Health & Place 40 (2016) 51–57

Contents lists available at ScienceDirect

Health & Place

journal homepage: www.elsevier.com/locate/healthplace

Where are the schools? Children, families and food practices

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ARTICLE INFO

Article history:
Received 27 January 2016
Received in revised form
7 April 2016
Accepted 28 April 2016

Keywords:
Children
Families
Schools
Food practices

ABSTRACT

Reducing childhood obesity is an international priority and children's diets, food knowledge and practices have come under intense scrutiny in both policy and popular discourse. Notwithstanding evidence that health interventions which resonate with children's own views are the most effective, there is still relatively little research which mobilises children's everyday perspectives on food to inform public health policy. We report key findings from a qualitative study with 53 children aged 9–10, attending two socio-economically contrasting schools in the UK. The study explored children's understandings of food in everyday life and their ideas about the relationship between food and health. Throughout the study, despite recent attempts to position schools as key sites for public health interventions, children consistently emphasised families as the locus for enduring food practices. The research highlights the value of listening to children and applying our understanding of their perspectives to ensure that public health initiatives work with the important influences on their diet and health that they themselves identify.

1. Introduction

Children's relationships with food have come under close scrutiny over recent years prompted, to a significant degree, by popular and policy-based concern with childhood obesity. Obesity constitutes a major public health challenge throughout the Global North, and increasingly the Global South (World Health Organisation (WHO), 2012). Between the years 1980–2013, the worldwide prevalence of overweight and obesity rose by 27.5% for adults and by 47.1% for children (Ng et al., 2014). During childhood, obesity is associated with significant and far-reaching negative impacts for both physical health (including metabolic risk factors, type 2 diabetes, orthopaedic problems, sleep apnoea, asthma and fatty liver disease) and psychological wellbeing (including poor body image, low self-esteem, depression and reduced quality of life) (Pulgarón, 2013, p. A19). However, the long term effects may extend into adult life and childhood obesity has been described as a'ticking time bomb' (Chinthapalli, 2012), heralding a substantial burden of increased morbidity and mortality for the future, including diabetes, osteoarthritis, cancers, and major vascular disease (Ng et al., 2014). While encouraging children to eat healthily is seen as one important contributory factor in efforts to address the burgeoning problem of obesity, healthy eating has potentially much broader, though perhaps less frequently articulated, public health benefits, including protection against cancer and cardiovascular disease (Sproston and Primatesta, 2003) and the promotion of children's wellbeing, optimal growth and emotional development (Shepherd et al., 2001).

1.1. Children, food and schools

With the increasing universalisation of schooling, schools have come to be recognised as key sites for public health interventions (Roberts, 2012), through which food-related initiatives can be directed towards children. According to the World Health Organisation (WHO, n.d.), their Health Promoting Schools Programme represents one of the most widespread settings-based approaches to improving health. Programmes have been established in all six WHO regions and in over 80 countries (WHO, n.d.). Integral to this broad-ranging initiative are nutritional programmes that focus upon the provision of, and children's learning about, food. Although the nature and type of food provision in schools varies between countries (Harper et al., 2008), schools are positioned as highly significant to young people's developing knowledge and practices. The US Government's Centre for Disease Control (CDC) (2014) argues:

> Schools play a particularly critical role by establishing a safe and supportive environment with policies and practices that support healthy behaviours. Schools also provide opportunities for students to learn about and practise healthy eating […].

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http://dx.doi.org/10.1016/j.healthplace.2016.04.013
1353-8292/

A recent review mapping national school food policies across Europe, Norway and Switzerland (carried out as part of the EU Action Plan on Childhood Obesity 2014–2020, (European Union, 2014)), for example, found that all thirty countries have a School Food Policy (SFP) in place with an even split (15:15) of mandatory versus voluntary policies (Bonsmann et al., 2014). Policies vary between a list of foods which can(not) be sold on school premises (Cyprus) to extensive voluntary recommendations (e.g. Germany, Italy) or mandatory regulations (e.g. Finland, Slovenia). Nearly all SFPs utilise food-based standards and seek to improve child nutrition, teach about healthy eating and lifestyle behaviours and reduce childhood obesity. Common aspects include energy and/or nutrient-based standards, restrictions on vending machines and food marketing, and the importance of training school caterers (Bonsmann et al., 2014, p. 21).

In the UK context, the English National Healthy Schools Programme (NHSP) and counterparts in Scotland, Wales and Northern Ireland have proven extremely popular with schools and 99% of English schools voluntarily participate, with 76% achieving National Healthy School Status by 2010 (Aggleton et al., 2010). Reflecting the international picture, healthy eating is a key component of achieving Healthy Schools status. Alongside formal teaching about healthy eating (figuring in both Personal Social, Health and Economic Education (PHSE) and the science curriculum (Department for Education, 2015), a range of initiatives have been established in many schools including healthy tuck shops, water fountains and cooking demonstrations. Significant moves at a national level include the introduction of food and nutrition standards for schools, the establishment of the School Food Trust (now Children's Food Trust) as well as the School Fruit and Vegetable Scheme, in which all children aged four to six in Local Education Authority maintained schools receive a free piece of fruit or vegetable each school day (Department of Health (DH), 2010) and, most recently, the provision of free school lunches for all infant school children (Children's Food Trust, n. d.) (although the annual grant to help small infant schools fund this provision was withdrawn in early 2016 (Long, 2016)).

1.2. Children's understandings and ideas

In relation to the impact of initiatives such as the Health Promoting Schools and the Healthy Schools Programme, much research has focussed upon assessing children's knowledge of healthy eating. This body of research has highlighted that children are generally able to distinguish between what they perceive to be 'healthy' (often described in terms of eating lots of fruit and vegetables) and'unhealthy' (usually defined as eating too much sugar or fat) diets (Welch et al., 2012; Bisogni et al., 2012., Gosing et al., 2008). Indeed, although there seems to be confusion over the healthiness of foods containing multiple ingredients and uncertainty over diet-disease links (Stewart et al., 2006), the research generally demonstrates that children can and do articulate many of the key ideas promulgated in school-based teaching. However, although children can reiterate the messages there is no clear relationship in the literature between learning those messages and food practices.

In response to this, a small but burgeoning body of research in the social sciences has begun to try to understand the meaning of food and eating in the context of children's everyday lives. Informed by the Social Studies of Childhood (James and Prout, 1997) which recognises children as active social agents and as experts in and on their own lives (Christensen, 2004; Brady et al., 2015) the work privileges children's own experiences and perspectives. Punch et al. (2011) summarise some of the key themes to emerge from this body of work including the role of food in demonstrating care and affection (Punch et al., 2009), as a means of resistance and focus for negotiation (Pike, 2008), as a tool in the construction of children's identities (Curtis et al., 2009) and the importance of shared meanings (Kohli et al., 2011 and Pike, 2011). Recent work has also considered the notion of foodscapes as a way into exploring children's becoming as consumers (Brembeck et al., 2013), the impact of food provisioning on intergenerational relationships (Fairbrother and Ellis, 2016) the variation between families in terms of who controls children's food (O'Connell and Brannen, 2014), the similarities and differences in perceptions of home food and eating practices between teenagers in contrasting socio-economic groupings (Backett-Milburn et al., 2010) and children's understandings about the influence of family finances on opportunities to eat healthily (Fairbrother et al., 2012). Such child-centred research therefore provides important insights into the complexity of children's relationships with food in everyday life. However, to date, opportunities for such insights to inform public health policy and practice have not been fully realised. In this paper, therefore, we report on findings from a study which explored how children make sense of food in their everyday lives and their understanding of the relationship between food and health, in order to consider how this child-centred focus might inform public health initiatives geared towards improving children's food knowledge and practices.

2. Method

The study comprised two phases. First, 53 children aged 9–10 attending two schools located in socioeconomically contrasting urban neighbourhoods in the North of England participated in friendship group interviews and debates. This age group was chosen to reflect an international focus on reducing obesity among children under 11 (WHO, 2008). Second, a sub-set of eight family case studies were carried out to explore familial experiences and perspectives (Curtis et al., 2011) and understandings of the relationship between food and health in more depth. All interviews were audio recorded and transcribed verbatim. All data were anonymised and children chose their own pseudonyms. Formal ethical approval was granted by the University [removed for anonymization] Research Ethics Committee.

For phase one, a purposive sampling strategy designed to 'encapsulate a relevant range in relation to the wider universe but not to represent it directly' (Mason, 2002, p. 121) was adopted. Two contrasting schools (School A, the more affluent, and School B, the more deprived) were identified using census data, eligibility for free school meals and local area knowledge. Following a week of familiarisation, during which the first author worked with children in each class, children were invited to take a letter and leaflet home if they were interested in participating in the research. Giving primacy to children's own consent and consistent with a view of children as research subjects in their own right (Christensen and Prout, 2002), parents were only required to respond if they wished to opt their child out of the project. Before each interview, key project information was recapped and children were invited to ask questions before being asked to sign a consent form. In total, 53 children participated. Four children from School A were of minority ethnicity. The remaining children all identified themselves as White British.

For phase two, the sampling strategy was guided by the aim to ensure as diverse a sample of perspectives as possible, in order to facilitate conceptual generalizability of the findings. In total, eight children and their parents were recruited across the two schools (four children and four parents from each school). The guiding principles for the interview strategy were sensitivity to the potential power differentials between child participant and adult researcher and an aim to ensure the research process was as