: Not fair!

In this observation there is a controlling atmosphere in which Susan appears to view Joshua as irrational and does not listen to his objections or try to further explain to him why he has not received a sticker, she chooses to ignore him; whether this was done as punishment and a strategy to enable Joshua to learn about rules, or simply as a method to avoid conflict is unclear. During toothbrushing club and while the children are brushing, Susan constantly reminds them to brush at home and talks to them about their teeth and how to keep them healthy. In this instance there were two girls and two boys, the boys chose to stay quiet and listen. During this conversation the children displayed their attachment to the tooth fairy and what they understood about their baby and adult teeth. From the children's perspective the tooth fairy seemed to be a significant part of the tooth loss process. One child seems to

indicate that to her the tooth fairy makes it worth it and the thought of losing a tooth and not having the tooth fairy come for your tooth is upsetting. The children do not appear to have yet clearly understood the distinction of baby teeth and that adult teeth are the last set of teeth you will have. The following is a conversation between Susan and the children at the sinks before they start brushing.

Susan: Did you brush your teeth this morning?

Annie: No

Jessie: No

Susan: Why?

Annie and Jessie: I forgot

Susan: Didn't anyone at home remind you to brush?

Annie: No

Jessie: Mine neither!

Susan: What happens if you don't brush your teeth?

Jessie: They turn black and fall out!

Annie: Yeah, but it's ok then you can put your tooth under the pillow for the tooth fairy to come. I can't wait for my teeth to wobble!

Susan: Yes, the tooth fairy is nice. You know it is okay for these teeth to fall out. Do you know why?

Annie: Cause I'm gonna get big girl teeth!

Susan: That's right Annie, but we have to take really good care of our big girl or big boy teeth cause after that we won't be getting anymore. If they turn black and fall out you'll be left without teeth and have a gap of missing teeth. What happens if you have a gap? pause Sometimes you won't be able to do somethingdo you know what that is?

Annie: Talk?.....My Nan talks funny cause she ain't got no teeth here (points to her front teeth)

Susan: Yes but also you may not be able to eat as well!

Annie: You know April has two teeth! (Annie's baby cousin I later find out)

Susan: Wow! How many teeth do we have when we come out of our mommy's tummy?

Annie: Two! Like April!

Susan: (laughs) No, we have none. Then we get teeth.

The children looked a little confused especially Annie

Jesse: Susan, doesn't the tooth fairy come for your big girl teeth?

Susan: No

Jessie: Are you sad?

Susan: No, it's okay she came for my little teeth

Annie: That's not nice (frowning)

Jessie: Yeah, not nice!

Susan: What is?

Annie: Your teeth fall out and the tooth fairy doesn't come, that's no fun

Annie and Jessie appeared genuinely upset at the revelation that the tooth fairy would not come for their big girl teeth, this seemed more important to them than the revelation that they wouldn't be getting any new teeth after their big girl teeth.

During another conversation the children discussed whether they liked brushing their teeth at nursery and if they preferred it to brushing at home. There were varying responses for different reasons. All the children did like brushing their teeth at nursery, some said it was fun where another seemed to focus on the individual attention she was getting from Susan. Another boy stated that although he was okay with brushing at nursery he preferred brushing at home because he liked to brush with his batman character toothbrush and his flavoured toothpaste. For another boy it was the emotional attachment that was the reason that he preferred toothbrushing at home.

Susan: This morning you're going to brush your teeth at nursery aren't you?

Some children reply with a nod others say yes.

Susan: Do you like brushing at nursery?

Some children reply with a nod others say yes.

Susan begins to hand each child their labelled toothbrush, as she does this I whisper to Susan and suggest if she could ask them if they prefer to brush at home or nursery and why.

Ella: Nursery!

Susan: Why is that, Ella?

Ella: Dunno, it's justdunnofun

Sara: (giggles) yeah it's fun

Susan: That's nice

Ella: Yeah, I get to brush with my friends

Susan: How about you Sara?

Sara shrugs her shoulders

Susan: Sara...do you like brushing at nursery?

Sara: Yes

Susan: How about at home?

Sara: Yes

Susan: Do you enjoy one of them more than the other?

Sara: I guess

Susan: Go on

Sara: Well..... my mommy forgets to tell me to brush my teeth so I don't brush too much at home. But I get to brush at nursery and you stay with me....I like that

Susan: Ah, ok sweetie

Susan looks at me to see if there is anything else to ask, as the children have their backs to me I mouthed to Susan to continue with Ella and suggest that she remind her mommy.

Susan: Sara, do you think you could remind mommy when she forgets

Sara: Oh I always forget....even more than mommy!

Susan: Could you give it a try?

Sara shrugs her shoulders then says 'Okay'

Susan: James, how about you?

James: Oh no, I like at home much better!

Susan: Really? Why?

James: It's boring!

Susan: Boring?

James: Yeah..... at home I have a batman brush and strawberry toothpaste. Here all we have is plain toothbrushes and plain toothpaste!

Simon: I like brushing at home better too

Susan: Why?

Simon: Cause my dad stays with me when I brush before bedtime

The following example illustrates one of the ways in which children choose to participate and why some may decide not to. An EYP from another classroom was helping Susan with the children. She told the children to line up so they could go outside to play; Susan reminded her that the children had not yet brushed their teeth. So the EYP asked the children who were lined up at the door ready to go outside who would like to brush their teeth before they go to play. Annie and Emma both decided to stay as they said they had not brushed that morning and so wanted to brush their teeth. Susan then had a look at the toothbrushing rota and decided that there were two other girls that had to brush their teeth before they went outside. She called Lesley and Mia over to come brush their teeth and asked them if they had brushed in the morning at home.

Lesley: No, I keep forgettin'

Susan: well if you keep forgetting your teeth will get dirty.

Lesley: I've been to the dentist

Susan: what did he say?

Lesley: he said brush your teeth all the time!

Susan: do you know what will happen if you don't?

Lesley: dunno

Susan: They'll fall out

Lesley: yeah well Kian's teeth fell out and he has new white ones!

Susan makes a face that appears as if she was unprepared for Lesley's response and is thinking of what to say to her

Lesley: See....it's ok don't worry 'bout ma teeth"

This interaction shows that when they were given the freedom to choose Annie and Emma made their own choice to stay and participate in the toothbrushing and although they were not in the rota that day Susan decided to accept their choice and seemed pleased that they had made an argument for why they needed to brush which is that they did not brush at home. Both girls displayed their agency in choosing to participate which was based on an understanding that they needed to brush every morning. Lesley on the other hand did not choose to participate and had to be told by Susan; however it becomes apparent that she does not have the same understanding as the previous girls as she has formed her understanding from observing her older brother's teeth. For Lesley, although the dentist and Susan advise that not brushing will lead to teeth being dirty and falling out; she has based her logic on Kian's new white teeth to which she seems to like. Based on her situated knowledge around brushing and teeth falling out she challenges Susans' logic and takes ownership of the situation in telling Susan in a comforting reassuring voice to not worry about her teeth. Interestingly, Susan's interactions with the children during toothbrushing club are of a completely different nature than to those during playtime or tidy-up time which can be interpreted as narrow interactions. This is a significant observation as it illustrates how adult-child interactions are not static and are affected by the context and not solely dependent on the adult's view of the child or child participation.

5.2.4.5.3 Spacious and narrow interactions in the nursery setting

We have seen that staff at the two nurseries exhibited different forms of interactions with the children and this differed according to context. Although the children's individuality was demonstrated to be valued at Rainbow Ways nursery, many of the pre-planned activities such as the toothbrushing club are designed with the collective in mind.

Taking a relational perspective to participation, the size of the group and nature of the activity appears to have led to the children being distanced and lacks the more spacious type of interactions described by Bae (2009) and seen during times such as story time and playtime. They appeared to be acting as members of a collective with staff facilitating the accomplishment of a task. This illustrates the tension that exists within an early years setting bound by its institutional rules.

In Crayon Town Nursery, Susan's interactions with the children during toothbrushing club are of a spacious nature and are quite a contrast to the narrow nature of Susan's interactions during playtime whereas she appears to be unresponsive to their world and takes on a view of learning of 'awaiting the child's maturity'. The children are viewed differently in that context and they are not afforded the opportunity to experience and create meaning. For example, in her interactions with the young boy who wanted to pour water to make things grow or the young girl who wanted the seashells in the toilet so they could be in water. The children were heard but not listened to in those situations however during the toothbrushing session they appear to enjoy a communicative relationship where they were listened to and able to express themselves and their views of teeth and a healthy mouth. This led to an important finding; that children's participation was significantly shaped by the contextual factors of their setting and not dependent solely on the practitioners' capacity, views of childhood and children's participation.

5.2.5 Outcomes

The outcome of the oral health intervention differed in the two nurseries. Rainbow Ways nursery can be said to have achieved the intervention aim of daily fluoride application whereas Crayon Town nursery failed to do so and focused on skill development instead.

Another significant difference between them was in the approach each nursery adopted and thus the process differed with differing opportunities of participation. Rainbow Ways took on a goal oriented approach and as they had a suitable number of staff was able to have all the children brush collectively, in line with the norm of a nursery environment.

Crayon Town on the other hand was not able to have all the children brush every day and adopted an individualistic approach, unlike the norm of the nursery, as they did not have the structural capacity to do so. Although they did not meet the aim of the intervention there was however a focus on skill development within the tooth brushing club.

It's interesting to note that upon revisiting Rainbow ways Nursery at the beginning of the new school year, I found they had changed this collective approach that I had previously observed during data collection. They now adopted a more individualised approach due to the introduction of a number of children with special needs and thus the staff/child ratio had changed. This emphasises the dynamic nature of the nursery environment.

Table 3. Summary of Rainbow Ways and Crayon Town toothbrushing clubs

Rainbow Ways toothbrushing club	Crayon Town toothbrushing club
Collective approach	Individualistic approach
Children brush everyday	Children brush twice a week
4-5 staff members supervise all the children as a group	1 staff member with 4 children
Brushes collected all together and rinsed together	Brushes collected separately and rinsed separately
Staff aim for fluoride exposure every day for all children	Staff focus on thorough brushing; skill development in using a toothbrush
Children brush while seated at tables	Children brush at sinks
Narrow adult-child interactions	Spacious adult-child interactions

This chapter has presented the findings of this study; analysis highlights the influence of context on participation and on oral health promotion. The two nurseries had contrasting toothbrushing clubs each with different processes and differing opportunities for participation and had different outcomes. This could be explained in terms of their different structural capacities. This is a significant finding for settings-based health promotion.

Chapter 6 Discussion

The aim of this study is to explore the dynamics and meaning of children's participation in an oral health promotion (OHP) programme implemented in nurseries. This is an ethnographic case study which is a novel approach to dental research and involves participant observation of children and EYP's within 2 nursery settings as case studies and 6 semi-structured interviews with professionals. The main findings of this study are firstly, that the model of children's participation adopted by health promotion does not sit well with that being used actively and daily by EYPs in the nursery setting. This is discussed in detail in the next section. Secondly, the curriculum is central to determining what goes on in early years settings because it establishes the priorities that EYPs should work to. Thirdly, oral health related skills are not actively promoted throughout the curriculum as part of health education generally and it appears that the mouth is still being separated from the body which means oral health fails to be integrated holistically. Fourthly, health promotion programmes such as the toothbrushing clubs are typically conducted under tight fiscal conditions and therefore are unable to promote wider engagement within the community. Indeed, it would be unreasonable to expect EYPs to go beyond their role to promote the wider levels of engagement necessary to attain real change at the level of the community. Each of these findings emphasise the importance of understanding the context and how this relates to participation. This chapter discusses the findings in relation to the literature on children's participation in oral health and dentistry, the wider literature on participation in health promotion and the early years education literature on participation. During the process of discussing the implications of the findings, the chapter also considers the strengths and limitations of this thesis and concludes with recommendations for policy and future research.

6.1 Implications for oral health promotion

Children's participation within various literatures (children's rights, health promotion and dentistry) positions genuine meaningful participation as being increasingly about choice and decision-making. In the health promotion literature participation is described as a tool for enabling change (WHO, 1986). These positions assume a rights-based or political perspective

on participation. Although these concepts are without doubt important for children, it may be that they are not always possible, or achievable. For a variety of reasons, other authors have suggested that this becomes even more challenging when it comes to working with younger children because they are not a homogenous mass with universal capacities; they differ in developmental capabilities, social skills and personality (James et al., 1998). Therefore, the ‘individualistic’ interpretation of participation that we find in these literatures tends to be focused on decision-making and this appears to be rooted in adult concepts such as democracy, citizenship and agency; leading to confusion on how to apply them. This confusion appears to stem from the lack of context because participation appears to be something that exists in a vacuum and has not been defined in any depth for children, with adult models being applied to the world of children. Some authors argue that in order to be realised in practice it is crucial that the articles in the UNCRC be *contextualised*, and go through a constant process of interpretation which takes into account cultural, temporal, local and age-related factors (Penn, 2009). The findings of my study illustrate that the daily opportunities for children’s participation within the toothbrushing club are shaped by the contextual factors of the nursery.

If we consider that context appears to be ignored in the existing models for child participation and apply Hart’s taxonomy at face value to the findings of this study then children’s participation in the toothbrushing club appears to be nothing more than tokenistic. For instance, if we consider Hart’s four requirements that must be fulfilled to attain genuine participation:

1. The children understand the intentions of the project
2. They know who made the decisions concerning their involvement and why
3. They have a meaningful and not simply a decorative role
4. They volunteer for the project after the project was made clear to them.

(Hart, 1992:12)

We find that the fourth requirement: “They volunteer for the project after the project was made clear to them”, stands in opposition with the overriding aim of the toothbrushing clubs.

The original aim of these clubs was to apply fluoride to the teeth of all the children in order to prevent tooth decay. The toothbrushing clubs were not seeking to promote participation. Indeed, we could suggest that they portray a certain level of utilitarianism with respect to their goals. Once children's parents consented, children themselves were not offered a choice, and so *it may appear* that children could not meaningfully participate as individuals. The guidance document; *Implementing child rights in early childhood* states:

*“Article 12, as a general principle, is linked to the other general principles of the Convention..... and, in particular, is **interdependent** with article 3 (primary consideration of the best interests of the child).”*

If we take the more holistic interpretation of the UNCRC and consider the child's best interests, not affording them the choice to participate in a toothbrushing club which is aimed at improving their oral health, then we may in fact have upheld their rights.

From this perspective, the toothbrushing clubs could be argued to be working towards a balance of rights that serves children's best interests. In this respect Hart's framework may not be suitable for understanding participation within the toothbrushing clubs. This further illustrates the complexity of drawing uncritically on adult conceptions of participation. The findings of this study suggest within a nursery setting, it may be more appropriate for oral health promoters to understand participation from the perspective that exists in the early years education literature which is one that values relational interactions and places emphasis on the adult as the enabler of participation.

For example, in taking this perspective to identify children's participation in the toothbrushing clubs, we can see how Susan the EYP during the Crayon Town toothbrushing club talks and listens to the children as they brush their teeth (section 5.2.4.5.2). She is sensitive and responsive to them as they share with her insights of their world and in the process they become co-learners, participate in meaning-making, and enjoy genuine participation. Within the toothbrushing club Susan contributes to the development of a 'listening culture'; this has been viewed as a form of empowerment for children in participatory processes such as in the 'High Scope Study' which employed a participatory learning approach with one group, and compared it to a group who received no preschool

program with conclusive findings for participatory approaches (Schwinhardt and Weikart, 1993) the work is further supported by Lancaster (2009, Lancaster and Broadbent, 2003, Lancaster and Kirby, 2010) in their work on listening to and learning from young children and how a listening culture leads to participation.

We can suggest here that if children's participation possesses a purely individualistic bias; by focusing only on decision-making, then this risks a lack of appreciation for the importance of forming different social relationships. These relationships mediate the development of important social competences such as respecting one another, cooperation, sense of belonging and sense of community. The development of these social competences work towards the development of citizenship through building social capital which has been shown to be a barrier to children's participation in decision-making (Morrow, 2011). We can clearly see that the nature of Susans' interactions during the toothbrushing club is different to her interactions during other activities where she appeared to be less responsive to their world. For example, her interactions with the children during tidy-up time or play-time the children were mostly unheard. In contrast, during the toothbrushing sessions the children appeared to enjoy a communicative relationship; they were heard and able to express their views of teeth and a healthy mouth. This degree of participation would not be identified if we were to simply use Hart's framework which may be inappropriate for understanding participation within the context of the nursery. The perspective on participation in the early years education literature extends beyond an individualistic rights-based approach. It offers a *relational* perspective in which children's autonomy and agency is developed through relationships with adults who are conscious of the power imbalance and use their power to support rather than hinder children's participation.

The perspective on children's participation offered by the early years education literature has yet to be fully appreciated in oral health, dentistry and health promotion. Yet it has implications for oral health promotion. If this perspective was adopted it might be that we could find ways to further improve oral health promotion programmes such as Childsmile. As Christensen (2004) argues the pluralistic and interactive nature of health requires children to "*create meaning for themselves and to develop their own positive health practices*"

(Christensen, 2004:383). The findings of my study illustrate that EYP's are very important facilitators and can significantly contribute to this process.

The educational literature suggests that it is through reflective quality interactions that adults may enable very young children's participation (Clark and Moss, 2001, Lancaster and Broadbent, 2003, Lancaster and Kirby, 2010). The adult is therefore a facilitator of children's participation and if children are to experience a genuine form of participation at a very early age, adults need to understand the value and impact of child-adult interactions (Bae, 2010). Therefore, the implementation of children's participatory rights, particularly articles 12 and 13, challenges conventional schools of thought regarding adult-child relationships and requires redefining the role of adults who take care of children (Woodhead, 2005).

In her interactions with the children Susan takes a child's perspective, which enables their world to be seen and heard. It illustrates how even very young children in nursery are able to voice their thoughts, feelings and experiences through various forms of expression supported by adults who have the capacity to listen and interpret the child's expression. Therefore the concepts of participation and taking the child's perspective have been argued to be interdependent (Skivenes and Strandbu, 2006). Subsequently if EYPs' are able to come close to a child's perspective they can then enable children to experience a form of genuine participation in their own educational practice. This has been supported by Bae, who argues that *"the quality of processes between children and adults creates premises for the realisation of a relational and holistic understanding of participation"* (Bae, 2010:215). Bae suggests that in order to understand the child's perspective, the adult must value children's culture and appreciate their particular ways of experiencing and making sense of their environment. Taking this position enables a form of child participation in which children experience their world being seen and heard and appreciates that even young children have the capacity to express their thoughts and feelings through various modes together with adults who strive to interpret the child's behaviour. Work done by Johannsson emphasises the impact of practitioners' understandings of childhood and views of children's competencies on children's participation (Johannsson, 2004). An important starting point is adults need to be willing to re-evaluate and reflect on their own views towards children's participation rights and be able to interpret and translate those rights in local settings (Bae, 2010).

My study found that EYP's view regarding children's participation is not static. For example, the same practitioners behave differently and are observed to enable different levels of participation, suggesting that the EYP's view of participation is dynamic and entwined with context. If we consider the Rainbow Ways Nursery toothbrushing club the interactions were narrow and their participation passive, which was in contrast to the interactions and participation observed during story time and playtime. In Crayon Town Nursery there is a difference in Susan's interactions during toothbrushing club and daytime activities this can possibly be explained by structural and process variables. If we briefly recap that the structural variables in childcare settings include qualifications, group size, setting size and equipment, staff turnover, management and child-to-adult ratios. Whereas process factors focus on the manner in which the children experience the care provided to them. Process variables may include the quality and nature of interactions and conversations, the variety of stimulating materials, and the manner in which activities are arranged. Since structural variables may promote quality process variables, then in this instance by having a smaller adult-child ratio within the toothbrushing club provided the opportunity for Susan to engage the children in conversation and have responsive interactions. The smaller group size in addition to Susan's sensitive attitude also may have contributed in the children expressing themselves and sharing their views. This supports Parker's (2013) argument that high quality care is a mixture of both structural and process variables; highlighting how the availability/lack of resources impacts on the daily affordances of children's participation. Therefore, to enable children's participation requires careful consideration of the context; considering *both* structural and process variables. This leads to an important finding; that children's participation was significantly shaped by their setting in addition to the practitioners' capacity, views of childhood and children's participation.

Even when the EYP views the children as competent beings and is reflective about their role in enabling children's participation, this may not necessarily lead to children's participation as there may be structural constraints. These include the manner in which the timetable is structured with no room for flexibility and adaptation, or the EYP-child ratio. It is important to recognise that this ratio does not accurately represent the responsibilities placed on the EYP as it is not uniform. Different cohorts of children have a particular combination of needs

and challenges depending on their developmental capabilities as well as their socio-economic backgrounds that a number or ratio fails to represent. This has implications for the toothbrushing clubs since the dynamics of it will change not only with a change in staff but a change in the cohort of children as well and therefore continual re-evaluation may be needed. The dynamic nature of the context of the setting appears to be something that is largely ignored in the health promotion literature.

6.2 Implications for policy

The findings of this study suggest how the lack of an explicit referral to oral health within the early years curriculum makes it more difficult for OHP professionals to convince nursery managers to agree to run a toothbrushing club and for nursery managers to convince their staff to deliver it. One of the goals explicitly stated in the curriculum is to promote health and well-being; however *oral health* is not mentioned.

Given the apparent discrepancy between policy and practice it appears that the mouth is still being separated from the body and oral health is viewed in isolation to general health. Furthermore, there appears to be a lack of liaison between education and health policy makers, despite having a mutual agenda focused on having a healthy, well-educated population. Earlier in this thesis I argued that the historical antecedents for nurseries and early years education were rooted in the public health requirement for health and well-being (Hamlin, 2002; Ball, 2013). The underlying goal being that early years education would contribute positively to the society and economy of the country. For health promotion to deliver better health outcomes that achieve impact and are sustainable then a shared vision for change begins with closely defining policy. So despite both education and health policy makers having a shared agenda focusing on a healthy population, they do not appear to have a shared vision as to the ways this may be achieved.

The EYPs described how learning goals are interpreted differently by each nursery setting depending on their demands, priorities and resources. The opinions voiced by the EYPs are supported by Duffy (2010) who argues that a problem that practitioners face is not all aspects of the guidance are clear and are “*hidden by the words that surround them*” (Duffy,

2010:105). Differences may exist not only from setting to setting but even within the setting, the nature of the adult-child interaction may differ greatly from one adult to another due to staff having different qualifications, training and levels of experience. We could suggest here that knowing the qualifications of staff within a nursery setting may be a vital starting point for health and oral health promotion teams in order to build more effective interventions.

The findings in my study show how senior EYPs have made an independent choice to interpret “promoting health” to include oral health and this is based on their own beliefs. They believe there are opportunities to integrate the promotion of oral health within the existing curriculum. For example, in assessing physical development, ‘can they hold a pencil’ add *or* toothbrush ‘on their own?’ The EYPs suggested that this reinforcement of oral health throughout the document would add to the legitimacy of oral health being part of the nursery daily routine, linking to healthy eating and hygiene. This would contribute towards making promoting oral health in the early years settings more manageable and sustainable. We can also argue here that the experience, knowledge and skills of each nursery practitioner may also have an impact on the importance that they attach to health and oral health. This is an important consideration as it is the EYPs who deliver the toothbrushing club and are in a unique position to promote the oral health of young children. They are an important asset and it is crucial that they are enabled to be effective health promoters through appropriate support and training, thereby enhancing their knowledge, awareness, and skills. However, there is little evidence of appropriate training being given that is required to enhance their contribution to promoting children’s health (Dewhirst et al., 2013).

It is important to recognise that the curriculum depends on the people who deliver it. It’s been argued that the role of the practitioner may be more important than the curriculum itself in children’s learning experience (Bowman et al., 2000). For Bowman, there are many important and significant factors that play a role in the child’s learning experience, such as adult-child relationships, socio-economic and cultural factors as well as the child’s own individual disposition. He argues that focusing solely on the curriculum for a more effective setting is not the answer. My findings show that the capacity of each nursery may influence the approaches that EYP adopt in promoting oral health; this has implications as it highlights

the importance of the need for capacity building through continuous professional development of staff-human resources.

6.3 Implications for oral health promotion practice

If we apply the models of health promotion proposed by Whitelaw et al., (2001), the toothbrushing clubs remain a fragmented approach due to their targeted goal orientated focus; which is to merely deliver fluoride onto teeth. There are political reasons for this because the service is underfunded and lacks the resources for a more sophisticated approach. A consequence for the oral health promotion team is that they are unable to go beyond the immediate nursery setting to work with families and the wider communities. The programme is therefore unable to extend from the physical boundaries of the nursery setting to a wider place-based approach that can co-ordinate and integrate different spheres and develop partnerships to improve health and well-being. A consequence of this is that the problem (toothbrushing) risks being understood to rest with the individual and there is little capacity to go further in creating a supportive setting in which to positively develop oral health behaviours and practices. Another issue is that some children may not be attending early years settings and it may be more effective to reconfigure these settings to include place-based approaches which would address schools and the wider community whilst focusing on including children who may be in greater need of oral health promotion. This means using a tiered approach to health promotion using a framework that moves between oral health promotion, prevention, and treatment.

The toothbrushing programme has also been set up in isolation from other health promoting programmes in the area and it may be more beneficial to integrate oral health into strategies for promoting general health within areas so resources are not duplicated, there are not conflicting messages and there may be a wider benefit for larger numbers of children. Some studies acknowledge the limitations and adopt a common risk factor approach to address inequalities in oral health in early childhood (Do et al., 2014) the Child Health Action to Lower Oral Health and Obesity Risk (CHALO) for young South Asian children study in the USA due to start in late 2017 (Karasz et al., 2017), or consider poor quality of diet as a

common risk factor approach for both obesity and dental caries (Crowe et al., 2017). Despite the weaknesses of the toothbrushing initiative, it was not limited purely to oral health education. Observation illustrated that oral health and toothbrushing was more than merely passive and efforts were made to integrate it into the internal structure of the nursery.

The nurseries in this study each took on a different approach to their toothbrushing club. Rainbow Ways nursery took on a collective approach in which all the children brushed everyday thus fulfilling the aim of daily fluoride exposure. In contrast, Crayon Town nursery adopted an individualistic approach, focusing on thorough brushing and developing brushing skills, with only 4 children brushing per day. For them, this resulted in each child brushing twice a week and not meeting the objective of the toothbrushing club as set by the OHPT. Thus it is important for oral health promoters to appreciate that each nursery has different structural capacities and wider environmental influences that contribute to the unique contextual factors which define them as individual settings, this argues against a one-size-fits all approach. On reflection we can see that considering the contextual factors has implications for introducing and implementing supervised toothbrushing programs within nurseries and may lead to demands for increased resources in order to fulfil the aims of the programme.

This thesis illustrates that contextual factors such as structural resources shape the toothbrushing club and its delivery. These include the size of the nursery and its capacity to host a toothbrushing club and EYP oral health beliefs and values. Nurseries with inadequate structural capacity, particularly those relating to humans as resources, either are unable to host the toothbrushing club or deliver it as intended and therefore fail to meet its aim. Although agreeing to host the toothbrushing club, Rainbow Ways did not have the capacity at that particular time to have all children brush every day. We can therefore see that it is important to appreciate that different nurseries have different operationalization techniques. These are in turn dependent on structural and process variables, making each nursery a unique setting. This is in tension with current thinking around health promotion setting based approaches which has a tendency to ignore the diversity of the setting. If we employ a one-size-fits all approach to oral health promotion, ignoring the complexity of the setting then we run the possibility of merely adding to existing health inequalities that people experience (Scriven and Hodgins, 2012). This is why it is important that the professional development

of individuals involved in healthy promoting settings move beyond enhancing competence in terms of knowledge, skills and attitude but also develops professionals' ability to be flexible and adapt to varying situations, generate new knowledge and continually reassess ways for improvement (Rosas, 2017).

Finally, it is important to recognise that the toothbrushing club is embedded within the nursery and lasts only for a few minutes and if efforts of an oral health promotion programme to promote oral health are focused merely on the toothbrushing club they may not reach their full potential. Although health is integral to positive educational outcomes health promotion programs are commonly viewed as an add-on rather than an essential component to be integrated into the tasks of educational settings (St. Leger et al., 2007). First and foremost oral health should be part of the ethos of the nursery for a more holistic approach to promoting health. Integrating oral health into other health related or educational activities offers children more opportunities to enjoy different forms of participation. Particularly activities that offer more space and are less structured than the toothbrushing club, for example, role play and small group story time. Thus it could be argued that participation afforded to the children within and outside of the toothbrushing club contributes to their development as active health agents.

Furthermore, work on sustainable and effective health promoting schools identifies that they partner with and depend on their network of relationships with parents, community members, other schools and the health sector (Victora et al., 2005). Partnerships are now integral to health promotion because they are part of a shared commitment and share resources through networking, co-operation, collaboration and integrated partnerships which moves communities towards greater levels of collective impact (Jones and Barry, 2011). The nurseries in this study however, appeared to only be in connection with the OHPT. The intervention was confined to the setting and did not involve families or other community partners. The nurseries also had not established a supportive network with other nurseries which may have been useful for them in terms of comparing processes and exchanging ideas. As previously discussed the EYPs are in a key position to promote health however often they are expected to take on roles they are not suitably trained for such as the skills required for planning, coordinating and developing partnerships with the community (Rosas, 2017). The

findings regarding the challenges faced by the OHPT team and EYPs in introducing and delivering the toothbrushing club support the findings of Ingemarson et al. (2014) which found that health promoting school initiatives required greater consideration of the capacities and resources of the organisation. They found that issues such as lack of consensus, inadequate collaboration and process management posed barriers for successful delivery of health promotion initiatives.

6.4 Challenges of research with children

The importance of reflexivity in ethnography has already been discussed in depth in Chapter 2; it is also essential for research with children. Reflexivity should be a fundamental part of any research process that involves children (Davis, 1998), the researcher must critically reflect on the methods chosen and in addition to their role and value judgements. It is also particularly important for the researcher to challenge their assumptions regarding children and to accommodate to the needs of each child and not presume there is a universal solution to the methodological and ethical issues of research with children (ibid). One of the issues a researcher must be aware of is the power imbalance between them and the child thus making the child more potentially vulnerable (Punch, 2002). In my study, I viewed children as active agents rather than passive subjects. To reduce the power imbalance as much as possible, I observed children in their natural setting, where they felt comfortable. Interaction with the children took place in the form of playing or storytelling because these were the main methods employed in the nursery for children's learning and they were familiar with them. Storytelling is a recognised educational tool and has also been used effectively in health promotion for adults to reduce the power balance with different cultural groups (Haigh and Hardy, 2010). Storytime in my study proved to be a time where the majority of children were eager to participate in the conversation. The topic of the story could be chosen to facilitate and direct the conversation according to the intended purpose. I therefore used storytelling as a participatory research method, alongside books and stories that related to hygiene, being unwell, and visiting the dentist to facilitate conversation and share knowledge of oral health. These types of methodological tools are not mentioned in child oral health research.

In this study I assumed different levels of participation depending on the situation, at times I was a passive participant and at times a moderate participant which allowed for a good extent of involvement to build rapport yet maintain a level of detachment (Schwartz and Schwartz, 1955). Reflecting on my role as a researcher, I feel that being a mother of young children worked to my advantage in being able to communicate and understand some of the children's non-verbal expressions it also helped in understanding some of the demands on the EYP's. I also feel that my experience as a mother made me more appreciative of the efforts of the EYP's. As a dentist I am aware that I have my own values in relation to oral health and I had to continually take a step backwards when assessing a situation to ensure I was taking a balanced approach to what I was observing.

6.5 Strengths and limitations

Nature of the study

This study explored the concept of participation applied to young children within an oral health initiative in an early years education context providing greater insight into the contextual factors involved in the daily running of the toothbrushing club and factors that enable or constrain children's participation on a micro-level and implications on the effectiveness of toothbrushing clubs.

This research is an addition to knowledge in oral health promotion and dental public health. It significantly adds to the theoretical understanding of child participation providing improved understanding of the contextual factors involved and facilitating existing oral health practice. It also adds to the literature on participatory research methods with younger children.

Methodological approach

Research design

This is an ethnographic case study; it is qualitative, allowing for more flexibility and adaptation to a changing setting. This is particularly important for health promotion research which involves the study of complex human behaviour in natural settings that cannot be controlled for scientific investigation. In any particular setting, participants are bound by

intrinsic rules and norms that they may be so familiar with that they act automatically and thus it is something that is difficult to articulate but may be observed (Guest et al., 2013). In observing things as they occur, a more accurate picture can be acquired and subtleties may be revealed which other methodologies may not be able to unveil. A participant observer attempts to discover, understand and analyse aspects of social settings and how they operate. This is a particular strength of ethnographic research because it allows the researcher to explore in-depth the contextual dimensions that influence a social phenomenon. Ethnography focuses on natural, ordinary events therefore it is suitable to study participation and facilitates insights into the factors that enable or disable participation; providing a comprehensive perspective for the dynamics of participation as a process.

Ensuring rigour

To ensure the quality of the study an iterative process of verification was employed. This included checking data repeatedly and systematically while maintaining a focus of the research question and analysis and interpretation were checked and confirmed continually throughout the study (Morse et al., 2002). In addition to verification the following strategies were also applied to ensure validity and reliability. A sufficient amount of time was spent in each nursery to build rapport with children and the EYPs and to better understand the setting and social context facilitating a more in-depth understanding and better interpretation of the phenomenon being studied (Creswell, 2013). Provision of a rich, thick, detailed description (Geertz, 1973) of the setting context. Data triangulation involved using more than one method to gather data, including participant observations, interviews, and documents (Hammersley and Atkinson, 2007) in an attempt to provide a more comprehensive approach to understanding the complexity of human behaviour within a setting. In order to involve interpretations beyond the researcher and minimise bias the research process was reviewed by two experienced qualitative researchers.

Limitations

Data collection occurred in only two nurseries in a discrete geographical area and therefore statistical generalisation to populations was not expected. Instead the study offered analytical generalisations which seek to expand and the theoretical understanding of the field (Sandelowski, 1995).

6.6 Conclusions and recommendations

The findings of this thesis are significant in that they suggest that the relational perspective of child participation offered within the early years education literature provides a better understanding for facilitating and enabling child participation in health promotion within nursery settings. This perspective has yet to be fully appreciated in oral health promotion.

The findings also emphasise the importance of recognizing that health promoting settings are dynamic in nature and the context of the setting is an essential factor when planning and implementing interventions. Context is not limited to structural resources and the external environment, process variables must also be considered. This study has shown that children's participation is significantly shaped by the practitioners' capacity, views of childhood and children's participation in addition to their setting. However, EYPs views regarding children's participation is dynamic depending on the particular context and time. Attention needs to be given to the capacity of each nursery to respond as this exerts an impact on the approaches that EYPs adopt in promoting oral health. The daily affordances of children's participation are greatly affected by the availability of resources.

Furthermore, the lack of linkage of oral health to general health within the early years curriculum means there is a failure to integrate oral health into a holistic approach to health promotion. This makes it more difficult for OHP professionals to convince nursery managers to agree to run a toothbrushing club and also for nursery managers to convince their staff to deliver it.

Recommendations

- Public health and education policy makers working collaboratively to produce policy that serves the interests of both sectors and thus making it more holistic
- Policy makers need to take into account both structure and process variables within a setting to enable genuine children's participation because these define any programme
- There is a need to emphasise and apply the common risk factor approach and link it to general and oral health
- Educational policy should be lobbied to introduce the term "oral health" into the curriculum as an indicator and predictor of general health.

Future research recommendations

- Comparison of a range of nurseries as holistic health promoting settings in different areas perhaps with Scotland post Childsmile
- An exploration of the partnerships and skills involved in holistic health promotion that enable partnerships to function effectively
- An exploration of the social networks that form part of children's lives and can act as a supportive mechanism for health promotion

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Appendices

Appendix A: Ethics approval

Appendix B: Participant information

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Appendix A: Ethics approval



School of Clinical Dentistry

**University Research Ethics Committee
(School of Clinical Dentistry)**

Research Ethics Lead – Dr. Lynne Bingle

Email: l.bingle@sheffield.ac.uk

Ms Sarab Elyousfi
The School of Clinical Dentistry
University of Sheffield
19 Claremont Crescent
Sheffield
S10 2TA

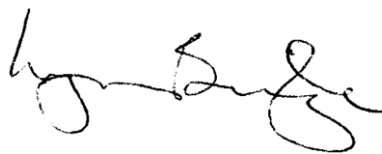
18th March 2014

**Full title of study: Exploring participation as
a new perspective for child oral health
promotion Reference number: 68**

On behalf of the committee, I am pleased to provide my ethical opinion for the above research based on the supporting documentation. If any further changes are made to these documents the Ethics Committee should be informed and their opinion requested.

With the Committee's best wishes for the success of this project

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Lynne Bingle'.

Appendix B: Participant information sheet

Your toothbrushing club

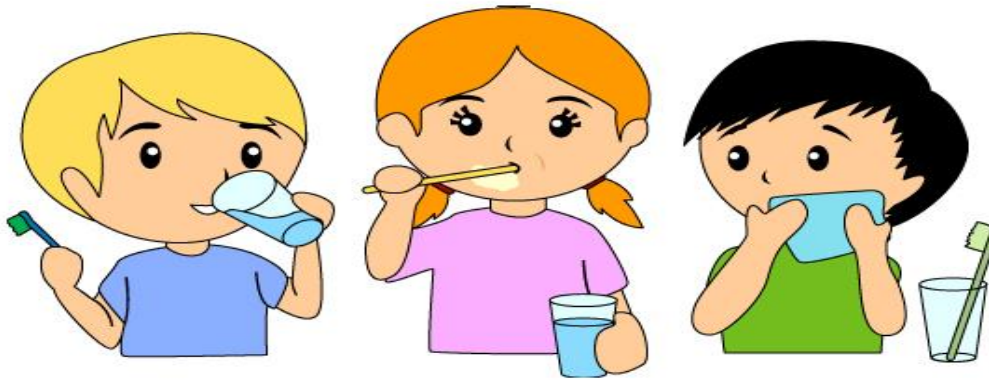
Who am I?

My name is Sarab Elyousfi.

I am from the University of Sheffield.



I would like to see you and your friends while you are brushing your teeth.



Then I may ask to talk to you about what you do at your toothbrushing club



Thank you for reading this. I hope to meet you soon

Appendix C: Participant assent form

Please circle the right answer

Are you happy for me to watch you brush your teeth?

NO

YES



Are you happy to talk to me about your teeth?

NO

YES



Do you know that you can stop at any time?

YES NO



NAME.....

DATE.....

Thank You!





Appendix D: Parent/Guardian information sheet

Thank you for reading this information sheet. It will tell you all about a study we are doing, which your child is invited to take part in. My name is Sarab Elyousfi and I am a researcher at the University of Sheffield. Before you decide if you would like your child to take part it is important that you know why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask us if there is anything that is not clear or if you would like more information. Take your time to decide whether you are happy for your child to take part. The information sheet will tell you the purpose of this study and what will happen if your child takes part.

What are you researching?

We are carrying out this research to better understand what we mean by participation in children's oral health promotion.

Why are you doing this research?

Not very much is known about children's participation in oral health promotion. We would like to give children the opportunity to have their voices heard about what they think of oral health and programmes such as the toothbrushing club aimed at improving their oral health. We are also interested in observing the ways that children participate to better understand how to include them more and make it a better experience.

Why do you want to talk to my child?

Your child has been invited because he/she attends a toothbrushing club.

Does my child have to take part?

No, it is entirely up to you and your child to decide whether or not you wish your child to join the study. If you agree to take part, we will then ask you to sign a consent form. You are free to withdraw your child at any time **during the research** without giving a reason

What will happen to my child if we agree to take part?

I would like to observe the children while they are participating in the toothbrushing club. Afterwards, your child may be invited to have a talk with me where we will chat about their teeth.

What do I have to do?

If you agree to your child being involved in this study I would be grateful if you could sign the consent form and return it to school.

Is there anything to be worried about if my child takes part?

There are no known risks to your child taking part in the study.

Will my child's taking part in this study be kept confidential?

All information that your child provides through their participation in this study will be kept private.

The only people who will see the information will be the researchers. All the information from the research will be kept securely on password protected computers at the University of Sheffield. The reports from this research will not name any of the participants. Your child's name will **not** be used in the analysis or writing up of the findings derived from the study. Their details, which will only include their name and age, will be kept in a locked cabinet and will only be reviewed by the researchers.

What are the possible benefits of taking part?

It is hoped that the study will allow for children's voices regarding their participation and oral health be heard. It provides an insight into children's perspectives on oral health and participating in measures aimed to improve their oral health. It is hoped that through increased understanding of children's perspectives and their participation, oral health promotion programmes can be better tailored to suit them.

Who has reviewed the study?

Before any research goes ahead it is checked by an Ethics Committee. They make sure that the research complies with ethical procedures. This project has been checked and approved by the University of Sheffield Ethics Committee.

What do I do next?

Please read the children's information sheet with or to your child and help them to complete the assent form. If you and your child are both happy to take part in the research we would like to ask you to sign the consent form and return both the consent and assent forms to the school.

If you would like to speak to me about your child's participation or any other aspect of the research, please contact me by telephone: 0114 271 7877 (I can call you back if you like). I can also be contacted by e-mail: selyousfi1@sheffield.ac.uk

What will happen to the results of the research study?

The findings will be analysed and the results will be included in my PhD thesis and will also be published in a scientific journal. We also plan to report our findings at national and international dental conferences so health promoters will benefit from knowledge gained from this study.

What happens when the research project stops?

When the study has finished we will look at all of the information that has been gained from your child and other children. A findings report will be written and you will receive a copy. This will be available at your child's nursery after we finish the study.

What if there is a problem or something goes wrong?

We cannot see anything going wrong during this project. But if you or your child feels unhappy about anything to do with the project, we will be very happy to talk to you about your concerns. Your child is also free to stop being in the study at any time.

What if I am not happy about the way the study has been conducted?

If you have any cause to complain about any aspect of the way you have been approached or treated during the course of this study please contact the project supervisors in the first instance.

Names:

Dr Barry Gibson b.j.gibson@sheffield.ac.uk

or

Dr Jan Owens jan.owens@sheffield.ac.uk

Tel: 0114 271 7885

If you do not obtain a satisfactory response, you can also use the normal university complaints procedure and contact the following:

Research Consultative Unit: Tel: 0114 222 1469

Who is organising and funding the research?

The study has been organised by the Academic Unit of Dental Public Health, School of Clinical Dentistry at the University of Sheffield, UK. Mrs Sarab Elyousfi is sponsored by the Ministry of Education, Government of Libya.

Who can I contact for further information?

Further information about the study is available from Mrs.Sarab Elyousfi Academic Unit of Oral Health and Development, School of Clinical Dentistry, Claremont Crescent, Sheffield S10 2TA. Telephone: 0114 271 7877, email: selyousfi1@sheffield.ac.uk. I will also arrange to be available on certain dates at your child's nursery school where you can enquire regarding any questions or concerns you may have.

Thank you for reading this – please ask any questions if you feel you need to.

Appendix E: Parent consent form

Your child has been invited to take part in a research project to find out what they think about oral health and participating in a toothbrushing club. This may involve your child completing some activities such as drawing.

The purpose of this agreement is to make sure that you agree to your child taking part in the above research project and that use of the research material is in strict accordance with your own and your child's wishes. Your child's contribution to the research project will be valuable but will also be anonymous. Taking part in this project is entirely voluntary. If you and your child decide to take part you may change your mind at any time and this will not affect your child's care in any way. All the information gathered in the study will be confidential. All the information from the research will be kept securely at the University of Sheffield. No one will have access to it except the researchers. Neither your child's name nor anything that identifies them will be used in any reports of the study.

I would like to watch the children while they brush their teeth and later on talk to some of them about their teeth. If you have any concerns or feel you would like to know more, please contact:

Sarab Elyousfi

Academic Unit of Dental Public Health

School of Clinical Dentistry

Claremont Crescent

Sheffield S10 2TA.

Telephone: 0114 271 7877

Email: selyousfi1@sheffield.ac.uk

Parent consent form

Name of the young person to be involved in the research:

Participant Identification Number for this project:

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
2. I understand that our participation is voluntary and that we are free to withdraw at any time without giving any reason.
3. I understand that any information will be used for research purposes only, including research publications and reports, and that anonymity will be preserved at all times.
4. I agree for my child to take part in the above study.

Name of parent/carer: _____

Signature: _____

Date: _____

Name of parent/carer: _____

Signature: _____

Date: _____

Appendix F: Interviewee information sheet

Hello, my name is Sarab Elyousfi and I am a research student at the University of Sheffield. Thank you for reading this information sheet. It will tell you why this study is being done and what it will involve. Please take time to read the following information before deciding whether you are happy to take part. If you would like to speak to me about your participation or any other aspect of the research, please contact me by telephone: 0114 271 7877 or by e-mail: selyousfi1@sheffield.ac.uk and I will be happy to answer any of your questions.

What am I researching?

I am carrying out this research to better understand what is meant by participation in children's oral health promotion.

Why am I doing this research?

Not very much is known about children's participation in oral health promotion. I would like to give children the opportunity to have their voices heard about what they think of oral health and programmes such as the toothbrushing club aimed at improving their oral health. We are also interested in observing the ways that children participate to better understand how to include them more and make it a better experience.

Why do I want to talk to you?

I have approached you as you are a professional involved in oral health promotion or an early years practitioner. Your views provide a valuable insight in better understanding matters related to oral health promotion programmes that are aimed towards young children.

What will happen if you agree to take part?

If you agree to take part, you will be asked to sign a consent form. You are free to withdraw, at any time during the research without giving any reason.

What do I have to do?

I would like to arrange with you a convenient time, date and place to meet where we can have an informal chat. The session can last as long as you wish but on average should last up to an hour. Please note that an audio-recording will be made of the conversation so your views are represented accurately and will only be used for the research purposes explained previously.

Is there anything to be worried about if I take part?

There are no known risks to you by taking part in the study. Your identity will remain **anonymous** and your name or anything that may potentially identify you will not appear in any report written about the study. You will only be referred to as either dental professionals or early years professionals depending on your profession.

What are the possible benefits of taking part?

It is hoped that this study will allow for children's voices regarding their participation and oral health to be heard as well as the voices of the professionals involved in children's oral health promotion programmes. This will hopefully provide a more comprehensive understanding of the context and factors that are important in the design and delivery of a suitable oral health promotion program for children and one that enhances their participation.

Who has reviewed the study?

Before any research goes ahead it is checked by an Ethics Committee. They make sure that the research complies with ethical procedures. This project has been checked and approved by the University of Sheffield Ethics Committee.

What happens when the research project stops?

When the study has finished I will look at all of the information that has been gained from all the participants. A findings report will be written and I can send you a copy.

What if I am not happy about the way the study has been conducted?

If you have any cause to complain about any aspect of the way you have been approached or treated during the course of this study please contact the project supervisors in the first instance.

Dr Jan Owens: jan.owens@sheffield.ac.uk

or

Dr Barry Gibson: b.j.gibson@sheffield.ac.uk

Tel: 0114 271 7885

If you do not obtain a satisfactory response, you can also use the normal university complaints procedure and contact the following:

Research Consultative Unit Tel: 0114 222 1469

Who is organising and funding the research?

The study has been organised by the Academic Unit of Dental Public Health, School of Clinical Dentistry at the University of Sheffield, UK. Mrs Sarab Elyousfi is sponsored by the Ministry of Education, Government of Libya.

Thank you for taking the time to read this. Please feel free to ask any questions if you need to.

Appendix G: Interviewee consent form



Consent form

Participant identification number:

Project title:

Name of researcher:

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and I am free to withdraw at any time, without giving any reason.

3. I understand that any information will be used for research purposes only, including research publications and reports, and that anonymity will be preserved at all times.

4. I understand that audio-recordings will be made and that the purpose for which the material will be used has been explained in terms which I have understood.

5. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Researcher

Date

Signature

Appendix H: Example of labelling of data and coding

<p>So we've all got the certificates now for oral health which we did find really interesting because when Julie came she brought us the statistics so we found out that we were probably, we were the worst area in Sheffield for kids with decay which made it feel even more worthwhile. I think as doing what we do and you know we do it the best that we can to our abilities, we fit it in to the routine somehow you know, weekly or some weeks we do it more some weeks we do it less it just depends.</p>	<p>Sense of responsibility</p> <p>Toothbrushing club dynamic</p>
<p>Like this week it got on hold cause it's Christmas but I think as long as we're starting that education process on oral health then I think we're giving the kids their own independence and self-confidence and self-worth to initiate it at home and get the parents to do it with them so I think it's definitely worthwhile.</p>	<p>Nursery events</p> <p>Personal oral health belief</p>
<p>So I think it definitely has an impact and we're really really grateful and I were really shocked to find out that Sheffield were thinking about reducing the money they're spending on this sort of stuff and I think for areas of deprivation like we're in, I think it'd be a real shame for us not to be able to get those. I mean we'd probably try and get funds to carry it on and get our own sort of toothbrushes and stuff like that.</p>	<p>Positive impact</p> <p>Geographic area/deprivation</p> <p>Sense of responsibility</p>
<p>It is difficult for us to fit it in to the routine you know we've got so many targets to meet so many sort of things to provide throughout session, it's not in the curriculum, it could be you know. They could put it in there you know brushing teeth it'd be a benefit to us because then it'd be part of what OFSTED would be looking for.</p>	<p>Curriculum</p>
<p>Yeah, it's in there it does say hygiene but it could be a bit more...when you look at the break down they could say they're able to wash their hands on their own can they brush their teeth on their own?</p>	
<p>Yes it is, so for us, it's in there. We've got it in there and it's a bonus for us but I don't think everywhere would look at that sort of thing and people that ...nurseries that are in Dore and Totley won't be really concerned about dental care because they know that the kids will be booked in every 3-6 months depending on what the dentist</p>	<p>Self-interpretation</p> <p>Geographic</p>

<p>recommends you know but not everyone does that.</p> <p>So that helps with the time as well but we sort of manage it that they'll do it in small groups. I think because then you can concentrate more on the methods of how to brush and you're not missing anyone out so they're getting quality so it might be that they don't do it every day but the quality is there so they're taking that home.</p> <p>Yeah, we did that cause we started and we did it every day, but it took that much time to do that in small groups and that's why we decided that we rotate it so everyone's on the list every week but it's a rotation so it only takes a member of staff out for a shorter period of time just because the way our rooms are set up there's only 2 members of staff in each of the rooms so to take a member of staff out it could leave someone vulnerable so that's the way we do it so it's just a quick 5 minute job once a day so that works best for us, I think.</p> <p>Yeah and I think we do that because ...I know they don't have to be at a sink because you can do it in a paper towel or you know whatever, but I think at home people tend to do it in the bathroom don't they? Near a sink so it's just giving that familiar feel to it for the children that are not comfortable with doing their teeth it just feels more like home I suppose.</p> <p>Well I think we're lucky cause we don't have a quick staff turnover. When one staff are with us they stay with us and that's why I've made everyone do the training this time just in case they do move rooms. It's very rare someone leaves here cause once they're settled, they just stay and we don't change the staff round that much so I think for the staff that are doing it regularly it just becomes part of what they do once they've settled into a routine, got the new cohort of kids into because obviously that'll change yearly or you get a new child coming in halfway through a term so you have to get them used to it.</p> <p>So that's the measures we've taken but from OFSTEDS point of view you know you're asked to promote healthy eating and healthy living but as I said it is a self-interpretation, so it's the settings interpretation of that and what they see as being acceptable because you might go to another nursery and they might take a bottle of juice from a parent and let a child drink it we would say while they're with us we'd</p>	<p>area/deprivation</p> <p>Toothbrushing dynamic Personal oral health belief</p> <p>Time Staff Room layout Staff Time</p> <p>Personal oral health belief</p> <p>Staff turnover</p> <p>Cohort of children</p> <p>Ofsted</p> <p>Self-interpretation</p>
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<p>prefer if you could bring them milk or water.</p> <p>I would imagine they would be anxious because of pressure, they've got lots of pressure from OFSTED and they're meeting lots of targets already so it's another thing to fit in and I would think that's what they would think about. They'd think 'oh it's another thing to fit in' but then I think if they saw the statistics for their local area they were in... an area that needed to improve. I think they'd probably feel really guilty and want to do it so maybe if they sent the statistics for that locality when they introduced it or asked them about it they might change their mind cause then I think they'd feel a duty to do that but every setting sees things differently we sort of take safeguarding and health you know personal, social and emotional is one of our upmost important things in our curriculum. These children need stability they need routine they need all the things that might not be there at home and that's why we felt that it was important and valuable to give it a go really. I just hope we can always carry it on that's the worry that if it's not there.</p>	<p>Ofsted</p> <p>Burden</p> <p>Geographic area</p> <p>Guilt</p> <p>Sense of responsibility</p> <p>Self-interpretation</p> <p>Curriculum</p> <p>Significance of geographic area</p> <p>Sense of responsibility</p>
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Appendix I: Examples of codes used and emerging themes

Codes

- Staff turnover
- Staff numbers
- Number of children
- Cohort needs
- Time
- Room layout
- Managerial expertise



Size and capacity of nursery

Codes

- Personal oral health beliefs
- Sense of responsibility
- Guilt
- Burden
- Self-interpretation



EYP oral health beliefs and values

