Title: Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System

Candidate: Dara Glynn
Student Number: 93416440

Research Masters

Supervisor: Dr. Linda Biesty
G.R.C.: Dr. Maura Dowling, Professor G. Mac Ruairc, Dr. Marcella Kelly
Head of School: Professor Dympna Casey

Submitted to National University of Ireland, Galway, August 2020.
Table of Contents

Table of Contents .................................................................................................................. 1
List of Tables & Figures ........................................................................................................ 8
Author’s Declaration .......................................................................................................... 9
Abstract .................................................................................................................................... 10
  Background .................................................................................................................... 10
  Aim of study .................................................................................................................. 11
  Research methodology and methods ............................................................................. 11
  Findings ......................................................................................................................... 11
  Conclusion ..................................................................................................................... 12
Acknowledgements .......................................................................................................... 13
Abbreviations .................................................................................................................... 14

Chapter 1 - Background and Context for this study ..................................................... 16
  1.1 The Informed Health Choices – A Brief Introduction .............................................. 16
    1.1.1 The IHC primary school resources ................................................................. 18
    1.1.2 Assessing the effectiveness of the programme ............................................... 18
    1.1.3 Ongoing work on the IHC resources .............................................................. 19
  1.2 Aim and Objectives of this Study .......................................................................... 19
    1.2.1 Aim .................................................................................................................. 19
    1.2.2 The Objectives of this Study .......................................................................... 20
  1.3 The Educational Landscape that IHC Finds Itself In ............................................. 21
    1.3.1 Achieving a vision for IHC .............................................................................. 21
    1.3.2 The Global Educational Landscape ............................................................... 21
    1.3.3 The Educational Landscape in Ireland ............................................................ 25
  1.4 Summary Conclusion ............................................................................................. 33

Chapter 2 - This Study – A confluence of 3 stories. ................................................. 34
  2.1 Introduction ............................................................................................................. 34
  2.2 Health Literacy ...................................................................................................... 34
    2.2.1 Health literacy - arriving at a definition ......................................................... 34
    2.2.2 A history of health literacy .............................................................................. 35
    2.2.3 Why health literacy is so important today .................................................... 38
  2.3 Irish Primary School Curriculum and Health Education .................................. 43
    2.3.1 Evidence of Health Education in Irish primary schools up to the 1970’s .... 43
    2.3.2 The New Curricula of 1971 and 1999 .............................................................. 46
The Informed Health Choices Programme ............................................ 47
2.4.1 The Informed Health Choices Group ........................................... 47
2.4.2 Rationale for the IHC Programme .............................................. 48
2.4.3 Key Concepts for making good health choices .............................. 49
2.4.4 Focus on primary schools ............................................................ 49
2.4.5 Developing resources with teachers in Uganda .............................. 50
2.4.6 Development of the CLAIM Evaluation tools ............................... 51
2.4.7 Trial process evaluation of the resources in Uganda ..................... 51
2.4.8 What the IHC programme looks like ........................................... 52
2.4.9 The expanding influence of the IHC programme and Concepts ....... 52
2.5 Convergence of the above 3 – IHC in Ireland .................................... 53
2.5.1 Convergence of Intended Learning Outcomes .............................. 53
2.5.2 Room in a crowded curriculum? ................................................ 54
2.5.3 Rationale for this study .............................................................. 55

Chapter 3 - Methodology & Methods ......................................................... 56
3.1 Introduction ..................................................................................... 56
3.2 Arriving at a Design – Participatory Action Research ....................... 56
  3.2.1 Action research ........................................................................ 56
  3.2.2 Participatory action research ..................................................... 57
  3.2.3 Aligning this study to the characteristics of PAR ....................... 59
  3.2.4 PAR underpinned by the qualitative paradigm ............................ 60
3.3 The PAR Cycle for this Study ............................................................. 61
  3.3.1 Objectives and the PAR cycle .................................................. 63
Methods ................................................................................................. 64
3.4 Sampling ......................................................................................... 64
  3.4.1 Purposive sampling .................................................................. 64
  3.4.2 Recruitment process ................................................................. 65
  3.4.3 The participants in this study .................................................... 66
3.5 Ethical Considerations ..................................................................... 68
  3.5.1 Consent .................................................................................... 68
  3.5.2 Confidentiality ........................................................................ 69
  3.5.3 Right of refusal/withdrawal ....................................................... 70
  3.5.4 Child protection – ethical issues considered in relation to this study ... 70
3.6 Operationalising this PAR Study – An Overview of the Cycles .......... 71
  3.6.1 Cycle 1: .................................................................................. 71
  3.6.2 Cycle 2: .................................................................................. 74
3.7 Data Collection Methods ................................................................. 74
  3.7.1 Interviews .............................................................................. 75
  3.7.2 Focus Group .......................................................................... 77
  3.7.3 Teacher reflection - lesson feedback sheets ............................ 80
  3.7.4 Non-participant observation of IHC lessons ........................... 81
3.8 Data Analysis ............................................................................ 82
  3.8.1 Thematic analysis ................................................................. 82
  3.8.2 Socio ecological model (SEM) for data presentation ............ 85
3.9 Rigour ...................................................................................... 87
  3.9.1 Credibility ............................................................................ 88
  3.9.2 Transferability ..................................................................... 90
  3.9.3 Dependability ...................................................................... 90
  3.9.4 Confirmability .................................................................... 91
3.10 Conclusion ................................................................................ 92
Chapter 4 – Findings ...................................................................... 93
  4.1 Introduction ............................................................................... 93
  4.2 Socio-Ecological Framework .................................................... 93
  4.3 Findings .................................................................................... 94
    4.3.1 Personal Level – Try it, you’ll like it .................................... 96
    4.3.2 Interpersonal Level – Something for everyone – Broadening the appeal ................................................................. 109
    4.3.3 Organisational Level – Getting past the gatekeepers ........... 116
    4.3.4 Environmental Level – This boat will sink without captains ... 118
4.4 Conclusion of the Findings ....................................................... 120
Chapter 5 - Discussion ................................................................. 121
  5.1 Introduction – Summary of Findings ....................................... 121
    5.1.1 Personal level summary ...................................................... 121
    5.1.2 Interpersonal level summary .............................................. 121
    5.1.3 Community/Organisational level summary ....................... 122
    5.1.4 Environmental level summary .......................................... 122
  5.2 Were the Aim and Objectives Achieved? ............................... 123
  5.3 The Themes ............................................................................. 124
    5.3.1 Try it, you’ll like it ............................................................... 124
    5.3.2 Something for everyone – Broadening the appeal ............. 129
    5.3.3 Getting past the gatekeepers. ............................................. 132
    5.3.4 This boat will sink without captains. ................................. 134
| Appendix 3 | Reflections on implementation of the unaltered IHC programme in researcher’s own school prior to PAR cycles | 202 |
| Appendix 4 | Teacher preparation programme for IHC | 205 |
| Original IHC Teacher Training | 205 |
| Irish IHC Teacher Training | 208 |
| Recommendations that informed the contextualised teacher programme | 230 |
| Feedback from Irish teacher CPD sessions | 232 |
| Appendix 5 | Lesson evaluations and observations | 234 |
| Teacher’s lesson evaluation form | 234 |
| Researcher lesson observation form | 239 |
| Appendix 6 | Interview guides | 243 |
| IHC Original Template | 243 |
| Modified Irish interview guides | 252 |
| Interview Prompt Sheet | 256 |
| Interview Guide for Children’s Focus Group | 257 |
| Prompt sheet for focus groups | 261 |
| Post-programme interviews with teachers | 262 |
| Appendix 7 | Data and coding samples | 266 |
| 1. Transcription (excerpt from an interview transcript) | 266 |
| 2. Reading/familiarisation - taking note of items of potential interest | 270 |
| 3. Coding – complete; across the entire dataset | 274 |
| 4. Searching for themes | 275 |
| 5. Reviewing themes (producing a thematic map – i.e. themes and subthemes and the relationships between them) | 277 |
| 6. Defining and naming themes | 279 |
| 7. Writing – final analysis | 285 |
| Appendix 8 | Adjusted children’s book – Sample chapter | 286 |
| List of changes made to IHC programme text | 291 |
| Appendix 9 | Teacher’s Guide – Samples illustrating changes | 292 |
| Appendix 10 | Other contextualised resources developed for Ireland | 297 |
| Flashcards - sample | 297 |
| Bank of local claims | 298 |
| Additional poster – sample – Lesson 1-5 review | 302 |
| Appendix 11 | Audit trail data checklist | 303 |
List of Tables & Figures

Table 1.3.3a “Irish Primary School Curricula” .................................................25
Table 1.3.3 “Weekly minimum subject time in the Primary School Curriculum (1999)” ..................................................................................................................26
Table 2.2.2 “Annual number of health literacy papers published, 1990-2015” .................................................................37
Figure 3.3a “An action research cycle” ...............................................................62
Figure 3.3b “PAR Cycles for this study” .............................................................63
Table 3.4.3 “Participant Profile” ........................................................................67
Table 3.8.1 “The Socio Ecological Model (SEM)” .............................................85
Figure 4.3 “SEM Presentation of Data in this Study” .........................................94
Table 4.3.2a “IHC Curricular Map for Ireland – An overlap document” ..........113
Figure 4.3.2b “Proposed Curricular Framework (NCCA, 2020)” .................115
Figure 4.3.2c “Thematic subject area – Fostering wellbeing (NCCA, 2020)” ....116
Table 5.2.2 “How each of the objectives of this study were achieved” ...........123
Figure 5.3.4 “Structure of teacher preparation programme roll-out” .............135
Table 5.1 “Estimated cost of IHC Teacher Preparation Programme” .............140
Author’s Declaration

I hereby confirm that I am the sole author of this dissertation, and it is the result of my own original research and not the work of any other individual. All primary and secondary sources that have been consulted have been identified and acknowledged in the appropriate way. No part of this dissertation has been previously submitted, either in full or in part, to this or any other institution.

Signed: __________________________

Dara Glynn
Abstract

Background

The world is awash with easily accessible information, this is the information age. This dizzying rise in this availability of information, particularly online, has been matched by a similarly speedy rise in the availability of misinformation. Using the information available to us we make decisions every day, in relation to all aspects of our life including our health. The decisions we make about health can have immediate and long-lasting effects on our wellbeing, and so it is important that we have the skills to assess the accuracy and truth associated with any information in relation to health and health claims. These skills are located under a broad area of literacy referred to as health literacy. Recognising the benefits of health literacy as a response to health claims an international collaboration of researchers lead by a team in Oslo developed the Informed Health Choices initiative (IHC) https://www.informedhealthchoices.org. The initiative centres on a framework that identifies Key Concepts people need to understand and assess health information. While the IHC group envisage that the Key Concepts will be used as a foundation for educational interventions for people of all ages and backgrounds their first suite of such work focused on primary school children in Uganda (they developed learning resources to be used in conjunction with an education programme to teach children (ages 10-12 years). The resources included a textbook for children, a teacher’s guide, activity cards and a poster. These resources support nine classroom lessons with learning objectives are achieved using a comic book format that depicts a story set in an Ugandan village). Although tested extensively in Uganda, it is not yet known how useful these resources are for the education system in Ireland. With a different national curriculum and priorities in Ireland, there may be a need to adjust some of the content and delivery of the programme. The extent to which this contextualisation is needed was the focus of this study.
Aim of study

The study aim was to explore the need for and, if necessary, to develop a contextualised version of the IHC programme, with the input of the relevant stakeholders, suitable for use in Irish primary schools.

Research methodology and methods

This Action Research study used a participative approach informed by the qualitative paradigm. Stakeholders from a broad range of the primary school sector, including children, participated in the two action research cycles sharing their perceptions and experiences of the IHC and identifying any adaptations necessary in its content and/or delivery.

The IHC programme was facilitated in three primary schools in Ireland. Individual semi-structured interviews were conducted with stakeholders across the Irish national primary school setting (n=11). Interviews (pre and post the programme) with 3 teachers. Two focus groups were conducted with children (n=15). Nine observations of classroom sessions occurred, reflection entries and evaluation of lessons compiled by the teachers also contributed to the data. With the input of all participants the findings of this study have helped to create a contextualised prototype of the IHC programme for use in Ireland.

Findings

This study found that the IHC and resources were well received by stakeholders and students, but some adjustments were proposed and developed for its use in Ireland. This adjusted programme included changes to the teacher training programme (to help prepare the teachers prior to facilitating the IHC), the format of the student and teacher books, some additional associated resources for use by the teacher in the class and
exercises to provide a home-school link for children and their parents. Attention was also given to the promotion of the IHC to ensure stakeholders were aware of the contribution it could make to the learning outcomes of the curriculum in Ireland.

Conclusion

A contextualised programme (a prototype) was developed and run in a third school but this action research cycle was halted due to the global pandemic and school closures associated with the coronavirus (SARS-COV-2). Further exploration of the developed prototype is required in order to prepare the IHC for further presentation to school and for testing in the future within the context of a research trial.
Acknowledgements

I would like to express my eternal gratitude to my supervisor, Dr. Linda Biesty for her astute guidance, professional engagement and endless patience during this study. I never felt alone and I am extremely thankful for that.

Thank you to the IHC group, who very generously supported this study with raw content and templates. This programme, developed so well by them, is available to all for free. That tells you all you need to know about them.

I would like to thank the staff in the HRB–TMRN (NUIG), KEDS, and Professor Declan Devane, for affording me this opportunity.

Thank you to all the participants in this study. They were generous with their time and free flowing with their opinions and insights.

Thank you to my family, who demonstrated great patience with my thinly spread availability to them.

To Amanda. I don’t deserve you. Thank you for putting up with me over the last two years. You make everyone around you better.
Abbreviations

CPD  Continued Professional Development
CSL  Centre for School Leadership
DCYA  Department of Children and Youth Affairs
DEAR  Drop Everything And Read
DES  Department of Education and Skills
EAL  English as an Additional Language
IHC  Informed Health Choices
ILO  Intended Learning Outcome
INTO  Irish National Teacher Organisation
IPPN  Irish Primary Principals’ Network
ISM  In-School Management
NEPS  National Educational Psychological Service
NCCA  National Council for Curriculum and Assessment
NCSE  National Council for Special Education
NUIG  National University of Ireland, Galway
OECD  Organisation for Economic Cooperation and Development
PAR  Participative Action Research
PE  Physical Education
PDST  Professional Development Service for Teachers
PISA  Programme for International Student Assessment
RCT  Randomised Controlled Trials
TA  Thematic Analysis
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SEM</td>
<td>Socio-Ecological Model</td>
</tr>
<tr>
<td>SESE</td>
<td>Social, Environmental and Scientific Education</td>
</tr>
<tr>
<td>SPHE</td>
<td>Social, Personal and Health Education</td>
</tr>
<tr>
<td>START</td>
<td>Schools Teaching Awareness of Randomised Trials</td>
</tr>
<tr>
<td>UL</td>
<td>University of Limerick</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Chapter 1 - Background and Context for this study

1.1 The Informed Health Choices – A Brief Introduction

Making good choices about our health has never been easy but, in the modern world where we are bombarded with health information and misinformation about health matters, it has become even more difficult (Austvoll-Dahlgren et al, 2015, Cusack et al 2016, Alonso-Coello et al, 2016, Chalmers et al, 2018).

Recognising the need for a set of skills to interpret claims in relation to health, a multidisciplinary group of researchers, the Informed Health Choices Group (IHC group), defined a set of principles/concepts necessary for assessing the trustworthiness of health claims and so lead to informed health choices (Austvoll-Dahlgren, 2015). These 32 principles were titled the IHC Key Concepts and have, since their development, been reviewed and refined following input from key stakeholders and fieldwork in several countries (Oxman et al, 2019b). The list current contains 44 concepts under three domain headings relating to recognising claims with a bad basis, learning to check the evidence from treatment comparisons and developing the skills needed to make informed health choices (Oxman et al, 2019a). The Key Concepts can be viewed as a framework to guide the development of educational programs and resources to teach the public to think critically about health claims (Oxman et al, 2019b). The IHC group chose to develop an education program and resources for primary school children as their first project using the principles as set out in the Key Concepts (Nsangi et al, 2020b). The program for primary school children was based on the understanding that children have the capacity to learn many of the concepts required to asses health claims (Chalmers, 2009). However, rather than include the complete list of concepts the IHC group decided to focus on 12 concepts (Figure 1.1).
### Key Concepts for Primary School Children

1. Treatments may be harmful

2. Personal experiences or anecdotes (stories) are an unreliable basis for assessing the effects of most treatments

3. Widely used treatments or treatments that have been used for a long time are not necessarily beneficial or safe

4. New, brand-named, or more expensive treatments may not be better than available alternatives

5. Opinions of experts or authorities do not alone provide a reliable basis for deciding on the benefits and harms of treatments

6. Conflicting interests may result in misleading claims about the effects of treatments

7. Evaluating the effects of treatments requires appropriate comparisons

8. Apart from the treatments being compared, the comparison groups need to be similar (i.e. “like needs to be compared with like”)

9. If possible, people should not know which of the treatments being compared they are receiving

10. Small studies in which few outcome events occur are usually not informative and the results may be misleading

11. The results of single comparisons of treatments can be misleading

12. Treatments usually have beneficial and harmful effects

(Nsangi, 2019)

Figure 1.1

To assist in this education the IHC group developed a set of resources specifically for primary school children and their teachers (including a student textbook and teacher’s guide), to support the implementation of the program in mainstream classroom settings. (Nsangi, 2019).
1.1.1 The IHC primary school resources

The first complete draft of the IHC primary school resources was introduced to Uganda in the context of a programme of research in April, 2016 (Nsangi et al 2017a). This research included a cluster-randomised trial (Nsangi et al, 2020a) and a process evaluation to identify any factors influencing the impact, implementation and scaling up of the intervention (Nsangi et al, 2019). Using a user-centred design approach (involving researchers, journalists, policymakers, schools, teachers and students), these resources were introduced in other settings and prototyped, piloted and user-tested in Uganda, Kenya, Rwanda and Norway (Nsangi et al, 2020b). This refining of the resources was done initially through participatory observation of resources in action and later, when the resources were more finalised, through non-participatory observation of the programme in schools (Nsangi et al 2020b).

1.1.2 Assessing the effectiveness of the programme

The evidence supporting the effectiveness of the IHC programme is based on testing children’s relevant knowledge using the Claims Evaluation Tools set (Austvoll-Dahlgren et al, 2017). This tool is used to assess people’s knowledge of the Key Concepts as it applies to concrete situations described in each question. The trial in Uganda noted that nearly 70% of students engaged in the IHC programme achieved a passing grade in comparison to just under 27% of students in the control group (Nsangi et al 2020a). A follow up study to assess the effects of the IHC one year after the cluster-randomised trial noted that over 80% of children in receipt of the IHC programme achieved a passing score on the Claims Evaluation Tool one year later in comparison to just over 50% in the control schools (Nsangi et al, 2020a). This is a promising indicator of the long-term potential benefit of this programme.
1.1.3 Ongoing work on the IHC resources

The IHC group have supported other international research groups who wish to translate and contextualise the resources for various locations throughout the world. The IHC group have provided translation/adaptation guides (Informed Health Choices group, 2017; Rosenbaum et al 2019a & 2019b), summaries of ongoing work (Informed Health Choices Group, 2018) and ancillary supporting resources such as a music video for children and a podcast for parents in Uganda (Semakula et al, 2019). This supportive stance has resulted in ongoing translation and contextualising projects in a variety of countries including China, Italy, Spain, Ireland, USA and Brazil (www.informedhealthchoices.org). The groundwork for the development of a set of secondary school resources has now commenced (Oxman et al, 2019d; Rosenbaum et al 2019).

The IHC project is an international, living and developing body of work focussed on addressing a shortfall of the education system when it comes to equipping our citizens to make good health choices in their lives (Oxman et al, 2019b). A more extensive review of the IHC is developed in Chapter 2 (section 2.4).

1.2 Aim and Objectives of this Study

1.2.1 Aim

The study aim was to explore the need for and, if necessary, to develop a contextualised version of the IHC programme, with the input of the relevant stakeholders, suitable for use in Irish primary schools.
1.2.2 The Objectives of this Study

1. To complete a curricular mapping of the IHC programme onto the Irish Curriculum. Effectively mapping the programme will help to define its potential role within the Irish Primary Curriculum
2. To identify and respond to key stakeholders views of the IHC program and their experiences of facilitating / participating in the IHC in a primary school setting in Ireland
   • This will include reference to the content, the processes and the resources of the IHC
3. To explore the participating stakeholders’ and end-users’ experience of the contextualised programme
4. To produce an adjusted version of the IHC programme that is ready for trialling in Irish Schools

1.2.3 Positionality of the researcher before the study

The researcher for this thesis is a primary school teacher with 20 years of experience, 15 of those years as a Principal. He has served in all sizes of Irish schools in both rural and urban areas. His interest in Health Literacy was peaked when he became involved with the START (Schools Teaching Awareness of Randomised Trials) competition in its foundational year. It was clear from the competition that learning about trial methodology was something that children could do and its importance became clearer to the researcher as he saw the breadth of applications it had in school projects that were relevant even to the daily lives of those children. During the search for a suitable learning resource for teaching children about the importance of randomised controlled trials, the team came across the IHC programme. The researcher was asked to explore how it might fit into the Irish school system, thus creating the focus of this study. Although excited by the prospect of such an interesting long term project, the researcher was concerned about how the time commitment would interfere with his role as a parent, husband and
Principal of one of the largest primary schools in the country (670 pupils and 50 staff) in the middle of a 12.5 million euro building project.

1.3 The Educational Landscape that IHC Finds Itself In

1.3.1 Achieving a vision for IHC

The vision underpinning the contextualisation of the IHC programme (including resources and processes) is to provide a programme that is a viable option to incorporate within the curriculum of primary schools in Ireland.

1.3.2 The Global Educational Landscape

a. Countries are compared to and copy each other

Ireland currently finds itself in a globalised educational landscape where policy borrowing between different countries has become increasingly prevalent (Walsh, 2016a). Departments of Education often look to successful practices/programmes/procedures in other jurisdictions with a view to adopting them in their own context (Walsh 2016a). A recent example of this in Ireland is the possible move towards a fully inclusive education model for children with special needs, similar to the ‘New Brunswick’, a model of total inclusion adopted in that Canadian province (National Council for Special Education, NCSE, 2019). Decisions such as this may be informed or influenced by access to data and information that compares the educational systems of different countries in some way. Inevitably, an unfavourable comparison on an international ranking system such as the Programme for International Student Assessment (PISA) leads to pressure from politicians for system reform (Araujo et al, 2017). Examples of this trend include:

- The McKinsey Report – How the World’s Best Performing School Systems Come Out on Top (Barber & Mourshed, 2007) - an explanatory narrative was attached to international comparisons,
postulating as to what made the higher scoring education systems successful. The narrative could be read by politicians as a possible signposting for best practices to adopt in their countries.

- Literacy and Numeracy for Learning and Life (Department of Education, 2011) - A decline in international comparison results for Ireland inspired this reactionary plan, which included the adopting of some international best practices on teaching and management in schools.

b. The rise of standardisation

The rise in comparisons, and the rationalising of how success happens in some jurisdictions and not in others, has led to the belief that standardising practices should lead to better performance (Araujo et al, 2017). This is discussed further in part c (see below).

c. School leadership

Standardisation is also now applied to school leadership. It is now a commonly held belief that leadership is a skill that can be effectively taught to anyone (Linsky and Lawrence, 2011), implying that it can be standardised. This view seems to be supported by the rise in educational leadership organisations over the last 15 years in Ireland such as the Irish Primary Principals’ Network (IPPN) and the Centre for School Leadership (CSL), and the prevalence of leadership courses for primary school teachers such as the Postgraduate Diploma in Educational Leadership, Misneach, Cómhar, Forbaírt, Táiniste and CSL’s Principal Mentoring Programme. This study is not concerned with the risks or benefits of standardised leadership processes. However, a standard approach to leadership implies a more predictable pattern of decision-making processes and this could be useful for improving implementation spread of the IHC programme. Knowing how educational
leaders make decisions could help to inform a more effectively adjusted programme.

d. Curriculum and planning

The Irish primary education system has not been immune to the rise of globalised managerialism and neo-liberal influences on educational theory (Ummanel et al, 2016). This has resulted in curricular changes – e.g. the primary school curriculum has moved from a fully child-centred, holistic, spiral curriculum to now having become a more competence-based curriculum. The learning outcome model associated with a competence-based curriculum has resulted in more recent interpretations of the primary school curriculum to integrate knowledge, skills and attitudes and attempt to transcend subject learning (Walsh 2016a). The shift to pre-set learning outcomes and product-based pedagogy in the U.K. pressurises teachers to justify every topic choice and reduce time spent on less academically productive matters such as Physical Education (Rainer et al, 2012). This standardising of approach allows teachers’ planning and assessment paperwork to become more comparable (Rainer et al, 2012). This move towards the more quantifiable and comparable learning outcomes, in theory, allows for the replication of educational interventions and programmes more easily. The implication of this for Ireland is the greater feasibility of adopting learning programmes developed in other countries.

e. A standardised approach does not always give a standardised result

Ireland has already adopted some programmes by borrowing from internationally successful programmes (e.g. Reading Recovery, Accelerated Reader, Friends for Life). However, there remains basic contextual and structural difference (e.g. the use of Irish as a second language, varying pupil-teacher ratios, relative quality of teaching standards, funding models) even between otherwise overtly similar education systems. The countries where
these programs have been developed (Reading Recovery comes from New Zealand, Accelerated Reader comes from the USA, and Friends for Life is Australian) have not always performed as well in some international comparison tests as Ireland (Programme for International Student Assessment, PISA, 2019). The recently published PISA results place Ireland 6th in the world for reading, with New Zealand and the USA coming in 10th and 11th respectively. This implies that the successful implementation of a programme in different countries may be influenced by more than core content and other factors must be considered, such as the different context in each jurisdiction.

There is no standard approach to education that works equally well in every country (Organisation for Economic Cooperation and Development, OECD, 2016, 2019). For example, Finland and Singapore are both high achieving systems that score very well on international comparison tests, but they are countries that take very different approaches to education in terms of methods and approaches (Hui Lin Li et al, 2014). Therefore, the lessons from the globalisation, and the associated sharing/borrowing/imitation of educational programmes, is that an educational programme, even an evidence-based one, cannot be assumed to have the same effect in every national context. There can also be nationally specific inhibitors to the successful introduction of a new programme (further discussed in section 1.3.3 below). It is important, therefore, to get local stakeholder input and to take account of national practice and curricular norms when introducing any program, including the IHC to a new jurisdiction such as Ireland. Without making any changes to the key concepts or core content of this programme, this study sought to explore and respond to a process of information gathering on the Irish context and the views of stakeholders involved in primary education here.
1.3.3 The Educational Landscape in Ireland

There are many specific characteristics of the Irish Primary school system that should be considered when exploring the integration potential of any new programme. This section seeks to outline these factors and draw attention to points that informed the design of this study. Items such as curriculum, teacher training, system flux, initiative fatigue, school/student/teacher numbers and distribution and parental choice of schools all warrant consideration to ensure an understanding of the cultural context in which this study occurred and the processes associated with the primary school context in Ireland.

a. Curriculum

Setting aside the Global Educational Landscape and the pressure it places on education systems (section 1.3.2), the current national curriculum for primary schools in Ireland was originally written as a child-centred, holistic and spiral curriculum document (Government of Ireland, 1999a). Child centred, in that it places the child at the centre of the learning process as an active participant (and not just a vessel for pouring knowledge into by the teacher).

Holistic, in that it seeks to encourage the development of all aspects of a child’s life including the spiritual, moral, cognitive, emotional, imaginative, aesthetic, social and physical (curriculum online, https://www.curriculumonline.ie/, accessed 27/07/2019). Spiral in that it revisits the same topics or themes in greater depths each successive year.

Although the aims and objectives are set, the content and methodologies of education and teaching are encouraged rather than prescribed by the Department of Education and it is left to schools and individual teachers to pick the 8-year path travelled by the children during their time in primary school (Government of Ireland, 1999b, pg. 10). Accordingly, there is enough
flexibility in the curriculum to allow variations in local context, priorities and teaching styles, in line with its child-centred, holistic ethos.

Excluding Religion, there are 11 subjects in the curriculum:

Irish Primary School Curriculum

<table>
<thead>
<tr>
<th>Core subjects</th>
<th>English, Irish and Maths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social/Environmental subjects</td>
<td>History, Geography and Science</td>
</tr>
<tr>
<td>Arts subjects</td>
<td>Drama, Music and Art</td>
</tr>
<tr>
<td>Other Subjects</td>
<td>Physical Education Social, Personal and Health Education (SPHE)</td>
</tr>
</tbody>
</table>

Table 1.3.3a

Time allocated to these subjects is prescribed and proportionate to their perceived importance according to the Department of Education. As per Table 1 below (NCCA, 2016), a core subject has 4+ hours per week whereas SPHE, the subject most closely aligned with IHC (see IHC Curricular Map for Ireland, Table 4.3.2a, Chapter 4), is allocated 30 minutes per week:
Weekly minimum subject time in the Primary School Curriculum (1999)

<table>
<thead>
<tr>
<th>Curriculum Area</th>
<th>Full Day (age 7-12)</th>
<th>Infant Day (age 4-6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Language 1 of the school</td>
<td>4 hours</td>
<td>3 hours</td>
</tr>
<tr>
<td>Language 2 of the school</td>
<td>3 hours 30 minutes</td>
<td>2 hours 30 minutes</td>
</tr>
<tr>
<td>Mathematics</td>
<td>3 hours</td>
<td>2 hours 15 minutes</td>
</tr>
<tr>
<td>Social, Environmental and Scientific Education (History, Geography and Science)</td>
<td>3 hours</td>
<td>2 hours 15 minutes</td>
</tr>
<tr>
<td>Social, Personal and Health Education</td>
<td>30 minutes</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Physical Education</td>
<td>1 hour</td>
<td>1 hour</td>
</tr>
<tr>
<td>Arts Education (Visual Arts, Drama and Music)</td>
<td>3 hours</td>
<td>2 hours 30 minutes</td>
</tr>
<tr>
<td>Discretionary curriculum time</td>
<td>2 hours</td>
<td>1 hour</td>
</tr>
<tr>
<td>Religious education (typically)</td>
<td>2 hours 30 minutes</td>
<td>2 hours 30 minutes</td>
</tr>
<tr>
<td>Assembly time</td>
<td>1 hour 40 minutes</td>
<td>1 hour 40 minutes</td>
</tr>
<tr>
<td>Roll call</td>
<td>50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Breaks</td>
<td>50 minutes</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Recreation (typically)</td>
<td>2 hours 30 minutes</td>
<td>2 hours 30 minutes</td>
</tr>
</tbody>
</table>

Table 1.3.3

The Irish Curriculum was informed by the view that learning experiences are influenced by the context in which they occur (Dewey 1938). Therefore, the curriculum originally was child-centred in its planning and implementation, where teachers were expected to approach new learning from the perspective of the child. This includes considering the child’s current understanding and then providing the child with an appropriate, context-relevant learning opportunity. For example, learning how to add and subtract money may necessitate playing ‘shop’ first so that child can see the relevance of the new learning to their own life.
As part of the flexibility built into the National Curriculum’s structure, teachers are free to use integration (where content addresses the objectives of more than one subject) and linkage (where content addresses the objectives of more than one area within the same subject) in their lessons (Government of Ireland, 1999b, p 16, 56, 67 and 69). They also have some additional discretionary time each week to allocate to prioritised content (see Table 1, above). This means that they can sometimes address two or more subject areas with one lesson by focusing on a theme topic or learning experience, called a thematic approach or integrated curriculum model (Chon Min et al, 2012). This has the dual benefit of complying with time allocations in the curriculum while also freeing up more space in the week’s timetable for other activities. Although the Irish curriculum’s structure restricts time allocation to SPHE (IHC’s closest subject counterpart), the philosophical underpinnings of the system may allow teachers to divert more time to a programme such as IHC under certain circumstances such as when an overlap occurs with other subject areas.

b. Teacher Training

The education of primary school teachers is currently a 4-year degree course with academic and practical elements. The post-graduate training course, a route for those with any primary degree, to become a primary teacher is now a two-year Masters level nine program (National Framework Qualification). Education and training are provided in 4 third level institutions and 1 online provider. The education is tailored to prepare teachers to work in the Irish system although the high calibre of teachers produced is internationally recognised (Harford, 2010). Teaching remains a relatively desirable occupation in Ireland with new entrants taken from the upper end of Leaving Cert results requiring over 470 points (Careersportal.ie, 2019). According to the most recent occasion that this type of independent study was commissioned by the Irish Government, the academic standard of entrants into primary school teaching is amongst the highest, if not the highest, in the World (Department of Education and Skills, 2012). Once teachers secure
permanent employment, they have full job security and qualify to receive a public sector pension. The teachers are of a high quality, and the performance of students in the Irish primary school system is also high, scoring 6th in the world for reading (OECD, 2019) (Reading is often viewed as the go to for international comparisons).

It would be anticipated, therefore, that the IHC programme would be delivered by well educated, high quality teachers in Ireland.

c. A System in Flux

The Irish Primary school system finds itself in a state of flux (Walsh, 2016a). The effect of regular international comparison has resulted in an increased rate of introspection, self-evaluation and change (Quinn, 2012). As Walsh (2016a) remarks, the ongoing review, reform and development of curricula are necessary to enable reflection on their content and methods to ensure they keep pace with wider societal developments. A culture of continuous self-evaluation and self-improvement at organisational level has been nurtured in Irish Schools (Numeracy and Literacy Strategy, 2011. Quinn, 2012). This may have the effect of opening schools up to the possibility of introducing a programme like IHC. Conversely, it may also temporarily shut the door to new programmes like IHC if those programmes do not fall within the area identified for self-improvement by the school.

The Irish State has also already begun an update of the 1999 National Curriculum (National Council for Curriculum and Assessment, 2020) on a phased basis with a new Language Curriculum for English/Irish having recently been implemented and the new Maths curriculum due for introduction soon. This updating will extend to all areas of the curriculum in the coming years, with a proposed re-organisation that would see weekly time allocated to subjects like SPHE double (National Council for Curriculum and Assessment, 2020).
An evidence-based programme, such as IHC, can lay a strong claim for a place in a curriculum where change and development of curriculum and approaches has become the norm. Indeed, one of the principles underpinning the proposed new curriculum framework is that teachers would favour evidence-based pedagogical approaches (NCCA, 2020). As the Irish system is in such a state of flux, it may be argued that this is the ideal time to introduce the concept of new programmes such as the IHC.

d. Initiative fatigue

As the above noted changes continue, they may also add to an already growing sense of initiative fatigue in the Irish primary school system (Ummanel et al, 2016). The Department of Education prescribes national policy and procedural change primarily through the issuing of departmental circulars. It is then the responsibility of schools to implement changes as indicated and within the timeframe as may be stated in the circular. Between 1970 and 1999, the average number of circulars issued annually was 32 (https://www.education.ie/en/Advanced-Search/?q=circulars, last accesses 16/08/2020). Such is the pace of change nationally and internationally that, on average, that annual figure has risen to 80 in the last 15 years (Department of Education 2019). The increased work required to respond to these changes has led to a sense of initiative fatigue across the primary school system (National Principal’s Forum, 2018). This has manifested itself in terms of Principal Teachers perceiving themselves as over-burdened with administrative responsibilities, particularly if they are recently appointed (Ummanel et al 2016). The response to this has been a move by Principal Teacher Organisations to supporting Principal Teachers to restrict and prioritise change (Irish Primary Principals Network, 2014) within their own schools. Within such a culture, it is possible that a more sceptical view towards a programme such as IHC, with its lack of curricular mapping or government support/endorsement, might be taken by Principal Teachers. This is important to note, given that the most likely first point of contact in any school in Ireland will be the Principal Teacher.
Teachers have also reported negatively on their increased workload. Teachers have cited increased demands from inspectors, greater numbers of outside agencies to deal with and the perception that there is an increased expectation to solve societal problems through schools as all adding to their professional role (Irish National Teachers’ Organisation, 2015). These would all add to the possibility of initiative fatigue.

In summary, there is voiced sense of ‘overload’ in the Irish Primary School System from teachers and Principal Teachers. It is important for this to be considered when introducing a programme such as IHC.

e. School/Student/Teacher numbers and distribution

According to the Department of Education’s report on enrolment projections for the next ten years: There are currently over 37,000 teachers in 3,240 primary schools in the Republic of Ireland, providing education to just under 568,000 students (Department of Education, 2019). The report states that 44.1% of schools are defined as small schools (4 mainstream classrooms or less) and are attended by only 14.5% of students, which has implications for any programme wishing to spread nationwide. These smaller schools are generally more densely spread along the western seaboard counties. In Ireland, 60% of primary schools have a teaching principal (Department of Education, 2019).

In comparison with the Ugandan context (where the IHC intervention was initially trialled), where just over 9 million children (UNESCO, 2019) are serviced by 12,000 schools (Ministry of Education and Sports, Uganda), the Irish primary school student population has a median school size of 175 (750 in Uganda, 237 in Norwegian public schools). Any roll out and implementation strategies would need to be cognisant of this difference, as the smaller median size of schools implies a greater number of small schools where the classrooms would be multi-level (i.e. 2-4 class levels in the one room). It is important for this study to consider the impact on planning and delivery of the IHC programme in multi-class situations.
A feature of the Irish System is that parents have a constitutionally enshrined set of rights as the primary educator of the child (Government of Ireland, 1937). According to Buchannan and Fox (2008), this means that in principle, if not always in practice, every state supported primary school in Ireland is a school of choice.

Primary schools are not required to publish academic standardised test results. There are no restrictions on parental choice of school (other than those embedded in practice by each school as part of their enrolment policy). Accordingly, the question is begged: What factors influence parental choice and motivates them to send their child to one school rather than another? According to Kristen (2008) there are three stages in parental school selection decisions: the perception of school alternatives, the evaluation of these alternatives, and school access. This implies that the choice is relative to the perceived quality of the alternatives. Accordingly, perception implies a subjective value judgement which, in the absence of evidence, can only be made on reputation and added value measures (what the school provides in addition to core curricular activities).

With the impending projected decrease in numbers of the primary school-going population size from a little over 568,000 in 2018 to around 530,000 by 2023 (Dep of Education Statistics, 2018), it can be argued that the issue of school choice will become a factor in protecting teacher numbers in every school. Reduced student numbers result in permanent teachers being reassigned to other schools, through a localised panel system, where numbers can support their existence. This then reduces the affected school’s overall capacity to deliver added value programmes.

If the projected figures are realised, then the future in Ireland is one where schools will be competing for a shrinking pool of students. In such circumstances, and with parental choice of school enshrined in the constitution, the additional activities, programmes or services offered by each school will become more important as the parents evaluate the alternatives. It
is in this climate that this study is introducing a new initiative to primary schools.

How programs such as the IHC are perceived by schools as adding value to their offering, thereby attracting parental choice, may be considered and influence its acceptance and implementation into individual schools.

The Irish Educational Landscape is structured and resourced in such a way that it has the capacity and supporting curriculum to deliver the IHC programme. It is possible, however, that issues such as initiative fatigue and work overload may act as inhibitors to the introduction of a new programme. However, the declining student population at primary level and the embedded right of parents to school choice may serve to push schools to shelve their reservations and adopt best practice programmes in order to stay competitive.

1.4 Summary Conclusion

This chapter looked at the aim and objectives of this study. Programmes do travel internationally, and education systems will look abroad for options, but the contexts and outcomes of even seemingly similar systems vary. There is a place for the IHC within the curriculum of primary schools in Ireland, however, given the current context of education in Ireland, there may be a perception among its well-trained teachers that there is no room or time for it. The system is undergoing change over the next few years that may include increased time for programmes like IHC. This, in combination with projected declining student populations over the coming years and the competition generated between schools due to Ireland’s parents’ choice of school model, suggests that the timing for this study is good.

The rational underpinning this study, in exploring the need for contextualisation, is important. Schools are, in operation, reflective of and responsive to socio-political, economic and religious influences (Walsh 2016a). Any attempt to introduce a change or a new initiative into schools would be well-advised not to ignore context.
Chapter 2 - This Study – A confluence of three stories.

2.1 Introduction

In this chapter, the converging narratives of health literacy, the Irish Primary School Curriculum and the Informed Health Choices (IHC) programme will be explored. Each will be discussed individually first. Then the commonalties will be found and tied together to demonstrate the relevance of the IHC programme to Irish primary schools and the rationale for this research study.

2.2 Health Literacy

2.2.1 Health literacy - arriving at a definition.

Although it may seem like a statement of the obvious, health matters (Kickbusch, 2009). Making decisions about our health, with the complex array of treatments and information/opinion available to us in this modern world, has become more difficult than in the past (Austvoll-Dahlgren et al, 2015, Cusack et al 2016, Alonso-Coello et al, 2016, Chalmers et al, 2018). This growing complexity has drawn attention to the skills needed for people to navigate and make good choices about their health (Austvoll-Dahlgren et al, 2015, Cusack et al, 2016). Accordingly, there is now a recognised form of literacy, called health literacy, being explored and advanced by researchers (World Health Organization, 2013; Sorenson et al, 2012; Nsangi et al, 2015). Finding an appropriately accurate definition of health literacy has been difficult, primarily because of the continuously growing skillsets deemed necessary to be considered ‘literate’ in relation to one’s health (Berkman et al., 2010). These have included literacy, numeracy, communication (written and oral), technology, cognitive and social skills. Drawing from so many sources, health literacy appears to be a complicated and highly engaged activity in its application.
The definition that is most helpful in the context of this study is:

“Health literacy is a concept associated with the field of general literacy and refers to a person’s capacity to make sound health decisions in everyday life” (Kickbusch, 2008, p 101).

This definition is used because it connects literacy and health literacy, which is important in the primary school setting in relation to both children and teachers. It also provides the intended general application for those who develop the skill, thereby indicating that health literacy is relevant to primary school education as well as to everyday life. In the context of this study to a primary school setting, the definition serves to highlight the features of the IHC programme that make it relevant, such as:

- A text rich, narrative driven student book that can serve the dual purpose of developing literacy and health literacy.
- The IHC programme intends to equip children with knowledge and understanding of a set of skills (Key Concepts) necessary for making informed health choices.
- The IHC programme, through stories, exercises and activities, attempts to relate the content back to children’s everyday lives.

2.2.2 A history of health literacy.

An old Obsession

Our current obsession with health and self-care is not new: “Tis in ourselves that we are thus or thus. Our bodies are our gardens to the which our wills are gardeners” (Othello, Act I, scene 3). Indeed, Western medicine was intertwined with religion and philosophy until its first individualisation as a separate line of study in Bologna during the 12th Century (Illich, 2017). More recently, Illich (2017) argues, our increased obsession with perfect health seems to have diverged with reality. Illich (2017) states that despite all the metrics pointing to an increasingly healthy society, the population’s positive response to the question ‘How are you?’ has declined in equal measure, a sign
that health literacy in the general public is needed. This points towards a society that has lost the very social sense of the question.

*It used to be just ‘Literacy’*

The history of health literacy is linked to the evolving understanding of the term ‘literacy’ in the modern world (Kickbusch, 2008; Berkman et al, 2010). Before the American Civil War, a person’s ability to sign their own name on a document rather than just an ‘x’ was considered an indicator of literacy (Lockridge, 1974). Over the next hundred years, the definition and required minimum standard to be deemed literate evolved and rose (Berkman et al 2010). The term ‘functional literacy’ was coined in the early 20\textsuperscript{th} century, meaning the basic level required to function in society, and this was set as society’s minimum requirements for literacy (Berkman et al 2010). In the early 20\textsuperscript{th} century, this was set at the completion of 3 years of education but by the 1970’s, this set standard had risen to that of high school diploma level (Kaestle et al., 1991). The splintering of ‘Literacy’ into multiple new subsets has continued. For example, digital literacy, media literacy, functional literacy, early literacy and critical literacy are just some of the terms that have entered the vernacular of teaching (Lynch, 2019). The changes in the definitions and standards associated with literacy reflect the change in society from an agricultural economy to an industrial and, ultimately, to an information-based economy (Berkman et al, 2010).

*The rise in interest in health literacy*

The previously mentioned link established between low literacy, health status and outcomes was one of the reasons that led, during the 1990’s, to the establishment of health Literacy as a field of research (Berkman et al, 2010). There was a marked increase in the number of health literacy publications, in the four bibliographic databases studied (Scopus, PubMed, CINAHL, and Web of Science), every year from 1991 to 2015 (Massey et al, 2017). Less
than 50 were produced annually during the 1990’s and this rose to an average of well over 400 per anum by 2008:

Annual number of health literacy papers published, 1990-2015

According to Berkman et al (2010), another reason for the development of health literacy as a field of study was the realisation that a generally high academic attainment did not necessarily equate to sound health choices. Much as an individual’s academic attainment is not generally evenly distributed between subject areas, this was also true when it came to the skills needed to make good health choices (Berkman et al, 2010). Furthermore, with the increased complexity of the range of medical treatments and interventions available, the gap between the user’s and the provider’s (e.g. the health care professional) understanding has widened, requiring a conscious effort on the part of professionals to make the information they provide accessible and digestible to the user (Raynor, 2012).

Although first mentioned in health research in the 1990’s, the concept and study of health literacy only began to really gain traction within education and educational research in the last 10 years (Massey et al., 2017). This is in line with the belief that health literacy is dynamic and can be influenced
throughout a person’s life through educational intervention (Chalmers, 2018, Cusack et al, 2018). With the right interventions and programmes it can be argued that significant progress could be made in developing the health literacy of a population in schools (Nsangi et al, 2017). This is be reflected in Ireland by the inclusion of Social, Personal and Health Education (SPHE) in the Irish Curriculum (Government of Ireland, 1998) and the evolution of the Irish Curriculum (discussed later in this chapter).

2.2.3 Why health literacy is so important today

*Loss of health has consequences*

Being healthy is a pre-requisite to full engagement with all that life has to offer.

“It is health that is real wealth and not pieces of gold and silver.”

(Mahatma Gandhi)

It is in our interest to improve our knowledge and understanding of the Key Concepts for making good decisions about maintaining our health, preventing a loss of health where possible, and improving our chances of recovery when sick (Austvoll-Dahlgren et al 2015).

*Healthcare has become very complicated*

Treatments and medicines for maintaining, recovering and improving health are becoming more and more advanced and healthcare is complex (Tien, and Goldsmith-Clermont, 2009). Tien and Goldsmith-Clermont (2009) cite several examples including:

- Customisation of medical interventions such as genetic interventions.
- Broadening of health insurance products resulting in often complex offerings that result in the individualisation but also often the exclusion of some from the cover they need.

In many cases, not only are treatments advancing but there can be multiple treatments for the same issue. For a headache, here is an unscientifically obtained but possibly quite representative list of just a few treatments drawn from personal and local experience:

- Take one of a wide number of pain relievers.
- Drink water or coffee.
- Stop doing what they are doing (if, for example, they have been staring at a screen).
- Take a herbal remedy.
- Massage their head.
- Reduce their alcohol intake in future.
- Go for a walk outdoors.
- Eat something salty.
- Realise, after several painful days or weeks, that they have hay fever and take an antihistamine.
- Do nothing.

(list drawn from personal experience, admittedly a bad basis for a claim according to the IHC)

A quick search on the internet or reference to friends and family will provide all the confirmation bias needed to proceed with any of the above-named treatments, as these are often more trusted sources (Chalmers et al, 2018). Considering that the breadth of all the world’s good scientific knowledge and research makes up a fraction of the content on the internet, it lays bare the complexity of making good health choices with a system so awash with bad information.
Health literacy affects our daily lives:

When looking at potential treatments for even the most mundane of issues such as a headache, one can begin to see how fundamental and essential health literacy is as a life skill. Some basic health literacy activities include:

- Understanding what a health care professional says to you
- Understanding information on food packaging
- Participation in activities that improve our health and well being
- Assessment of the reliability of information about an illness in the mass or social media
- Knowing in advance how much a treatment will or should cost
- Ability to find information on how to manage mental health problems such as stress, anger or depression

(Lytton, 2013,p35)

Indeed, there is a growing body of research examining and establishing the link between health literacy, behaviours and health outcomes (Fleary et al, 2017; Davis and Wolf, 2004; Kickbusch, 2009; Lytton, 2013; Sharif and Blank, 2010). Sharif and Blank (2010) highlighted the positive correlation between higher health literacy and better health outcomes in adults, citing 34 studies that supported this claim. Indeed, health literacy is one of the strongest predictors of health status (Lytton, 2013), and literacy is a more powerful predictor than race or education of disparities in health outcomes (Sentell and Halpin, 2006). Fleary et al (2017) conducted a systematic review of the literature to explore the relationship between reported health behaviours in adolescents and health literacy. Seventeen studies were included across which seven measures and eight unique definitions of health literacy were noted. A meaningful relationship between health literacy and adolescents’ health behaviours was noted, highlighting the importance of developing their health literacy to empower them to make good choices. However, the reviewers also acknowledged the difficulties posed by the absence of agreed definition and measures of health literacy. Davis and Wolf (2004) draw the link between low adult literacy, health literacy and the associated poor outcomes in
accessing preventative medicines, understanding their own medical condition, adherence to medical instructions and self-management skills. They highlight some implications for family medicine, including the possible need to reduce the reading level requirements of health information leaflets (e.g. according to Wallace and Lennon, 2004, 75% of the American Academy of family Physicians’ information leaflets at the time were pitched at an above adult average reading level of 8th grade). Kickbusch (2009) discusses health literacy in terms of a whole range of practical activities from effectively interacting with health professionals to gauging the sugar content in coke or even buying a condom. She also highlights the importance of schools for bridging the health literacy gap, particularly for disadvantaged citizens.

The understanding of health literacy has recently extended in scope to include a digital health literacy element, defined as a person’s ability to search and locate health information online and to understand, apply and use this information (Vicente & Madden 2017). Specific to the modern age, with easy access to the internet for individuals using a personal device, the core problem is the inability to distinguish between biased and non-biased or evidence and non-evidence-based information sources (Vicente and Madden, 2017).

The effects of a health literacy deficit are not limited to the individual. White et al (2013) indicate that there is evidence in the literature to support the idea that improving parental knowledge and behaviours will impact on child health when specific efforts are taken to address health literacy deficits. Improving the health literacy of a parent can affect health behaviours and outcomes for the entire family (Liechty et al, 2015).

The importance of health literacy in the modern age extends even further beyond, accumulating to form societal trends (Illich, 2017). The consequences of a health-literate population have wider economic implications in terms of making sounder decisions about their health, productively interacting with healthcare providers and their effective response to political decisions (Kickbusch, 2008). It is an ethical and economic imperative to promote health literacy (Kickbusch, 2009).
Kickbusch cites the example of Switzerland where the data suggested that limited health literacy cost the exchequer 1.5 billion Francs annually.

Health literacy as a subject to be taught

With nearly half of all adults, tested in eight European countries, having inadequate or problematic health literacy skills (Lytton 2013, Dahlgren, 2020), the benefits of promoting health literacy are clear. Health literacy can be considered a logical and measurable outcome of Health Education, where an observable set of skills are developed through effective communication and/or teaching (Nutbeam, 2019).

Lytton (2013) suggests that health literacy, as a subject, should be given equal weighting with the knowledge of other Arts and Sciences that constitute the main curricula of life. He suggests this based on the assertion that poor health literacy adversely affects a person’s health. He points out that, to varying degrees, modern societies allow the promotion of unhealthy lifestyles and the vigorous defence of products through scientific muddying of the waters.

All the points about health literacy in adults may equally apply to children. For example, a correlation was found between higher literacy and lower body mass index, adjusted for age and gender (Sharif and Blank 2010). Health attitudes and behaviours formed in childhood have a strong predictive influence on adult patterns of health behaviours (Borzekowski, 2009). Health literacy also has an immediate relevance to children’s lives as consumers (Broder, 2017). This speaks to the potential benefits of targeted health literacy intervention. Key Concepts relating to health literacy can be taught to children (Nsangi et al, 2017) and can have a lasting effect on their ability to make good health choices (Nsangi et al, 2020a). The Informed Health Choices programme can contribute to the promotion of health literacy and it can do it at an early age (10-12 years) with children potentially reaping the benefits for the rest of their lives.
There’s an absence of health literacy programmes

The absence of a structured development of health literacy has been recognised by the European Commission, characterised in their promotion of health literacy programmes for people of different ages as a means of citizen empowerment (Sorenson et al, 2012). There is a natural overlap between the everyday goals of early/primary level education and those of health literacy as they both seek to promote independent, well informed and critical thinking to promote personal development and empowerment (Mc Daid 2016). However, in spite of the recommendations of the European Commission (Sorenson et al, 2012) and the World Health Organisation (Mc Daid 2016) to include health literacy in education of children there is a notable lack of programmes that specifically teach critical thinking skills for health literacy in Ireland (National Educational Psychological Service, 2015).

2.3 Irish Primary School Curriculum and Health Education

The Irish primary school curriculum has had an ‘on again, off again’ relationship with health literacy throughout its history. In one form or another, health related topics and subjects have been taught to Irish students since the very formation of the system in 1831.

2.3.1 Evidence of Health Education in Irish primary schools up to the 1970’s

Civilising the population

Pre-1831 education in Ireland primarily took the form of Hedge Schools, where every provider was independent with full authority over the curriculum being taught (Murnane, 1986). Naturally, this makes it difficult to establish any specific pattern of education, including that relating to the prevalence of Health Education at the time.
There has been a formal National School System in Ireland since 1831, with its intention of socialising the Irish population into certain norms and providing for basic numeracy and literacy (Walsh, 2016a). Although the delivery modes and norms may have changed in the intervening centuries, it could be argued that this intent of a structured education system has not changed. It exists, for better or for worse (Rossides, 1984), to preserve and perpetuate society (Bass, 1997). That is to say, though education has become more child-centred with modernised teaching methods and tools, it is still the function of education to self-replicate our civilised society by developing and preparing children for citizenship. Indeed, indoctrination and conditioning are now considered among the basic objectives of education (Schofield 2012).

Within the structure of Ireland’s literacy curriculum in the 19th century was a focus on lessons that also taught new habits of the body and mind in the hopes that students would, among other things, adopt higher standards of personal cleanliness (Nolan, 2008).

Although no direct reference to any form of Health Education was explicitly mentioned in the literature relating to the pre-1970’s curricula in Ireland, the very creation of a structured system was in part a response to prevailing health issues at the time (Coolahan, 1983). There was an ongoing population explosion in Ireland with an associated drop in living standards and an extreme vulnerability to potato crop failures (Coolahan, 1983), of which there were many long before the Great Famine. The potential threat of this enlarged, hungry, disadvantaged and, therefore, increasingly angry population sparked the formation of the structured national school system (Walsh, 2016a). The intervention certainly lifted the civility and value of the Irish population with them becoming one of the first examples of a higher skilled internationally mobile workforce (Nolan, 2008).

*Health Education was often an incidental part of learning*

During the second half of the 19th century, the hidden health curriculum included the popular Vere Foster’s writing books where children would write
and commit to memory sayings such as “too much bed makes a dull head” (Nolan 2008). A hidden curriculum is one characterised by a lack of formal or conscious planning, but includes values, intergroup relations and celebrations that enables students’ socialization process (Kentli, 2009). According to Nolan (2008), another widely used school text described the desirable standard of personal hygiene “girls and boys… their hair combed, their faces and hands clean… on their way to school”. In both examples, the health-related learning is not specifically stated as an intended consequence of the curriculum. Yet it was there, and it did happen.

In 1900, a revised curriculum was developed and introduced across the country which included, among other new obligatory subjects, health-related subjects such as elementary science, cookery and laundry (Walsh, 2016a). These subject additions showed an increased interest in health-related subjects in the curriculum formation process.

A parting of the ways to focus on rejuvenating Irish identity

Irish independence saw the development of governance structures for education in Ireland, located in Ireland. It also saw a reduction in subject range from the above to just a small core set of curricular areas, to accommodate the newly formed State’s attempt to consolidate and promote a national identity (Walsh 2016a). From this time until the mid-1960’s, the political and nationalistic frame of reference trumped pedagogical or educational best practice, with Irish language, culture and identity being prioritised (Walsh, 2016a). Accordingly, health related education fell off the agenda for several decades.
2.3.2 The New Curricula of 1971 and 1999

A response to a changing world

Government concern about Ireland’s lack of competitiveness economically on the international stage led to the construction of a more child-centred New Curriculum of 1971 (Walsh 2016b). Although this saw the return of Science to the curriculum, it was not widely taught in Irish classrooms (Greaney and Mulryan, 1991).

A 21st Century curriculum that included specific reference to health and decision making

The 1999 Primary School Curriculum brought the first formal reference to Health Education, with the addition of a new subject, called Social Personal and Health Education. The intention of this subject was to help children develop a “foundation of skills, knowledge and attitudes that will inform their decision-making in the social, personal and health dimensions of their lives, both now and in the future” (Government of Ireland, 1999a – SPHE Curriculum, p 2). A range of government supported health promoting initiatives and programmes, including Walk Tall, Incredible Years and the Active Flag, have been developed or adopted to meet the needs created by the SPHE curriculum (National Educational Psychological Service, 2015). However, none of these overlap with the content or objectives of the IHC programme. It is under the umbrella of this 1999 curriculum that the Informed Health Choices programme presents itself, as demonstrated by the curricular map in the Findings chapter.

In conclusion, Health Education has been represented in Irish Primary Education in a mostly incidental fashion since the advent of the National Schools System in 1831. It was only in the 1999 curriculum that the skills for health literacy were first specifically aspired to, albeit as a small part of a minor subject receiving only half an hour of tuition per week in the suggested timetable (Government of Ireland, 1999a). However, it was noted in the
previous section of this chapter that there has been a growing understanding of the importance of health literacy since the 1990’s. In the Irish context, this points to a need for an evidence-based health literacy. In the absence of any programme covering this topic, a pre-existing, evidence-based programme like Informed Health Choices (IHC) programme becomes potentially useful.

2.4 The Informed Health Choices Programme

2.4.1 The Informed Health Choices Group

The Informed Health Choices group wishes to equip the public with the skills and knowledge necessary to make use of health information to make better health choices in their lives (Nsangi et al, 2020a).

Health information, good and bad, is widely available and despite the increased availability of scientifically credible information sources online, the general public tend to question these and favour the more digestible and eye-catching health related headlines from media outlets (Glenton et al, 2006). A study conducted by Glenton et al (2006) explored the public’s attitude towards different health information sources in relation to chronic back pain. The participants were presented with information from a scientifically credible source, a chronic back pain information website where the content was populated based on Cochrane review data. The findings of Glenton’s study highlighted that the participants viewed the information provided by other sources (e.g. media sources, friends, family) as more trustworthy than the information provided by a scientific source.

This undervaluing of evidence-based information by the general public was the focus of one of the founding members of Cochrane Collaboration, Chalmers (2009), who highlighted the lack of understanding of Randomised Controlled Trials (RCTs) in adult populations based on a public survey in Scotland. He anecdotally contrasted this with the example of a class of 11-year-old Norwegian school children who, with the help of a talented mentor, could develop their own RCT effectively. They had the ability, at that age to understand concepts such as reducing biases of the observers and how a
potentially unbiased allocation schedule could be subverted by foreknowledge of the method of allocation. Ultimately, Chalmers argued, it should be possible to do better in engaging the public on matters pertaining to RCTs and he issued an invitation for examples or suggestions to that end.

The recognition by Glenton et al (2006) of the need for information to be presented with the consumer (public) in mind, and Chalmer’s (2009) argument that children were capable of engaging with RCT processes when adults found them so difficult, both influenced the first development in the genesis of the IHC. In 2013, the IHC project was founded with a 5-year grant from Research Council of Norway (IHC Group, 2018). The IHC Project was developed iteratively between 2012 and 2017 by a collaboration of researchers from Uganda and Norway. As noted in chapter one, recognising the skills shortfall, particularly in low-income countries, the researchers employed a user-centred approach to design a set of low or no cost school resources with their initial focus on primary school children (Nsangi et al, 2017).

2.4.2 Rationale for the IHC Programme

As noted in Chapter one, people of all ages are flooded with health claims (Summer et al, 2016). Many of these are not reliable (Summer et al, 2016; Schwartz et al, 2012; Moynihan et al, 2000) and many people lack the skills to assess their reliability, which can be to their detriment (Irwig et al, 2008). Humanity enters the second decade of the new millennium and the world is awash with claims about treatments that work from an unprecedented range of information sources. In an environment supersaturated with information and opinions offered as equally weighted, it can be difficult to separate them. The UK Academy of Medical Sciences reported from a survey of over 2000 adults that 37% trusted evidence from medical research while 65% trusted the experience of their friends and family (Chalmers et al, 2018). There is a growing movement in research that health literacy will need to be improved for people to engage effectively with this information and make good
decisions (Fleary et al, 2017; Kickbusch, 2009; Lytton, 2013; Sharif and Blank, 2010). Nearly half of adolescents in a US study used the internet to access information about health and about one quarter of them modified their behaviour due to what they read (Ettel et al, 2012). Indeed, it is now considered important that children learn the skills and knowledge required, rather than waiting until adulthood (Oxman et al, 2019b). Primary school is the ideal time to begin to teach these skills, to lay a foundation for continued learning and enable children to make well-informed health choices, as they grow older (Sandoval et al, 2014).

2.4.3 Key Concepts for making good health choices

Making good decisions about health is predicated on having the skills and understanding to do so – this, as previous mentioned in Chapter one, is the premise underpinning the IHC and the Key Concept List. Austvoll-Dahlgren et al (2015) published the first set of Key Concepts required to understand treatment effects. The list, initially developed by the project team was informed by a review of literature and tools generated for public, media and health professional consumption, was then presented to members of an advisory group for feedback. The advisory group consisted of experts from the health literacy field and the list was modified according to that feedback. Austvoll-Dahlgren et al (2015) proposed that the list of 32 Concepts derived from the process should form the starting point for developing a set of educational resources.

2.4.4 Focus on primary schools

Knowing, understanding and applying the Key Concepts is a life-long practice, and any educational resources developed should serve as teaching aids to equip students to do so. This could be taught to any children or adults (Chalmers, 2009). Indeed, Oxman et al (2019b) argued that it was crucial to
teach these Key Concepts to children because they were capable of learning at least 24 of them and early intervention was important. Therefore, the first set of IHC resources were developed for primary school children, 10-12 years of age, as the earliest possible intervention point.

The IHC Group explored the possibility and desirability of developing a set of resources for primary school children, on the premise that health related knowledge and behaviours developed during childhood are increasingly recognised as resistant to change through to adulthood (Nsangi et al 2015). Rather than addressing all the Key Concepts a prioritization exercise, involving a network of 24 teachers, was conducted by Nsangi et al (2015). The teachers attended a 3 day meeting during which the Key Concepts were presented and discussed. Using a modified Delphi technique they prioritised 12 concepts they deemed necessary to focus on when teaching primary school children in Uganda to assess claims about treatment effects.

2.4.5 Developing resources with teachers in Uganda

Nsangi et al (2017) developed and prototyped some learning games to support the teachers in Uganda to facilitate the IHC to children. Developing these resources involved a user-centred approach, entailing multiple iterative cycles during which students and teachers used and evaluated the resources (Nsangi et al, 2020b). The learning games were found not to be usable or understandable and the teachers delivering them struggled with the Key Concepts being taught, so the researchers took the more traditional route of developing a book to introduce and explain the Key Concepts. The resultant resources were found by student and teachers to be useful, usable, understandable, credible, desirable and well suited to them (Nsangi et al, 2017).
2.4.6 Development of the CLAI M Evaluation tools

The creation of a set of Key Concepts needed to assess claims about treatment effects was a new innovation (Austvoll-Dahlgren et al 2015). Accordingly, there was no means of assessing the impact of any intervention designed to teach the Key Concepts. Austvoll-Dahlgren et al (2016a) developed an assessment tool, the ‘Claim Evaluation Tools’ database, and described the methods used to develop it. The iterative methods of development, as well as purposive sampling of participants to include health professionals and patients in both low- and high-income countries, have resulted in an assessment tool database that is applicable in a variety of contexts and for people of 10 years of age and up.

2.4.7 Trial process evaluation of the resources in Uganda

In the spirit of the lessons being taught, a cluster-randomised trial, involving 120 schools and over 10,000 students, was conducted in Uganda in 2016. The aim of the study was to assess the effectiveness of the IHC programme at teaching 12 Key Concepts to upper primary school children. The participating teachers were trained and they facilitated the IHC programme was run in their schools (60 schools, 76 teachers, 6383 students). The control group consisted of 60 schools with 74 teachers and 6256 children. The researchers engaged in non-participatory observation of the lessons and a qualitative process evaluation (Nsangi 2020b). After the IHC programme was completed in the school, the researchers applied a multiple-choice test, taken from the content of the Claim evaluations tool database, with 2 multiple choice questions on each concept. The findings showed that over 80% of children in intervention schools achieved a pre-determined passing grade, in comparison to just over 50% in control schools. Accordingly, the IHC programme successfully taught children to think critically about the trustworthiness of claims about the benefits and harms of treatments, and that children retain what they have learned for at least a year (Nsangi et al, 2020a). Some changes were made to the resources in response to observations and feedback, with version 2 then
tested in Uganda, Norway, Rwanda and Kenya. This led to the current iteration, version 3, that was used in this study.

2.4.8 What the IHC programme looks like

In its current iteration, the IHC programme is an evidence-based initiative which, through storytelling, active learning, groupwork and reinforcement exercises, teaches primary school aged children a set of core Concepts that equip them with the tools necessary to assess treatment claims and make more informed choices in their own daily life (IHC Group, 2016).

The IHC programme includes a Teacher’s Guide, Student Book and some supporting resources (such as a printable review poster) (IHC Group, 2018). The books and resources are available digitally but also to print. In its full implementation format, the IHC programme begins with a two-day teacher training course (IHC Group, 2018). This includes the distribution of resources to the participating teachers, an introduction to the IHC programme and a deep dive into its contents. The IHC programme is then implemented in class over nine, approximately 80 minute, lessons (IHC Group, 2018). Lesson 1 is an introduction to the intent and format. Lessons 2-8 form the main body of the IHC programme with a comic strip narrative, in-class discussions/activities, and written reinforcement exercises. Lesson 9 is a review lesson to further reinforce the learning. The IHC programme prioritised and covered 12 of the Key Concepts identified (Appendix 1).

2.4.9 The expanding influence of the IHC programme and Concepts

Given that the IHC teaches children the Key Concepts needed to assess health claims in order to have the skills to make informed health choices the IHC now finds itself at various stages of engagement in over 20 countries around the world (www.informedhealthchoices.org). The engagement ranges from testing in schools, through translation into other languages, to contextualising
to the host country’s education system (IHC Group, 2018, 2020). Further educational resources are being developed for secondary schools (IHC Group, 2020). The Key Concepts, initially developed to address treatment claims, are now being seen as relevant to other fields such as interventions in the areas of agricultural, economic, educational, environmental, international development, management, nutrition, policing, social welfare and veterinary (Oxman et al, 2019a). The IHC primary school resources have been made available under creative commons licence (Informed Health Choices Group, 2016). Morberg et al (2017) presented a plain language glossary of terms relevant to the understanding of treatments, associated research and claims.

2.5 Convergence of the above 3 – IHC in Ireland

At its core, any health education programme will need to draw attention to how we make health related decisions (Lytton 2013). According to Karasimopoulou et al (2012), health education will need to reinforce children’s social skills through specific programs preventing rather than healing problematic matters that could affect health related aspects of their quality of life. The IHC programme provides that preventative formula, by drawing attention to how we make health related decisions and equipping students with the potential to make more informed and better health choices.

2.5.1 Convergence of Intended Learning Outcomes

There is a natural convergence between the IHC, health literacy thinking and the Irish Primary School curriculum.

Following the successful launch of Schools Teaching Awareness of Randomised Trials (START) competition in 2016, researchers in National University of Ireland were actively seeking to develop a more formalised resource for leading children to an understanding of the need for trials. The
competition was the product of an interprofessional collaboration between professionals from Health Research and Primary School Education. It provided a structure and support for schools to run their own trial on a research question important to them and then present the findings. Many of the principles of good RCT practice are applied during the process. Biesty et al (2020), in their exploration of student and teacher experience of the competition, found that participants saw the value of participation and demonstrated an understanding of the trial process. NUIG researchers became aware of the IHC and paid a visit to the IHC Group, Norway, in 2017. Here, they found a completed evidence-based resource that taught the Key Concepts and demonstrated the need for RCTs through a narrative text. It was also pitched at the same age group as the START competition.

The question that required further research was whether this resource could fit easily into the Irish Primary School Curriculum or not. Accordingly, this study was initiated with its stated aim and objectives.

2.5.2 Room in a crowded curriculum?

The IHC programme takes in excess of 9 hours of tuition time to complete (Nsangi et al 2020). In the 1999 Irish curriculum, the subject most likely to be closely aligned with IHC (SPHE) is afforded 30 minutes per week. In this form, the completion of the IHC programme would take up 18 weeks (half a school year). As SPHE covers a lot more than what overlaps with the IHC programme (Government of Ireland, 1999a), available weekly time is a probable obstacle to implementation in Irish schools. However, this is an issue under review in the Irish system, with proposals for increased flexibility in the timetabling of subjects and the possibility of a new curricular framework (NCCA, 2016, 2020). Oxman et al (2019a) expressed the ideal delivery mode for the Key Concepts in IHC as a spiral curriculum format. This is the format used by the Irish curriculum (Government of Ireland, 1999a).
2.5.3 Rationale for this study

Sharples et al (2017) in a British Medical Journal publication highlighted the importance of critical thinking in the area of healthcare and noted the opportunities to link with the education sector. They state that critical thinking skills are under-represented as an explicitly taught skill in medical education, and is generally under-valued in primary and secondary school practice despite their inclusion in many national curricula. Sharples et al (2017) hold up the IHC as an example of a programme that could address this shortfall.

A health literacy programme such as IHC may find it difficult to find a home as part of a subject in some jurisdictions and may find its importance diminished if not seen to be part of a core or examinable area (Mugisha, 2016). However, the proliferation of programmes such as IHC in primary schools is a World Health Organization ambition in relation to the promotion of health literacy (Mc Daid, 2016) and there is potential for inclusion in the Irish curriculum based on current curriculum guidelines (Government of Ireland, 1999a) and in future developments here (National Council for Curriculum and Assessment, 2020).

Although developed, initially, for and extensively tested in Uganda with a very clearly laid out set of lesson plans, it was not known how useful or transferable these resources might be for the Irish Education System. With a different national curriculum and priorities in Ireland, it was recognised that there may be a need to adjust some of the content and delivery to more closely align the IHC programme to Ireland.
Chapter 3 - Methodology & Methods

3.1 Introduction

This chapter describes the methodology and methods of this research study. The study aim was to explore the need for and, if necessary, to develop a contextualised version of the IHC programme, with the input of the relevant stakeholders, suitable for use in Irish primary schools. Therefore, an action research design, using a participatory approach (to include key stakeholders from the Irish primary school sector) was chosen. This chapter will identify how action research and specifically participant action research (PAR) was useful to meet the aims of the study. The chapter will also present the methods used, taking account of the value they brought to answering the research question and how they were operationalised in the field.

3.2 Arriving at a Design – Participatory Action Research

3.2.1 Action research

The sometimes-disputed origins of action research can be traced back to Kurt Lewin, a Jewish refugee from Nazi Germany, who is credited as the first person to coin the phrase Action Research (Mc Donald 2012). Intent on showing that worker motivation would improve if they were involved in decision making on how the workplace was being run (Wheeler 2008), his cyclical process of observe-reflect-act-evaluate-modify continue to influence researchers to this day. Action research is a practical form of inquiry that supports researchers from any professional background to investigate and evaluate their work in a disciplined, systematic way (Mc Niff, 2017). It is held as being a methodology that is particularly advanced in the fields of education, nursing, business and management (McNiff 2017). An action research study evolves from posing an insider question relating to an observation / concern relating to professional practice, taking an action to
address it, and generating knowledge or theory about that action as the action unfolds (Coghlan, 2019). While no unique definition of action research exists and different approaches to action research appear in the methodological literature, they are all consistent in their aim to generate new knowledge (McNiff 2017). The definition of action research guiding this study has been drawn from the work of Coghlan and Shani (2014):

“Action research may be defined as an emergent inquiry process in which applied behavioural science knowledge is integrated with existing organisational knowledge and applied to address real organisational issues. It is simultaneously concerned with bringing about change in organisation, in developing self-help competencies in organisational members and in adding to scientific knowledge. Finally, it is an evolving process that is undertaken in a spirit of collaboration and co-inquiry”.

In short, this study is based on the premise that the research is a collaborative relationship between the researcher and members of an organization or community, which aims both to address an issue of concern and to generate actionable knowledge (Coghlan, 2019).

3.2.2 Participatory action research

This study engaged with stakeholders (teachers, students and other professionals involved in primary level education in Ireland) to generate knowledge relating to their work environment with a view to applying action (creating and implementing a contextualised version of the IHC programme). In action research, practice must be thought about at several levels, and "practitioners" are not merely workers (those offering professional knowledge and skills such as teachers or surgeons); rather all people engaged in the practice are practitioners of something (Mc Niff, 2017). This extends the value of including in this study, not just the recognised educational ‘experts’, but also the students. Their lack of professional educational training does not devalue their input but rather, drawing from their personal experiences, enriches the study.
This study followed a Participatory Action Research (PAR) design, underpinned by the qualitative paradigm. PAR is an immersive, democratic and inclusive form of research in which the participants take an active part in the process (Whitehead and McNiff, 2006). It involves egalitarian participation by a community to transform some aspects of its situation or structures (Coghlan, 2019). Mc Taggart (1999) provides a useful definition of PAR by separating the three words that make up the phrase:

1. Participation: Authentic commitment to the studied enhancement of a social practice by its practitioners, that is, participation in the action and the research
2. Action: Wisely planned, deliberately implemented, and carefully studied research and participation in changes of practice
3. Research: Carefully observed and theoretically informed participation and action

(Mc Taggart 1999: pg. 496)

Paulo Freire (1970) saw PAR as a means of providing for social change, particularly for the poor and oppressed. Freire saw education as a dialogue from beginning to end (Beckett 2013), where the process of learning itself, in effect, amounted to a form of PAR. Whereas the person credited with coining the phrase ‘Action Research’, Kurt Lewin (introduced in section 3.2.1), was concerned with an outcome at an individual or localised level, Freire saw the interaction between system and end-user as a two-way street (MacDonald 2012). Referring to it as Critical Consciousness Development, Freire argued for facilitating the individual to engage with and become knowledgeable about their socio-political environment. This would then empower them to take action and change the oppressive elements of their context. These two foundations of PAR (shared ownership of the process and participant led change) have informed modern principles of PAR design and are what refine it beyond the description of action research alone. In many ways, through engagement with the participants, the researcher effectively makes them coresearchers (Braun and Clarke, 2013). Walker (1993) suggests that the collaborative nature of PAR, involving a community with a personal interest
in the actions associated with the objectives of the study as co-researchers aids in producing practical outcomes that are workable. The participants of this study, the education stakeholders and the end-users of the IHC, helped to identify issues and workable solutions. This added significant value to the implications suggested as a result of this work. The stakeholders invited were already experienced in their fields within the primary school education landscape. Coming from policy making, decision making, practitioner, customer (children), professional support provision and inspection backgrounds, these stakeholders, as co-researchers, provided input that was valuable and relevant to the study.

3.2.3 Aligning this study to the characteristics of PAR

The focus of this study was to take a well-defined educational programme (a pre-existing structure) and explore the contextualisation of its content and implementation to the Irish context. Based on the definition of PAR discussed in previous sections of this chapter the best sources of data to contribute to this study were provided by the practitioners (teachers) and end-users (teachers and students). Any change to practice, therefore, came from with those inside the educational system. For richness of data, the study needed to go beyond the mere recording of their experiences and actually share the journey with them. These are the very features that PAR supports. Streubert & Carpenter (2010, pp 306-308) suggest specific headings that help researchers to demonstrate how their work aligns with characteristics of PAR, these are evident in this study in the following ways:

The research is context bound:
The PAR cycles of this study all centred around primary school engagement with the IHC programme.

Full engagement by researchers and participants is sought:
This PAR study gave participants and key stakeholders from the Irish Primary School System ownership of the change and led to a more contextualised programme. In the case of this study, accessing the
breadth of stakeholders and end-users helps to build a system wide understanding of the IHC programme dynamics in the Irish context.

All involved are aware of the process and how it affects the lives of others: The participants were made aware that their input and involvement could ultimately impact on the experience of other schools. This provided the researchers with an extra layer of metacognitive data from the participants as they experienced the IHC programme on a personal and empathetic level. It helped to provide insight for how future participants might benefit from improvements to the content and delivery. Metacognition concerns how we monitor and control our cognitive processes, “thinking about thinking”, and this can also be applied to others (Frith, 2012).

Action and change are the focal points of the process:
Engagement in the process and the IHC programme was predicated on the shared understanding that there may be a need to change the content and/or delivery. This means the participants understood from the outset that a possible, if not likely outcome would be the need for change. This problem-solving focus means that PAR is research with practical outcomes and positive change (Walker, 1993).

The decision to implement action/change is in the hands of the stakeholders: Participants’ and researchers’ shared ownership of the process will lead to greater engagement and a more appropriately contextualised IHC programme.

3.2.4 PAR underpinned by the qualitative paradigm

In the PAR genre, knowledge is not produced with a view to a lag in time before incorporating it into practice as it is in other research; knowledge production is embodied in the enactment of emerging understanding (Mc Taggart, 1999). Embedded in the cycle of PAR is a process of evolution of knowledge and understanding through practical engagement and reflection. Given this ongoing engagement, the participatory nature of this research and
the important contribution of all stakeholders’ views, beliefs and experiences of the IHC, this study and the methods it used sit within the qualitative paradigm. Aspers and Corte (2019) define qualitative research as an iterative process in which improved understanding by the scientific community is achieved by making new significant distinctions resulting from getting closer to the phenomenon studied. Qualitative research in its broadest sense uses a naturalistic approach to seek to understand phenomena in context specific settings (Hoepfl 1997). Braun and Clarke (2013) enrich the definition even further by characterising qualitative research as capturing some aspect of the social or cultural world, as viewed by those experiencing it, recording the messiness of real life but then putting an organising framework around it and interpreting it in some way. Given the rich and complicated environment that is a primary school, applying a qualitative approach and methods within a PAR framework allowed for the exploration of the meaning and understanding shared and demonstrated by the stakeholders to initiate inquiry and highlight actions required.

Multiple methods contribute to the generation of qualitative data (e.g. interviews, focus groups, observations) (Hennink et al 2020) further documentation of how qualitative methods were applied to this study will be offered in sections 3.4 – 3.9 of this chapter.

3.3 The PAR Cycle for this Study

In action research, Mc Niff (2017) suggests a notional action plan is outlined. This involves a cyclical roadmap where the destination is not known but the process is. Coghlan (2019), suggests a basic action research cycle involving a pre-step and 4 basic steps (Figure 3.3a):
An action research cycle

In this approach to action research the pre-step, establishing context and purpose of the study, frames all later interactions (Coghlan 2019). As a focus, there should also be a desired outcome. In this study, the desired outcome is stated in the title of the work (i.e. a contextualised IHC programme, the rationale for which is stated in Chapter 2). The Constructing phase relates to the initial stakeholder interaction where the issues are identified, and this guides the development of the study. This returns to the idea of participants as experts and their opinions, beliefs and experiences inform this phase of data collection. The three action steps of Planning, Implementing and Evaluating focus on the ideas arising out of the constructing phase. This cyclical process was followed in the study.

After completion of the first cycle, the recommendations arising were considered and applied where feasible. This resultant, more contextualised, IHC programme would then be run in a second PAR cycle.

Ultimately, these building blocks for a workable PAR cycle can be seen in the final make-up of this study’s finalised process (Figure 3.3b):
3.3.1 Objectives and the PAR cycle

The objectives of this study (listed below) lent themselves to this iterative form of research with a two cycle PAR design. The objectives were:

1. To complete a curricular mapping of the IHC programme onto the Irish Curriculum. Effectively mapping the programme will help to define its potential role within the Irish Primary Curriculum
2. To identify and respond to key stakeholders’ views of the IHC program and their experiences of facilitating / participating in the IHC in a primary school setting in Ireland
   - This will include reference to the content, the processes and the resources of the IHC
3. To explore the participating stakeholders’ and end-users’ experience of the contextualised programme

4. To produce an adjusted version of the IHC programme that is ready for trialling in Irish Schools

Methods

As noted in Section 3.2.4, this study uses research methods of the qualitative approach. Although the methods happened in the cyclical manner noted in Figure 3.3b, it is easier to write about them using a more linear approach.

3.4 Sampling

Sampling involves the selection of an appropriate range of research participants with a view to generating enough data for analysis to achieve the objectives of the study (Braun and Clarke, 2013). In an ideal scenario, enough data would be generated to come close to what Hennink et al (2020) call ‘saturation’. This is where enough data has been generated to create robust and valid understanding of the subject being studied. The sampling was inclusive of examples from a cross-section of primary school education. The stakeholders (influencers, decision makers and practitioners) and end-users (practitioners and students) were all approached, in the spirit of PAR, with a view to generating data specific to the context of the study.

3.4.1 Purposive sampling

In quantitative research, effective sample sizes tend to be big and random (Choy 2014), with the aim of allowing the researchers to draw accurate generalisations about the general population from the results. Qualitative studies, such as this one, tend to have smaller sample sizes (Braun and Clarke
2013) with a richness of data derived from an in-depth engagement with each of the participants. This approach values the contribution these people can make individually.

In qualitative studies the participant sampling technique is generally purposively identified to maximise the range of data returned for analysis (Braun and Clarke, 2013; Streubert and Carpenter, 2010). Purposive sampling is a common qualitative research method that involves the intentional selection of participants based on their first-hand experience with a culture, social process or phenomenon of interest (Streubert and Carpenter, 2010). For this study, stakeholders were identified on the basis of their potentially rich contribution they might make. The strength of these information-rich sources is, according to Patton (2002), that they yield in depth insights into the central inquiry rather than just empirical generalisations. Accordingly, thinking about sampling means thinking about who we want to hear from and achieving a diversity of perspectives from within that group (Braun and Clarke, 2013).

3.4.2 Recruitment process

Drawing from over 20 years’ experience in primary education, a list of key stakeholders with experiences of different influential sectors within primary education was developed. Information in relation to this study was sent to the stakeholders using publicly available addresses or contact details. A Participant Information Pack was sent to these potential participants. This information pack included a letter of introduction, information leaflet and a consent form (Appendix 2). Information given included the purpose of the study, contact details for the researcher, the extent and nature of their involvement and information relating to confidentiality and withdrawal. Potential participants were invited to contact the researcher for any further clarification needed and to indicate their interest. Fifteen stakeholders were contacted in this way and ten contacted the researcher to express their interest in participating. Once consent was secured, and prior to any official face to
face meeting, the participants were furnished with the Teacher’s Guide and Student Book from the IHC programme.

A pragmatic strategy underpinned the recruitment of schools to this study. Information about the IHC was sent to and discussed with three principals in a specific geographical area. This area was chosen to make possible data collection (e.g. observation of classroom sessions during a school day (this was necessary to accommodate the needs of the study and also because of the full-time work commitments of the researchers). When principals and teachers were interested in hearing more about the study the same process, noted above, was followed. Three information packs were sent to three schools and three teachers agreed to participate.

The recruitment of children within the classroom was guided by the process employed at each particular school. The participating teachers were asked to distribute letters of introduction, participant information leaflets and consent forms to parents. The completed forms were collected by the teacher for collection by the researcher. The students and their parents/guardians each received letters of introduction, information leaflets and consent forms worded appropriately to their age. Again, the consent forms (indicating parental / guardian consent and the children’s ascent) were collected by the participating teachers for collection by the researcher. This process was conducted in line with the “Guidance for developing ethical research projects involving children” (Department of Children and Youth Affairs, 2012).

3.4.3 The participants in this study

In this case, Primary Education decision makers, primary education policy influencers, practitioners and end-users were included in this study.

There were 50 students from three schools, three principals, five teachers, one retired school inspector, one former member of the PDST (Professional Development Service for Teachers), the head of an Education Centre and a teacher training college professor (see Table 3.4.3, below).
The teachers and principals, all currently serving in schools, would be able to provide practical school-based feedback on introduction and implementation issues associated with this programme. Their insights would be based on the real-life experiences in the modern Irish classrooms, lending legitimacy and credibility to the findings and recommendations. The school inspector would provide insight into issues of compliance with Department of Education norms. The PDST member and Head of an Education centre would provide insight into current best practices for implementation and teacher training. One function of the teacher training college professor would be to flag current teacher training and curricular trends.

End-users, those directly using the IHC programme in class, included 3 of the individually interviewed stakeholders and the students of their class. Different school contexts, all in or within 20 minutes’ drive from Ennis, were identified for a balance of perspectives with examples of each approached and invited to participate:

Participant Profile

<table>
<thead>
<tr>
<th>Teachers</th>
<th>12*</th>
<th>3 implementing IHC in class (1 a teaching Principal)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1 recently qualified teacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 former inspector</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3 Principals</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2 heads of education centres</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 former PDST facilitator</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Lecturer in Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* 11 of these teachers took part in Cycle 1 interviews.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* 2 of those teachers in Cycle 1 interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>implemented the unmodified programme in class</td>
</tr>
<tr>
<td></td>
<td></td>
<td>engaged in post-programme interviews</td>
</tr>
<tr>
<td></td>
<td></td>
<td>* 1 teacher engaged in cycle 2 only and implemented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>the modified programme.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Students</th>
<th>50</th>
<th>40 students aged 10-12;</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>10 students aged 8-12</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Schools</th>
<th>3</th>
<th>1x medium sized suburban/rural school (class of 20</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>students)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1x small rural school (class of 10 students)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1x large disadvantaged urban school (class of 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>students)</td>
</tr>
</tbody>
</table>

Table 3.4.3
One teacher and one school (the large disadvantaged urban school with 20 of the students aged 10-12) took part in PAR Cycle 2. All the others were engaged during the first PAR cycle.

3.5 Ethical Considerations

Prior to study commencement or any data collection, ethical approval was obtained from the Research Ethics Committee at NUI Galway. The application was guided by the ‘Children First: National Guidance for the protection and Welfare of Children’ (Department of Children & Youth Affairs, DCYA, 2017) and the National University of Ireland, Galway’s ‘Child Protection Policy’ (NUI, Galway 2011). These guidelines identified the best practice in relation to promoting child protection and provided a pathway of reporting if any concerns in relation to the welfare of a child arose.

3.5.1 Consent

Participation was only on the basis of consent and this was vital for ethical and methodological reasons. Consent is an inarguable pre-requisite for engagement, especially with identifiable participants (Streubert and Carpenter, 2010) and due process was followed throughout this study to guarantee its observance.

The potential participants were provided with an information pack and asked to contact the researcher if they would like further information about the study for at least one week after they receive the Participant Information Pack (Appendix 2). These were collected by the researcher from the stakeholders, and by the participating teacher from the students (and were handed over to the researcher later).

There was direct contact between the researcher and adult participants and consent was obtained directly. Children (age 8 – 12yrs) formed one of the
participant groups of this study. Therefore, in line with the “Guidance for
developing ethical research projects involving children” (DCYA, 2012),
parental / guardian consent was required for the children to participate in this
study. The school was asked to distribute and collect a modified Participant
Information Pack specifically for the parents (Appendix 2).

The “Guidance for developing ethical research projects involving children”
(DCYA, 2012) notes that good practice also requires the children’s agreement
or assent. Therefore, a child orientated Participant Information Pack was also
developed (Appendix 2). Within that was included a Consent form asking
children to tick that they have read / have had the Participant Information
Leaflet and Consent form read to them. A signature requirement for the reader
was also included. The consent was verbally re-visited with participants prior
to each episode of data collection.

3.5.2 Confidentiality

There is an ethical duty to protect participants from potential public scrutiny
(Kellett, 2005). The participants were all assured of confidentiality and that
they would not be identifiable in the written text of the thesis. Pseudonyms
were given for each adult participant and will be used on transcripts of
interviews, consent forms. For the students it was the focus groups, not the
individual children involved, that were given individual codes. A file with
participant’s true names and contact details was stored separately, with each
participant given a code number, in a locked cabinet. A key connecting the
pseudonym data with the only the code numbers of the true identity data is
kept only in a password protected file on the researcher’s laptop. This will
allow necessary transcribed interviews to be sent to participants for
verification, or for potential follow-up interviews if they are seen to be
necessary as the theory emerges.

When the study is completed and the final report has been disseminated to the
participants, the file containing contact details and true names of participants
will be destroyed, and only the anonymised audio recordings and transcripts with the pseudonyms will be retained.

Transcripts will be stored on the OneDrive system supported by NUI Galway, accessible only to the researcher and supervisor, for a minimum of 5 years after the end of the study. After 5 years, the transcripts will be destroyed. This is in accordance with the NUI Galway Data Retention Policy. Records will be retained for five years, in line with the University Data Retention Policy.

Given the small geographical area in which this study occurred and the unique role of some of the participants all information which could in any way identify schools or individuals will be removed from any dissemination in relation to this study.

3.5.3 Right of refusal/withdrawal

The right of refusal was fully respected during the course of this study. It is best to approach the notion of consent as a continuous process and not just an action that took place at the beginning of participation (Hill, 2005). All participants were involved only with their consent and were fully informed of their right to refuse or to withdraw at any time. Children were not expected to participate without their consent (or their parents’). They were informed in the written materials and again at the beginning of interviews/focus groups that they were free to withdraw from the process at any time. By this means, verbal consent was re-established at every point of data collection.

3.5.4 Child protection – ethical issues considered in relation to this study

There were no anticipated risks associated with participating in this study per se, however, the researchers are very aware that there are specific ethical concerns that arise when conducting research with children. National University of Ireland Galway’s ‘Child Protection Policy’ (NUI, Galway 2011), the “Guidance for developing ethical research projects involving
children” (DCYA 2012) and ‘Children First: National Guidance for the protection and Welfare of Children’ (DCYA 2017) were used to identify the best practice in relation to promoting child protection. Children were not interviewed individually but in focus group interviews facilitated by 2 Garda-vetted researchers.

3.6 Operationalising this PAR Study – An Overview of the Cycles

Coghlan’s (2019) framework guided the cycles of this study (figure 3.3b).

3.6.1 Cycle 1:

a. Reflection

Cycle 1 opened with a reflective piece of work to allow the researcher to become familiar with the IHC programme in a classroom context. Action research is, in its nature, a value laden process and immersion in the materials as a practitioner is not in contradiction with this ontological fact. As Mc Niff (2017, pg. 42) put it, “The research field cannot be studied in a value-free way, because the researcher is part of the situation they are studying and brings their own values with them”. Accordingly, the researcher facilitated the IHC programme it in his own school setting to a 5th year class. The normal class teacher, who kindly agreed to allow the researcher proceed, remained in the classroom throughout the programme implementation. This allowed the researcher to absorb feedback from a common experience and so be better able to engage with stakeholders. The observations, experiences and reflection (See Appendix 3 for excerpts) helped inform the development of an interview guide, adapted from one of the IHC’s guide for IHC School Pilot user-test interview guides

Curricular mapping
Initiated at the beginning of Cycle 1 and completed during the planning phase of Cycle 1, the curricular mapping process has, in its implementation, followed this PAR cycle design also. It was initially informed by a comparison of the IHC learning objectives with those of various subjects in the Irish Curriculum currently in use (reflective piece). It was then further modified in response to Stakeholder and end-user feedback during each cycle. The first full draft of the map was completed during Cycle 1 and refined to completion during Cycle 2. The completed table can be found in Chapter 4 (Table 4.3.2a).

b. Constructing

This stage aligns with the recruitment process already outlined in Section 3.4.2. The consenting stakeholders were asked to review the Teacher Guidelines and Student Books, they received the resources at least one week in advance of their interview. They were then invited to participate in the interview to provide feedback on the IHC printed school resources, content and processes for delivery. Most of these interviews were conducted over a 3-month period before any class implementation, some were conducted during the action phase noted in the next paragraph. Some of the initial feedback helped direct some modifications to the IHC teacher preparation programme (see section 4.3.3). The teachers due to implement the IHC programme in class were also interviewed during this process.

c. Action Steps

i. Teacher training (planning action)

The teachers facilitating the IHC programme in their classroom had a half-day teacher training programme. This training was based on the IHC template developed for schools in Uganda. Some early adaptations had been made following feedback from the first 8 stakeholder interviews, where the need for a reduced duration for teacher preparation was highlighted. The main
adaptation was a reduced focus on walking through the narrative of each lesson. In the original teacher preparation programme, teachers experienced and discussed each full lesson and this took up most of the time. Summarising the narrative content reduced the time needed to complete the teacher preparation (see section 4.3.3 and Appendix 4).

ii. Programme implementation (taking action)

Teachers then delivered the 9 lessons of the IHC programme in their own classrooms. Generally, the teachers completed one to two lessons per week.

Teachers were also invited to complete reflection sheets after lessons (Appendix 5). These IHC templates asked questions in relation to timing, pacing and effectiveness of the lessons and teachers had the opportunity to complete tick box questions and also to record their thoughts on progress and quality of learning.

By prior arrangement with the teacher, the researcher visited each participating classroom 3 times to conduct lesson observations. A lesson at the beginning, middle and end was seen by the researcher in each school and no lesson was seen twice (i.e. the researcher saw 6 of the 9 distinct lessons during this cycle).

iii. Post-implementation (evaluating action)

Feedback from end-users comprised of Focus Group Discussion with students that took place shortly after the final lesson (on the same day in one of the schools). Other data on the end-user experience of the IHC programme (lesson observations, lesson reflection forms and post-programme feedback from teachers and student focus groups) were compiled. A second, post-programme, interview was conducted with each teacher. This took place a
couple of weeks after completion of the IHC programme in the respective schools.

d. Transition to Cycle 2

The data from stakeholder interviews, lesson observations, teacher reflection sheets and end-user interviews were analysed. Based on collected data and feedback given, adaptations to the content and delivery were made to the IHC programme to align it more closely to the Irish Primary School context.

3.6.2 Cycle 2:

This contextualised IHC programme was then used in Cycle 2, following the same operational template as Cycle 1. The programme was run, using the modified teacher training format, the adjusted book format and the additional co-produced supplementary materials. One additional main purpose of this cycle was to field test the changes made in response to the first cycle.

3.7 Data Collection Methods

The data collection methods have been mentioned in section 3.6 and the previous section notes their order in the PAR cycles. This section will discuss the process in more detail and highlight the rationale for choosing these particular methods of qualitative inquiry.

The goal of this study was to produce rich and relevant data for analysis. In order to achieve the aim and objectives of this study data were drawn from 4 main sources:

1. Interviews with 12 stakeholders.
2. Focus Groups with 2 groups of students who completed the IHC programme.
3. Reflections complied by participating teachers in relation to completed lessons.
4. Non-participant observation of the lessons by the researcher.

3.7.1 Interviews

The importance of the interview

A research interview is a conversation between two partners about a theme of mutual interest and is a specific form of human interaction in which knowledge evolves through a dialogue (Kvale, 1996). At face value, it is probably the most familiar and comfortable form of data collection for both interviewer and participants (Braun and Clarke, 2013). Action research assumes that we need to negotiate our values and forms of living with others (Mc Niff, 2017). Ultimately, the importance and intended outcome of the interview is the understanding of the meaning of experience for those who are a part of it (Streubert and Carpenter 2010). Koshy (2010) states that interviews gather responses that are richer and more informative than questionnaire data and that, in some cases, adults and children will give a more honest response in one-to-one situations. According to Streubert and Carpenter (2010) it is the gold standard of qualitative data collection.

Semi-structured interview

A semi-structured interview is where the researcher has a small core of questions to help guide the conversation, but the rest of the process is unscripted (Kellett, 2005). More open ended, face to face interviews offer people the opportunity to fully describe their experience (Streubert and Carpenter, 2010). The researcher works off a pre-prepared interview guide but is not required to rigidly stick to the wording or running order of the questions (Braun and Clarke, 2013). Influential in the choice of semi-structured interviewing is that the interviewer has more freedom to probe with follow up questions and when unexpected or interesting information comes
out, the interviewer can seek clarification and elaboration on the answers given (Henning et al., 2009). The interviewer, in the context of this study, needed to be able to probe and mine for richer veins of understanding when they appeared.

The interview guide

The interview guide was adapted from the Informed Health Choices (IHC) interview guide that was developed as part of the process evaluation of the IHC intervention (Nsangi, 2019). The adaptation was necessary to ensure that all question prompts related to the specific aims of this study. This was done in an iterative process with several drafts discussed by the researcher and supervisor. The guide was further refined with the input of researchers from NUIG and UL. Both versions can be found in Appendix 6.

Stakeholder interviews

There were 14 interviews conducted with 12 stakeholders during this study. All took place at a time and a place of the interviewee’s choosing. Most took place in during school hours with some taking place in the evening. Interviews ranged from 35 minutes to 90 minutes but were generally just under the hour in length. These were recorded and conducted in a supportive environment where the participant felt at ease about giving their opinions.

The initial semi-structured interviews with teachers/stakeholders (referenced as T002-T011 in Chapter 4) were conducted without them having experienced the IHC programme in class. To ensure that these stakeholders could provide rich data it was important that they had time to prepare. As noted in previous sections they were given the printed resources of the IHC (i.e. a copy of the Teacher’s Guide and Student Book) a minimum of one week before the interview.
The teachers who implemented the IHC programme in their classroom were included in post-programme interviews. T004 and T010 both ran the original IHC programme in class and were then interviewed again to get their insights into the programme in practice. The interview guide for this was also semi-structured but with all the points of interest, generated from the first set of interviews, re-visited after experiencing IHC first-hand (See Appendix 6). It afforded them opportunities to verbalise any changes or evolutions of opinion. This allowed the researcher to chart that evolution of opinion and ideas in relation to IHC.

T012 experienced the fully adjusted teacher preparation programme and ran the fully adjusted IHC programme. The post-programme interview guide was the same one as for T004 and T010.

3.7.2 Focus Group

The usefulness of focus groups

A focus group is a discussion involving a small number of participants, led by a moderator, which seeks to gain an insight into the participants’ experiences, attitudes and/or perceptions (Hennessy and Heary, 2005). Braun and Clarke (2013) describe them as a data collection method from multiple participants at the same time with a moderator (instead of an interviewer) who guides a discussion about a topic of interest. Focus groups can be very effective and take advantage of group dynamics to provide cumulative data generation and assistive recall (Streubert and Carpenter, 2010). This approach can often access information that might not be as forthcoming in a one to one interview (Kellett, 2005). The use of focus group interviews was chosen as the most appropriate means of hearing the students’ voice in this study. This observed child protection best practices while respecting the egalitarian spirit of PAR. Braun and Clarke (2013) identified the advantages of the Focus Group approach, many of which were relevant to this research:

- Flexibility in exploring unanticipated issues: With children being the most removed and distinct group represented in the data, focus group
interviews provided the ideal platform to explore their different perspectives.

- Access to everyday ways of talking about topics: With some generational translation, the opinions of the students could be compared and contrasted to those of the stakeholders.
- Access to interacting and meaning-making processes: Focus group interaction reflected the collective experience of the IHC programme by the children and was the most likely to elicit accurate feedback.
- Good for groups for whom research participation might be daunting: This approach allowed the children to engage with the research at their own level. Having their peers present allowed them to engage with each other rather than having to ‘answer the researchers questions’.

Working with children

There has been a tendency to perceive research with children as one of two extremes: that it is either just the same or entirely different from adults (Punch, 2002). One of the chief difficulties for a researcher is that the child cannot be imagined in the absence of an idea about what an adult is, and this can lead to a focus on the notion of difference (Christensen and Prout, 2005). One difference that did need attention was power dynamic, which Hill (2005) argues can be counteracted when research starts from the perspective of the children and involve them actively in the whole research process. Children are marginalized in adult-centred society and experience unequal power relations with adults and much in their lives is controlled and limited by adults (Punch, 2002). Due to the setting, the afore-mentioned power dynamic issue is further coloured by the fact that children have expectations regarding what is required of them when interacting with an adult in school contexts and their responses in interview contexts may well reflect these expectations (Westcott and Littleton 2005). This would be counterproductive to the purpose of the study, as honest and frank opinions were sought. The focus group setting reduces pressure on individuals to answer every question, provides a safe peer environment in a format they will be familiar with from groupwork in-class,
and all of this setting may also help to redress the power imbalance between adult and child that exists in one-to-one interviews (Hennessy and Heary, 2005). The moderator’s role is threefold: To put the children at ease, keep the topic of interest in focus and to tease out meaning through appropriate levels of probing (Hennessy and Heary 2005). As a tool for engaging in qualitative research with children, the focus group interview goes a long way to address the power imbalance that might occur between a child and the adult researcher, providing a safe environment of peers (Adler et al, 2019). Accordingly, during focus group sessions the researcher used his experience as a Principal and a teacher to put the participants at ease and quickly dispel any notion of an unequal power dynamic. This was done by welcoming them as equal participants in this research study, not talking down to them or using an ‘adult to child’ speaking voice, empathising and respecting them in how he responded to their thoughts, viewing them as people on their journey to adulthood where he was joining them for an hour of that journey. Once this dynamic was established, the moderating elements of keeping focus on the topic and progressing smoothly through the interview guide became straightforward as the children were more than willing to offer their opinions.

The interview guide for focus groups

The focus group interview guide was, in a similar fashion to the stakeholder interview guide, adapted from an IHC template. Both can be found in Appendix 6.

How the focus groups were conducted

Two Focus group interviews were conducted during this study, with 5 children in each. The focus groups were moderated by the researcher and the research supervisor was also in attendance. They were conducted in the children’s school (the library in one school and a learning support room in the other) for an hour directly after their final IHC lesson. The researcher was not
a stranger to the children, having observed three of their lessons during the IHC programme. An experienced teacher, the researcher quickly established a rapport with the children, set up the conversation as an egalitarian activity, and managed any signs of dysfunctional dynamics such as the groupthink that sometimes derives out of one voice taking over the conversation (Streubert and Carpenter, 2010). The focus group moderation was conducted by the academic supervisor associated with this study.

3.7.3 Teacher reflection - lesson feedback sheets

Reflective practice

Reflective practice is when we think about our work in a structured or ordered fashion (Malthouse & Roffey-Barrentson, 2013). In teaching and learning, Benade (2015) outlines the process as one of reflection in action (thinking about and reacting to a lesson as it happens), reflection on action (thinking about a lesson after it happens) and reflection for action (thinking about how to apply the learning for the next time). Reflective practice has become quite common in professions such as education and nursing and can be an extremely complex process when properly observed (Thompson & Pascal, 2012). It provides a counterbalance to the quantitative data driven dependency that has become pervasive in education and is a natural option for qualitative research in teaching (Galea, 2012). Teacher reflection is only useful when accompanied by action in response to it (Mc Niff, 2017).

How reflection by participating teachers was used in this study

In this study, that structure was provided in the form of Lesson Reflection Sheets (Appendix 5). Teachers were asked to complete them after each lesson. This process resulted in recorded feedback on lessons by the teacher and contributed fresh data with an immediacy that post-programme interviews may not capture. The feedback sheets paid particular attention to practical matters such as time keeping and lesson flow. It also allowed the teacher to
provide an immediate feedback of what they felt during and after the lesson. The sheets were clear and easy to fill out quickly. The action in response to reflection (McNiff, 2017) came in the form of making use of the data to confirm issues arising during interviews and to inform the lines of questioning to be used in subsequent interviews.

3.7.4 Non-participant observation of IHC lessons

Usefulness

Classroom observation is considered an important tool for providing data on teacher practices and student practices (Lei et al, 2018). It allows the researcher to see the participants in their natural work environment. A key principle that gives special significance to naturalistic observations is that such observations provide invaluable evidence on children’s real-life experiences and their reaction to those experiences (Dunn, 2005). Classroom observation is a very good way of describing broad patterns of interaction such as whether a teacher is interacting with a single individual, a small group of children or the whole class and how the children reciprocate (Croll & Hastings, 2012).

The purpose of classroom observation in this study

The purpose of visiting the participating classes during some of the lessons was to see how the children reacted to and engaged with the IHC programme in their normal learning environment, a form of non-participant, naturalistic observation. Accordingly, notes on levels of engagement and attentiveness, as well as significant interactions with each other and the teacher, were taken during every class visit. This study used a modified version of the IHC’s Lesson Observation Guide during the classroom visits and researcher observation notes were detailed and reflective of what happened during class (Appendix 5).
Classroom observation in practice during this study

The researcher conducted classroom observations three times in each participating school during PAR Cycle 1. One observation visit was made to the school in PAR Cycle 2. The visit took place according to the class schedule (i.e. when they normally ran the lessons) and lasted from 60-80 minutes, depending on the length of the lesson. During the visits, the researcher made notes in the observation guide as the lesson progressed. There is an inherent difficulty in engaging in an observation method that will accurately reflect the children’s experience. Dunn (2005, chapter 5) states that ‘any observational system reflects the theoretical ideas of the investigator’, the implication being that the observation of the children changes the nature of their experience. Accordingly, it was important to cause minimal disruption to the running of the lesson.

3.8 Data Analysis
3.8.1 Thematic analysis

A large volume of data generated during fieldwork for this study. Thematic analysis provided the researcher with an accessible vehicle to analyse the data and so achieve the objectives of the research.

Thematic analysis is a method for identifying themes and patterns of meaning across a dataset in relation to a research question (Braun and Clarke, 2013). Satisfied that data saturation had been achieved (Hennink, 2020), the researcher began the process of analysis.

Mindful of the research objectives, all data were coded using Braun and Clarke’s (2013) approach to Thematic Analysis (TA) as a flexible foundational method of qualitative analysis. They cite several strengths of this approach which rang true for this research study:
- Flexibility in terms of methods of data collection and sample size
- Accessible to researchers with little or no research experience
- Easy to learn and quick to do, relative to other qualitative analytic methods
- The findings can be accessible to a wider educated audience, making TA also suitable for Participatory Action Research where the participants might have a role in the analysis of the data they help to generate.

Braun and Clarke (2013) provide a very clear step by step guide to the stages of coding and analysis for TA:

1. **Transcription.** The aim of transcription is to provide a thorough written record of the words spoken during and interview / notes written in relation to observations.

2. **Reading and familiarisation; taking note of items of potential interest.** This immersion approach involved reading and re-reading the data. A researcher’s own bias will colour their initial interpretation of the data and it is only through actively and critically reading and re-reading the content that new points of interest may start to emerge. In practice, the researcher listened to the recorded interviews several times each. The transcriptions, observation sheets and lesson evaluation forms were read repeatedly as advised, with a broad sense of people’s opinions emerging.

3. **Coding – complete; across the entire dataset.** Every data chunk was mined for codes and these were clustered into identical or ‘close enough to be the same ‘codes (Appendix 7). The transcriptions, observation sheets and lesson evaluation forms were then given a deeper and more detailed analysis (a coding process), with the researcher seeking to identify the smallest units of thought in the text. Coding contributions and advice were also made by the supervisor. The units were given a locater code and then digitally cut and pasted into a second document to be listed individually and out of context.

4. **Searching for themes.** This involved reviewing codes and their associated data with a view to finding overlap. Finding interesting or
meaningful associations of codes can lead to the development of a candidate theme. Braun and Clarke provide a helpful set of questions to guide this process (pg. 226).

5. **Reviewing themes** (producing a thematic map – i.e. themes and subthemes and the relationships between them). This stage of the process involves attempting to determine the relative importance of themes. Braun and Clarke suggest that determining the importance of a theme is not about counting but rather about determining whether this pattern tells us something meaningful and important for answering our research question. A good theme will be distinctive and will make sense on its own. A hierarchical relationship between some themes may be established (creating subthemes). A visual map developed on a whiteboard by the researcher and supervisor was helpful to see and discuss the themes.

6. **Defining and naming themes.** Through prolonged and repeated engagement with the themes, a definition of each was developed and supported by appropriate excerpts from all the dataset. This process was applied across all data sets. These units were then grouped and regrouped in search of emergent themes. This process involved much discussion, comparison, negotiating of perspectives, and some robust debate.

7. **Writing – final analysis.** Braun and Clarke say that this involves writing up an analysis that achieves balance between data sets and analytical narrative. The researcher must speak for the accompanying data, not just restate it. Koshy (2010) advises revisiting the aims and expectations of the study before beginning the analysis process. She clarifies that, although one will be mindful of the these aims during the analysis, a good researcher will also be looking out for unexpected outcomes. Within each theme, associated findings were identified using supporting datapoint evidence and a set of recommendations was developed. Mc Niff (2017) makes it clear that evidence and data are not the same thing in qualitative analysis. This contrasts with the quantitative approach of attempting to include all data where possible to construct meaning and to fill in gaps where necessary.
Following the process of analysis, over 1300 individual units of code were generated, which were eventually distilled down and categorised into 4 main themes (see Appendix 7):

- School System and Environment
- Teaching Resources
- Students
- Teachers and Stakeholders

Accordingly, it was through engagement with the TA processes that the findings and associated recommendations became more clearly defined. These were subsequently deconstructed and reconstituted within different frameworks: the researcher’s own themes, the IHC templated domains and the current Socio-ecological Model (SEM). After considering all these models for the purpose of this thesis, it was decided that the SEM provided a framework to view the findings in a way that led to clear implications and actions in practice.

3.8.2 Socio ecological model (SEM) for data presentation

This study focuses on the opinions and experiences of several different participant groups. It is also important to note that the IHC programme is facilitated within a school system that is influenced by many factors – within the classroom, the local community, nationally and internationally. When referring to the findings of the study, and the subsequent actions arising from this work, the interplay between all these factors and influences has to be considered.

Bronfenbrenner (2009) notes that to gain an understanding of human development, the entire ecological system within which people exist needs to be considered. The SEM provides a conceptual framework that recognises behaviour as something that can be influenced at multiple levels (Robinson,
The model (Figure 3.8.1) consists of hierarchical levels (individual, interpersonal, community, organisational, policy / enabling environment) each lending themselves to leverage points for health promotion within organisations (Townsend and Foster, 2011).

The Socio Ecological Model (SEM)

Figure 3.8.1

The SEM draws attention to the interdependence of the levels and how they can influence and interact with each other (Langille and Rogers 2010). That is to say, the effects of action at one level can impact on the influence of other levels on behaviour. For example, a change in national policy (e.g. a sugar tax) will impact directly on a person but may also cause changes in approach
at other levels of influence (e.g. changes to school lunch orders due to the affordability of more high sugar meals). The Socio-Ecological Model helps in both the targeting of interventions to promote behaviour change and in focusing research into approaches by helping the researcher to view findings through the lens of the different influences (Townsend and Foster, 2011). For example, a no-smoking campaign could be viewed in how it interacts with the various levels of influence. Using this model gives insights into how the findings of this study and the actions initiated therein (the contextualisation of the IHC) accounts for the interactions of the stakeholders within the(ir) primary school environment in Ireland. To ensure this study gives adequate consideration that any contextualisation of the IHC will not occur in a social vacuum, the remaining chapters of this thesis have been aligned to the Socio-ecological Model (SEM).

A note on the Socio-ecological Model’s application in this study

The findings were reported in a manner compatible with the Socio-ecological Model of implementation, a process of that is familiar to both Health and Education. This is detailed in Chapter 4.

3.9 Rigour

The rigour of this study is defended based on the rationale, choice and accurate implementation of methodologies in the delivery of its objectives. By selecting and adhering to an appropriate and relevant pathway, the outcomes were then verified through re-engagement with some of the participants.

The notion of rigour for qualitative studies has evolved beyond the standards of reliability and validity alone (Streubert and Carpenter, 2010). At its core, establishing rigour in a study such as this is about arguing and providing evidence for the relative trustworthiness of the findings (Guba, 1981). All
research requires rigour, but action research needs even more attention given to rigour, particularly in methodology, because it often moves from a broad ‘fuzzy’ question to more specific actions and findings as the study progresses (Coghlan, 2014).

Nowell et al (2017) outline the pillars on which the trustworthiness of qualitative research is built:

3.9.1 Credibility

This refers to how well the study represents the phenomenon being studied, the degree to which it is recognisable to others, and the goodness or soundness of the study (Morse, 2015). There are different categories of validity, but the most relevant one to qualitative research is ecological validity (Braun and Clarke, 2013) where the relationship of the data to the real world is assessed. The credibility is established if it resembles and is meaningful to real life. One of the best ways to establish credibility is through prolonged engagement with the subject matter (Streubert and Carpenter, 2010). A number of actions and methods used in this study helped to support credibility:

Developing a coding system

Early organisation of data into a traceable coding system pays off as the study progresses (Mc Niff, 2017). All data in this study were individually coded, allowing the tracing of a finding through the various iterations of the themes back to the original appearance of the datapoints that informed it. The extensive and prolonged engagement with data and the focus on process design (dealt with earlier in this chapter) contribute to the overall credibility of the study (Maher et al, 2018).

Clarifying researcher bias

Morse (2015) mentions 2 types of bias a researcher needs to be mindful of, the ‘pink elephant’ bias where he is watching for an anticipated outcome and the more difficult to pin down ‘value laden’ bias. Much examination of
researcher bias took place before the first PAR cycle and is evidenced in the excerpts taken from the reflective process (Appendix 3). Writing one’s beliefs down is one of the most effective ways of explicating them (Streubert and Carpenter, 2010). The semi-structured interview guides (Appendix 6) included carefully chosen questions that were intended to keep the researcher in a neutral position relative to the possible outcomes predicted. This took place under the supervision of and with the input of the research supervisor. Self-awareness and neutral positioning helped to mitigate for bias.

Member checking

This refers to testing the data with the relevant data source groups (Guba, 1981) and typically involves presenting a written form of the research to some of the study participants for their feedback (Braun and Clarke, 2013). The findings and conclusions were sent to some participants of this study for feedback and confirmation purposes. The findings have also been presented to members of the IHC steering group including the developers and researchers from different countries engaging with the IHC. No adjustments were needed following the response received.

Triangulation

This refers to a process where two or more data sources are used to inform the research (Braun and Clarke, 2013). The use of two or more data sets increases the scope and depth of the research as the data sources may enrich or offer different perspectives on the subject being studied (Morse, 2015). In this study, four data sources were used (see section 3.7 of this chapter) and, during the analysis phase, all findings were informed by at least two data sources.
Prolonged observation

Prolonged observation at the site(s) of the study help reduce the effect of the observer presence and, therefore, support the credibility of the findings accruing (Guba, 1981). During this study, a total of seven visits were made to the three participating classes and all were at least one hour in duration.

Thick description

Prolonged engagement and observation may also lead to another desirable outcome, that being the securing of thick and rich description data (Morse, 2015). Descriptions that include context are considered thick (Braun and Clarke, 2013) and are thought by many researchers to be necessary for the understanding of a culture surrounding a topic (Streubert and Carpenter, 2010). The semi-structured interviews, focus groups and lesson observations provided much of the thick data of this study and helped lead to more relevant and credible set of findings.

3.9.2 Transferability

This relates to the generalizability of inquiry (Nowell et al, 2017). The findings have been presented to members of the IHC steering group including the developers and researchers from different countries engaging with the IHC. Similarities to issues in different contexts have been noted and the IHC community has gained useful insights from discussing the findings of this study.

3.9.3 Dependability

Dependability in qualitative research concerns itself with the stability of the data generated (Guba, 1982). To achieve dependability, researchers focus on
making the study process clear, logical and traceable for the reader, who can then judge the dependability for themselves (Nowell et al, 2017). Dependability ensures that process description is detailed enough for another to be able to replicate (Maher et al, 2018). In this study, dependability was supported by the use of a clear and logical methodology which has been laid out earlier in this chapter. It has been further supported using triangulation (described earlier in this chapter) and with the inclusion of an Audit Trail (Appendix 11).

Audit trail

This is a list of sample documents that chart the journey taken by the researcher during the study and make it possible for an external auditor to examine the process by which data was collected and analysed (Guba, 1981). It provides readers with evidence, which may include raw data, field notes, transcripts and/or a reflexive journal, of the decisions and choices made by the researcher regarding theoretical and methodological issues throughout the study (Nowell et al, 2017). This may be found in Appendix 7 and 11.

3.9.4 Confirmability

Confirmability is concerned with drawing a link between the data and the researcher’s interpretations of it to formulate findings (Nowell et al, 2017). The objective is to illustrate as clearly as possible the evidence and thought processes that led to the conclusions (Streubert and Carpenter, 2010). An adapted Audit trail from Guba and Lincoln (1985) was used in this study.
3.10 Conclusion

The methodology underpinning this study and the methods used to complete this research study have been detailed in this chapter. It outlines the influences and reasoning that led to the choice of methodologies and lays out how the methods were applied.
Chapter 4 – Findings

4.1 Introduction

This chapter details the findings of the research process as outlined in chapter 3. In keeping with the traditions of the qualitative research paradigm and to highlight the participatory nature of this action research study, the findings are presented using descriptive summaries supported with examples from the data (e.g. direct quotes). As noted in Chapter 3 the findings are mapped to the levels of the SEM. It was planned to present each cycle individually. However, it must be noted that partly due to the COVID pandemic, less feedback was provided by the second PAR cycle (please see T012 for reference to this teacher). Interview data was limited to the class teacher as there was no opportunity for focus group work with the children. One of the three scheduled classroom observations took place and the participating teacher was able to provide 3 lesson feedback forms. Therefore the findings are presented thematically. This is an acknowledged limitation of this study and is noted in Chapter 6.

4.2 Socio-Ecological Framework

It is possible to view the findings through the lens of 4 overarching groupings akin to a socio-ecological framework, with the community and organizational categories combined into one as a reflection of a typical Irish primary school.

The findings reported at the SEM Personal Level relate to the stakeholders affected directly by engagement with the resources. These findings reflect the participants opinions of and experiences with the IHC program.

The Interpersonal Level relates to social networks. The interactions of students, teachers and parents during the running of the IHC programme. The findings mapped to this level relate to the influence of the classroom norms,
including customs and traditions, their social network on their opinions and experiences of the IHC.

The Organisational Level relates to community networks and supports. This includes the resourcing for the school, the in-school management team, and defined supporting organisations external to the school such as the Professional Development Service for Teachers (PDST). How these networks were influential in the participants opinions and experiences of the IHC will be noted.

Finally, all the above exist under the umbrella of Irish primary school management at a national level. This includes the Department of Education and Skills, national policies that affect schools, and legislation. The findings presented at this **Environmental Level** note the impact that legislation and policy at a national level may have on future engagement with the IHC.

4.3 Findings

An over-arching theme will represent the findings of each level of the SEM. Each theme contains several sub themes which represents connecting but distinct elements of the findings.
SEM Presentation of Data in this Study

Figure 4.3

Personal
Teachers & students

Interpersonal
Parents & classroom norms and practices

Organisational
School management and Teacher preparation

Environmental
Department of Education

Personal
Try it, you’ll like it!

Interpersonal
Something for everyone—Broadening the appeal.

Organisational
Getting past the gatekeepers

Environmental
The boat will sink without captains
4.3.1 Personal Level – Try it, you’ll like it

This theme characterises the personal reservations expressed by some of the study participants about the IHC programme before their engagement with it. This is informed primarily by data from adult participants. The reservations centred around relevance of the narrative, content and setting to the Irish context and its workability in an Irish classroom.

*Most people liked the books*

The nature of engagement varied for participants, with the stakeholders reviewing the resources and giving feedback. Some of those stakeholders then implemented the unaltered IHC programme in-class with their students. One stakeholder then ran the contextualised IHC programme in their class. It is important to note that the depth of involvement with the IHC programme was reflected in people's feedback, with greater involvement resulting in a more positive feedback for the programme.

Stakeholders and students liked the look of the comic strip. Most feedback by stakeholders was positive with some notes on potential changes:

“I like the clarity of it, it’s just very, very well laid out and very easy to follow I think, which teachers appreciate” (T010 interview)

“I think the language there is very clear, it’s nicely presented” (T007& 008 interview)

“the cartoons would be what the children would be drawn to anyway and would be excited about.” (T004 interview)

“A4 size, the comic structure - Yes and even glossier and things like that” (suggested improvements during T004 post-programme interview)

Teachers’ perceived value of the resources increased after they implemented the programme, and this was reflected in their comments during the post-programme interviews:
“my initial thoughts on looking at the book that I didn’t think it would work but it did and it’s probably opened my eyes not to taking on new material that would be beneficial because it did, the class did benefit from it.” (T004 post-programme interview)

“I suppose another thing that struck me I didn’t think the children would engage as much as they did and ... I was very surprised with the way that they actually took something, and it was different maybe to the understanding I took out of it. So, I actually was surprised at the amount that I learnt* from them from the programme.” (T010 post-programme interview)

“What I found was, it wasn’t me teaching the kids; we were actually learning* all this together, if that makes sense” (T012 post-programme interview)

*Any activity that leads to learning is seen positively by teachers.

Many teachers and stakeholders felt the IHC programme was good but needed contextualisation.

It is important to note that this research study was initiated on this premise and the possibility of that this would be raised by the study participants. It became quite clear during the stakeholder interviews that this was indeed an opinion the adult participants (primarily) held. The opinion initially manifested itself in the form of a feeling that the cultural and racial demographics were too narrowly focused. Some stakeholders noted a lack of diversity in the characters from the book and saw this as a potential barrier to implementation. The concern was raised in the form of commentary, often accompanied by suggestions of changes that might be considered:

“I’d probably like to see maybe more of a mixed kind of a culture aspect to the book if that would be a possibility in the future” (T010 interview)

“nobody is suggesting, I hope, that this [IHC Programme] would be taken directly and put into an Irish context” (T011 interview)
Stakeholders also expressed the concern that students would be distracted from the learning objectives by the unfamiliar context in which the storyline is set. Given the importance attributed in teaching circles to making content relevant to the children’s own lives (Jenkins, 2011), the initial concern about setting and exotic narrative examples is understandable:

“I think if it was introduced as it exactly is at the moment it would be actually a source of confusion and possible bemusement for the kids because they would be kind of going this has nothing to do with, this is strange, it’s a strange situation presented to their context.” (T007 & 008 interview)

Some adult’s discomfort with the alien nature of the content (as they perceived and experienced it) was noted during lesson observations:

“Teacher struggled with some of the names of characters in the story for this activity.” (T010 – Lesson 2 observation notes)

It is interesting to note that the students did notice the different setting but did not see it as an obstacle to learning. In application, there were little or no issues with the setting and ethnicity of the characters as far as the students were concerned. The students saw the setting as interesting but irrelevant to the purpose of the IHC programme. They noticed the regional specific elements of the narrative, but this did not seem to matter as much to them as the adults:

“Well I found the fact that it was based in, in different countries interesting because like we saw how they lived and... the other countries don’t really matter, like everyone pretty much is a person, except for animals” (Focus Group 2 student)
The Children's Book is too big

There were some general and some specific comments about the length of the Children’s Book, highlighting a need to reduce the perceived size of the book. The incidents of overly prescriptive activities and exercises were held as one area as responsible for the size of the book. The size was seen as psychologically inhibitive and the concern was that teachers would shy away from them. The implication of this being that some teachers would not look beyond the shallow metrics of size and equate this to too burdensome a workload:

“The children’s book could be reduced considerably in size and still get across the key messages” (T003 interview)

“They could easily cut down on a lot of pages. (Laughing). Even that first chapter an awful lot of it could be condensed into two pages. We are gone to 23 pages now at the moment. I got lost reading those instructions. There’s a lot of them for something very simple, too many steps” (T004 interview)

“there’s a lot of pictures here it might have been better presented in an A4 format because there’s a lot of page turning” (T007 & 8 interview)

“I think they often waste paper in some - Especially in the start” (Focus Group 1 Student)

Teachers Guide is clear but too big

The consensus during interviews was that the Teacher’s Guide was very clear in relation to content and instruction. There was a mixed reaction to the presence of the full children’s textbook being embedded in the Teacher’s Guide. However, the stakeholders suggested that its size and the volume with what some considered unnecessary information could be seen as off-putting. Although some core subject Teachers Guides for teachers in Ireland can be large, the IHC guide was considered excessive and much of the content
included was deemed unnecessary. Non-core subject (i.e. subjects other than English, Irish or Maths) teacher guides tend to be much shorter with signposts rather than the fully detailed step by step instructions, along with every page of the student book, as included in IHC:

“this the teacher’s book, I think that could be made smaller and abbreviated. You just don’t have to explain everything, I think that people, like this could be revised to make it shorter with the core issues. Because if it’s too big and too long the core issues can get lost in lots of words and vocabulary” (T002 interview)

“it’s a very big manual and I suppose from my experience that can be a bit off-putting.” (T003 interview)

“I’m slightly confused in terms of you know the relationship between the teaching manual and this child manual. So, they both seem very similar, so...I'm just comparing this to work I’ve done with other classroom materials where we mightn’t be quite so prescriptive with the teacher manual. We might trust the teachers actually have been trained quite extensively to deliver this type of material or this type of information. We might suggest but we wouldn't lay it out in such detail, I think it says something about the view of teachers” (T011 interview)

Given the gatekeeper status of teachers, 300-page Teacher Manuals for one programme may be seen as off-putting and they may not even take that first step of investigating the contents. The content in the Teacher’s guide was reduced for cycle 2, the size of the book was not raised as an issue by the teacher facilitating the IHC at this stage of the study:

“With the teacher’s book, there’s lots in it but not too much and like with all the teacher’s books, am, you read up about the lesson, you check out the exercises and you dip in and dip out and you use the ones that suit it.” (T012 post-programme interview)

It takes a while to see value in the IHC programme.

For most of the stakeholders, and particularly for the participating classroom teachers, the full value of this programme was not immediately evident. There
seemed to be a link between the greater level of engagement with the text and a higher perception of its worth. There was a concern that this programme would be seen as additional work rather than something of value that would naturally draw teachers and decision makers to it. The raising of this concern was followed in most cases by ideas for how best to address this obstacle to teacher 'buy-in':

“when you’re talking to teachers and asking them to do anything extra you have to be careful” (T002 interview)

“If teachers are told that you know this is, if the evidence out there is that this is going to impact positively on the children, I do believe that most will take that on board” (T010 post-programme interview)

“I suspect the background of the people involved; I don’t know if there were some teachers involved but this wouldn’t rest easy with me this type of prescription” (T0011 interview)

Teachers’ understanding of the vocabulary was limited, initially

There was a difference in vocabulary understanding between primary school educators and those with a medical background who devised the IHC program. Teachers demonstrated a lack of health literacy in their critique of the content of this program and this gap is not sufficiently addressed in the content of the Teacher’s guide or the associated Teacher Training session. The Key Concepts made sense to the stakeholders but the nuance here is the understanding of the definition of words used to describe those Key Concepts. This was particularly pronounced in teachers’ understanding of some key definitions in the book, such as treatment, to mean something different to what was intended. For example, teachers saw treatment as a solely medical intervention for an illness. Stakeholders had some difficulties with other definitions, but it was most pronounced in relation to the word ‘treatment’, with it being mentioned at least once in every interview. They did not see health promotion/maintenance/abstinence as treatments:

“Again, with football as a treatment I think that would not be common language we would use” (T003 interview)
“...if I have a sore finger and it needs maybe Sudocream or something like that, talking about it being related to my health is nearly over the top.” (T002 interview)

Teachers’ opinions on definitions modified and matured as indicated in their post-programme interviews. It was only through the application of the knowledge during the IHC programme that the teachers modified their understanding retrospectively. It could be significant if teachers led class discussions and taught vocabulary without a complete understanding prior to implementing the IHC programme:

“I would have had a predetermined thought that treatment is more or less medicine and what the doctor gives and operations. But you know it’s how you treated your body really, when you look closely at the word and how you keep healthy and how you look after yourself.” (T004 post-programme interview)

The knowledge gap was bridged by engagement with the material and the results were evident in class. The students’ understanding of the terms evolve appropriately during engagement with the book. During one lesson observation, it was noted that:

“The children’s evolved understanding of ‘Treatment’ was clear. They discussed (teacher-led) the grounds for choosing a treatment on pg. 175” (T004 Lesson 9 observation notes)

There was a recognisable development arc of how the teachers saw the usefulness of the definitions and terms used in this program. The gap needs to be bridged (or at least that bridging process should begin) before the teachers deliver the program to their pupils. Otherwise, the danger is that the teacher is blindly finding their way through this program with the children or that they will not see the value in the program and not engage appropriately with it.
Teachers noted vocabulary difficulty levels and progression.

There were some reservations expressed during the pre-programme interviews that the vocabulary used might be too simplistic for the target age group. It became clear, particularly to those implementing the IHC programme in-class, that it became more challenging as the lessons of the program progressed. This finding was notable as it could manifest as a barrier to implementation where teachers mistakenly feel at the outset that the vocabulary is too easy for the children:

“I would find it’s a little simplistic, you could just research good and bad effects. It’s almost like something you would do with a younger class.” (T007 & 008 interview)

“Even continuing on, I have read ahead a little bit all right and it’s, I think we’d lose them straight away really because it would be too easy” (T004 interview)

“most of us when we heard treatment we thought like a, like a surgery or like, like just exercise, but like really we found out that like brushing your teeth, so it’s new to us” (Focus Group 1 Student)

The evolution of opinion is noted in examples such as this:

“Because there are aspects of it I found even in the later chapters were quite confusing because you were getting a lot of new terms and I had to sit down and reread it, there was something I think it was like advantages and disadvantages versus good and bad effects. Then you were talking about different types of good and bad effects and different types of advantages, unit six there was a whole load of fair and unfair comparisons. So, you know, this group and this group, I had to sit down and reread that again because I wasn’t clear, it wasn’t easy. But that probably showed that it was something that I needed to learn as well” (T007 & 008 interview)

Students recognised the need to broaden their understanding of definitions.

The students shared the same limited understanding of the definitions and terms in this program. However, in a justification of the principle of early
intervention, the children recognised that the need for a change and development of understanding was their responsibility:

“Yeah, because like, and like when you’re young you don’t really learn about these things, like even before like, we said this earlier today as well, like most of us when we heard treatment we thought, like a surgery or like, just exercise, but like really we found out that like brushing your teeth and like other, and just all those other things are like, they help you a lot and like we didn’t even know they were, so it’s new to us.” (Focus Group 1 student)

Students went even further than the teachers in that they were looking for additional definitions and explanations for examples used in the books. This spontaneous generation of curiosity for further information is a positive outcome of the IHC programme:

“Well I think, I think, you know the way it says how, however sometimes the infection will go away without any medicine, they should like have a little section or something there saying why it will just go away instead of like saying some, like why is it sometimes you need medicine and sometimes you don’t, so I think they should have something like that – Interviewer: Right, okay. Are you talking about your own body’s immune system, is it?

- Yeah, like there’s no mention, like because any kid, you know, like, he’s only starting to learn the, like the advantages of what the exercise treatments you can do for your body and what’s good for your body and not, I mean it should explain why so then they know how.” (Focus Group 1 student)

Taken in isolation, it could be argued that any one of the definitions in the children’s textbook is simple (e.g. good health, bad health, claim, basis). However, in their application throughout the program, these terms were at times difficult for the students to effectively process. The simple definitions would be combined or used in certain contexts to describe a more difficult concept. Some children recognised this fact themselves:

“sometimes the language, especially towards this end of the book, is a little bit confusing at times” (Focus Group 2 student)
The IHC program places an emphasis on repetition with terms often defined more than once in the book and concepts/instruction repeated during the narrative. However there were no resources provided to support environmental text for use in between lessons (e.g. flashcards). Environmental text as a reinforcement tool is a staple of Irish Primary School classrooms so it was not surprising that both classroom teachers in the first PAR cycle generated their own flashcards, considered an entry level form of environmental text. The provision of flashcards for cycle two was noted and appreciated by the participating teacher:

“I’d question how many SPHE directed vocabulary words have made any word wall in any classroom in the whole country...I think it was a novelty for the children that we had vocabulary words from a new book on SPHE... where the definition was clear and backed up with a story and an exercise” (T012 post-programme interview)

*Some of the narrative examples are not relevant to the Irish context*

Teachers felt that there was value in using narrative examples, like in the IHC program, but it was also generally thought that supplementing and even replacing with Irish examples would be more effective. The narrative examples used in this programme were seen by some as being quite alien and potentially obstructive to learning. However, in application, most examples formed a starting point for discussion and helped draw local examples from the students and teacher:

“Like say even putting cow dung on a burn, not really something that we would have heard of. We would talk about the benefits of saltwater...” (T009 interview)

“I think the examples are very context specific, culturally specific, so that would have to be worked on” (T011 interview)
Although the children seemed more immune to the distraction of an exotic setting than the adults, this opinion on narrative examples was echoed in their focus groups:

“But this book like, when they’re going back like the malaria thing, the malaria thing, that’s not really important to us because we live in Ireland, like we don’t have mosquitoes here” (Focus Group 1 student)

“I think like as well as like the malaria they probably shouldn’t have like the cow dung because no person would put their finger in cow dung” (Focus Group 1 student)

However, in the case of both teachers and students who experienced the program, participants saw greater value in the different geographical setting with different cultural narratives. One teacher, in their own lesson evaluation notes, said in Lesson 3 that “The examples were very relatable” Indeed, for the teachers who taught the program, there was a broadening of their opinion from pre to post-programme interviews:

“I’m an old fossil is right yeah. So yeah it was probably more of an issue for me than for them. They knew a lot more about the children they are well used to seeing television programs and things like that. They are more open-minded than what we are as adults I suppose. So, it was yeah, it was more my, something I thought would be a concern, but it wasn’t really.” (T010 post-programme interview)

“As my friend here, he was saying, that, he was saying that it was no point having the malaria machine, whatever, in it, but I think the point wasn’t really about the malaria, it’s just about the bad basis of the claims, so it wasn’t really anything to do with malaria, it was just, it was just using that as an example for a bad basis of a claim.” (Focus Group 1 student)

The use of reinforcing examples relevant to the students’ own lives is a staple of Irish classrooms so, notwithstanding the post-program altering of attitude towards the examples of health claims from other cultural contexts, the need
to contextualise the content in this regard is clear. This relates back again to the fact that the gatekeepers to the classroom, mostly teachers, will not have experienced the IHC programme yet when initially making the decision whether to commit to it.

*Students saw the need for some additional resources to compliment the book.*

This finding relates to the children’s motivation to learn, where the lack of variety, particularly in the reinforcement exercises was seen by some as a weakness of the IHC programme. It might be argued that because of a scientific process of development that the authors shied away from varying the delivery mechanism of reinforcement to ensure a repeatable learning objective result for every chapter. The children also expressed some concern over the length of the book without a review chapter in the middle, again a common feature of curricular books in Ireland:

“*You could make some of the activities different because at the end of every chapter it’s the same kind of activities*” (Focus Group 2 student)

“*Interviewer - So, when you say the one together do you mean a review chapter where you look back over, to stick in a review chapter every so often, okay?*

- *Well we did do one of those...At the back....like at the very end of the book....But we wouldn’t remember everything, so we should do it like at the, near the start, near the middle and near the end.*” (Focus Group 2 student)

*It was felt that the printed IHC resources could be further enhanced, including the use of additional methodologies*

Some felt that the printed IHC resources would benefit from additional enrichment exercises. Although the general consensus of the books being too
big was already established, improvements through the inclusion of additional or alternative texts was considered necessary:

“Mightn’t be a bad idea maybe to have a list of that somewhere within the teacher’s manual —

**Interviewer - So perhaps a teachers toolbox?**

- Yeah exactly with the different methodologies and you know you could use different strategies and things like that and different games that you could I suppose use within the teaching of it. It’s something you could dip in and out of. That suits your own style maybe.” (T010 post-programme interview)

“But that would demotivate teachers, the length of time. And maybe another thing there the lack of resources and games and puzzles and extra websites maybe.” (T004 post-programme interview)

Most saw skills transferability as a key bonus to the content being taught

Stakeholders saw potential in the IHC programme for developing transferrable critical thinking skills. Many examples of transferrable, lifelong skills being taught by this programme were mentioned during interviews. With the proposed new framework for Irish Curriculum (National Council for Curriculum and Assessment, 2020), thematic programmes with a broad curricular base and transferrable skills will be considered of greater value than those restricted to one subject area. This consequence of implementing the IHC programme was worthy of making a virtue of it, according to interviewees:

“I think this is a good thing, a good course that has a transfer of the learning to life in general” (T002 interview)

“Interviewer: It sounds like you’re also saying that this is a skill that might be useful for them in their on-line life.

- Yes, absolutely and especially into adulthood and things like that. It’s like with anything, the earlier you teach them, you know the more engrained it becomes.” (T010 interview)
Students also saw the importance of the skills being taught. They saw the critical appraisal skills as becoming more important for them as they get older:

“It’s important to your life. Well it’s not really important but it’s, you’d want to learn it like, when you’re older like you can learn it, not at this age” (Focus Group 2 student)

Indeed, the lack of connection to any one subject was seen as an advantage by the students. Although stakeholders seemed keen to define the IHC programme within the context of one or two subjects, the children did not recognise the IHC programme as related to curricular work. This effect is like that of Religion lessons, usually seen by students as a break from class rather than a distinct subject:

“at the start we were a bit dubious of it, but then as you get in to it you kind of enjoy it and it’s a good break from like a lot of writing and maths and Irish and it’s actually kind of fun” (Focus Group 1 student)

4.3.2 Interpersonal Level – Something for everyone – Broadening the appeal

Teachers noted there was no Home-School Link in the textbook

It has become standard practice in Irish schools to draw in the involvement of parents, particularly for what might be considered lower stakes curricular areas (e.g. religion, science/history project work, social studies). IHC was perceived in this light and stakeholders spoke of the importance of including the parents as co-learners for this programme.

The need for the same in IHC was repeatedly highlighted in both pre and post-programme interviews:

“They will go home and the kids absolutely love to go home and challenge their parents and say you know but you never thought of this so yeah it
definitely would lead to that and it would lead to maybe you know in the most cases lead to great positive debates at home.” (T010 post-programme interview)

“if the parents had some idea it could be discussed at home” (T002 interview)

“A home school link in there. Parents being informed so the children and parents are discussing it at home” (T009 interview)

Teachers felt that more differentiation was needed

Differentiation is the structured approach of providing extra work for early finishers and reduced/adjusted workload for children who are struggling with the content. It is a standard practice to have a pre-set selection of differentiated activities in the classroom to take some account of the range of abilities within a single class:

“we are told from colleges to differentiate lessons, to adapt them to the level the children are at.” (T004 interview)

“the only thing maybe would be to have an extra section for the children who are finished early, or you could push on a little bit further. So, the kids who are, you know high achievers, maybe a little section on that. That would be a nice touch, a nice aspect to it. And maybe actually on the other side of that maybe a differentiated kind of a work sheet for a child who maybe would find it difficult. So, you know would find it hard to understand maybe or you know would find the exercises difficult to complete.” (T010 interview)

Teachers see the lesson timetables in IHC as too prescriptive and incompatible with Irish classroom environments

The Teacher’s Guide does recognise that teachers will need to be flexible in the implementation of this programme to meet the unique needs of their classroom. However, some stakeholders felt that the highly prescriptive layout of the IHC programme would discourage teachers to do this in practical terms. There was a sense that there were too many steps and too much
unnecessary detail in the IHC proposed lesson plans. The standardised approach, it was felt, could not take account of the varied classroom contexts in the Irish system:

“I think the timing, the length of the program would be quite a lot really. Ten hours, I think. I suppose with SHPE, we’re talking maybe about half an hour per week and if you’re stretching that out, you’re talking 20 weeks to try and maybe cover the program and there’s lots more really to get covered really in the SPHE program.” (T004 post-programme interview)

“I think it would be difficult to implement it having 2nd and 3rd class in the room as well as the 4th, 5th and 6th... Multi-class and EAL (English as an Additional Language) scenarios would make accessing this material more difficult for children” (T010 Lesson 3 Self Evaluation)

The perception is that it fits SPHE best but may be linked to other subjects.

Teachers and stakeholders had a range of views about the curricular placement of this program in an Irish Primary school context. However, SPHE (Social Personal and Health Education: given 30 minutes per week in the curriculum) was the most named subject area, with 90% of interviewees specifically naming it:

“Interviewer - And is there any subject area you feel it has alignment with? - Well I suppose the SPHE would be the obvious one.” (T003 interview)

It became clear that although most closely aligning with SPHE (Social, Personal and Health Education), the IHC programme would be best described as a thematic approach programme due to the level of spill over into other areas of the curriculum:

“Ok so I think SPHE, maybe science, a little bit of geography there thrown in. So, it would be the SESE (Social Environmental and Scientific Education – this subject covers History, Geography and Science), the SPHE, maybe the
religion, a little bit even though. I know there isn’t really. I don’t know is there any Christian thing. I’m not sure. But certainly, the SPHE and the SESE and I would see kind of from 4th, 5th and 6th class, is what I would see.” (T009 interview)

“it could be used as an English reading lesson as well, with good comprehension questions at the end” (T012 post-programme interview)

In total, eight other subject areas in the Irish Primary School Curriculum were identified in connection with this program. Outside of SPHE, the most commonly mentioned subjects were English and Science, with PE, Maths, History, Geography, Religion and Drama all named. Given the impending shift away from narrowly defined subject areas to a broader understanding of the thematic learning (National Council for Curriculum and Assessment, 2020), a programme such as IHC that straddles multiple traditional curricular areas may find a greater welcome. Fitting this programme into a crowded curriculum has been a feature of this study. The general consensus was that this programme mostly fit with the Social Personal and Health Education (SPHE) curriculum. However, the half hour per week allocated to this programme, immediately causes a problem for IHC which requires 40-60 minutes per lesson to complete. As other subjects were mentioned by stakeholders, it became necessary to conduct a curricular mapping exercise to find any overlapping learning objectives between those of subjects in the Irish primary school curriculum and the IHC curriculum. The learning objectives listed in the table below from the Irish Curriculum subjects are limited to those overlapping with the IHC:
<table>
<thead>
<tr>
<th>Intended Learning Outcome (ILO)</th>
<th>Teaching and Learning Activities Used*</th>
<th>Assessment*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IHC</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Treatments may be harmful</td>
<td>Reading Aloud</td>
<td>Written Exercise</td>
</tr>
<tr>
<td>2 Personal experiences or anecdotes (stories) are an unreliable basis for assessing the effects of most treatments</td>
<td>Stories, Definitions</td>
<td>Teacher reflection</td>
</tr>
<tr>
<td>3 Widely used treatments or treatments that have been used for a long time are not necessarily beneficial or safe</td>
<td>Class Discussion</td>
<td>Questioning</td>
</tr>
<tr>
<td>4 New, brand-named, or more expensive treatments may not be better than available alternatives</td>
<td>Good and Bad Effects</td>
<td>Teacher observation (all chapters)</td>
</tr>
<tr>
<td>5 Opinions of experts or authorities do not alone provide a reliable basis for deciding on the benefits and harms of treatments</td>
<td>Group Discussion</td>
<td>Standardised test (after book)</td>
</tr>
<tr>
<td>6 Conflicting interests may result in misleading claims about the effects of treatments</td>
<td>Case Studies</td>
<td></td>
</tr>
<tr>
<td>7 Evaluating the effects of treatments requires appropriate comparisons</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Apart from the treatments being compared, the comparison groups need to be similar (i.e. “like needs to be compared with like”)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 If possible, people should <em>not</em> know which of the treatments being compared they are receiving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 Small studies in which few outcome events occur are usually not informative and the results may be misleading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11 The results of single comparisons of treatments can be misleading</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12 Treatments usually have beneficial <em>and</em> harmful effects</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>SPHE</strong></td>
<td>Discussion, Brainstorming, Circle work, Stories</td>
<td>Teacher Observation, Written Activities, Worksheets</td>
</tr>
<tr>
<td>1 <strong>Self-Identity - Making Decisions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Developing awareness of factors that influence decisions/choices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 <strong>Taking Care of My Body - Knowing about my body</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Recognise and examine behaviour that is conducive to health and that which is harmful to health</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b Realise that there is a personal and communal responsibility for the health and well-being of himself/herself and others</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Safety and Protection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>a Explore and examine the use of medicines</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Making Decisions</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>-----------------</td>
<td>---</td>
</tr>
<tr>
<td>a</td>
<td>Acquire a growing sense of importance of making informed decisions at many levels and identify some of the decisions he/she must make</td>
<td></td>
</tr>
<tr>
<td>b</td>
<td>Recognise that decisions have consequences and that not all people make the same decision all the time</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Developing Citizenship</td>
<td></td>
</tr>
<tr>
<td>a</td>
<td>Become increasingly critical and discerning in his/her own attitude to advertising and the techniques used to promote products, lifestyles and ideas</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Language</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reading for pleasure and information (Receptiveness)</td>
<td>Class discussion</td>
</tr>
<tr>
<td>a</td>
<td>Engage with books in a group or whole class setting</td>
<td>Group Discussion</td>
</tr>
<tr>
<td>2</td>
<td>Develop cognitive abilities through use of Language</td>
<td>Reading Aloud</td>
</tr>
<tr>
<td>a</td>
<td>Discuss ideas and concepts encountered in other areas of the Curriculum</td>
<td>Teacher Observations</td>
</tr>
<tr>
<td>b</td>
<td>Discuss the values, truth or relevance of popular ideas, causes and proverbs</td>
<td>Work Samples</td>
</tr>
<tr>
<td>c</td>
<td>Distinguish between fact and opinion, bias and objectivity in text and in media</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SESE</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Living Things – Human Life</td>
<td>Teacher Observation</td>
</tr>
<tr>
<td>a</td>
<td>Develop a simple understanding of food and nutrition</td>
<td>Student Work Samples</td>
</tr>
</tbody>
</table>

Table 4.3.2a
The mapping exercise revealed overlaps in 3 subjects from the Irish curriculum. In terms of planning, using IHC to address intended learning outcomes from English and Social, Environmental and Scientific Education (SESE) frees up a further 5½ hours of curricular time per week. Accordingly, the IHC would fall under the definition of an integrated curriculum programme where several traditional learning disciplines are brought together to address an important problem or question (Bacon, 2018). Viewing IHC in the light of a thematic approach makes its successful completion more achievable for teachers.

Furthermore, the proposed new curriculum for Ireland will further enhance IHC’s status as a curricular supporting, evidence-based programme:

Proposed Curricular Framework (NCCA, 2020)

* Broad learning outcomes in Arts Education would continue to support learning in visual arts, music and drama, as well as supporting other aspects of arts education such as dance, film and digital media, and enabling schools to engage with local, national and international initiatives and opportunities. The learning outcomes would also support integrated learning experiences in stages 1-2. While disciplines within Arts Education have a common creative process and share transferable skills, each has its own knowledge, concepts and skills. Subject-specific learning outcomes in stages 3-4 alongside a set of broader outcomes overarching the subjects, would ensure children experience a broad and balanced Arts Education.
Thematic subject area – Fostering wellbeing (NCCA, 2020)

<table>
<thead>
<tr>
<th>Fostering wellbeing</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Showing awareness of how to make good choices in relation to wellbeing</td>
</tr>
<tr>
<td>• Participating with growing confidence and skill in physical activity</td>
</tr>
<tr>
<td>• Being self-aware and resilient</td>
</tr>
<tr>
<td>• Acting responsibly and showing care towards self and others</td>
</tr>
<tr>
<td>• Being spiritual and having a sense of purpose and meaning</td>
</tr>
<tr>
<td>• Being persistent and flexible in solving problems</td>
</tr>
<tr>
<td>• Being able to assess risk and respond</td>
</tr>
</tbody>
</table>

Figure 4.3.2c

These figures (4.3.2b and 4.3.2c), excerpts from the proposed new curricular framework for Ireland, see SPHE and PE amalgamated into a theme entitled Fostering Wellbeing. There is an associated increase in time allocation and the report calls for teachers to focus on evidence-based programmes (NCCA, 2020, pg. 6). With trends in education pointing towards an integrated learning themes approach, the appearance of a contextualised program such as IHC would seem timely. This point was raised by stakeholders also:

“...there’s scope because the NCCA are developing a new delivery model”
(T011 Interview)

4.3.3 Organisational Level – Getting past the gatekeepers

Middle Management is important for IHC success/sustainability

Stakeholders recognised that it would be difficult for a programme like IHC to thrive organically, without any structured support, in the currently crowded curriculum. There were references made to national top-down directives, but also the requirement for an in-house driver in each school was identified. Most primary schools have a hierarchical structure of paid, delegated roles and their responsibilities are reviewed every two years. This is known as the In-School Management (ISM) team. When a principal wants a project or a subject area to receive a developmental focus, he or she will often assign it to
a paid driver in their ISM team. The alternative is having a volunteer champion of the programme, but this is dependent on an in-house enthusiast and is reliant on goodwill, which can be withdrawn without consequence. The consensus during the interviews was that Middle Management members and structures would play a significant role in the success or failure of IHC in each school:

“Normally there has to be some kind of a driver for this. So sometimes its funding, sometimes it’s teacher’s interests sometimes is a combination, something would have to drive this.” (T011 interview)

“Yeah, well if a school had a management structure where some teacher had particular responsibility for the area of health and fitness, that person obviously if such a post existed and it will in some schools...I suppose you know, that there has to be support from the management of the school, at board level and at senior management level” (T003 interview)

Most stakeholders expressed support for a shorter teacher preparation program with no methodological focus needed.

The consensus was that continuous professional development (CPD – Irish primary school teachers use this term to refer to any teacher preparation course or programme) was needed but for specific issues other than those outlined in the IHC guidelines. There is a broad spectrum of curricular subjects and programmes available in the Irish education system. At a national curricular level, subjects are delivered into schools by means of a series of Continuous Professional Development (CPD) days, staff meetings in schools and in-school support visits by the Professional Development Service for Teachers (PDST). There is a sliding scale of state sponsored interventions to support programme implementations where a school may access supports and CPD for a range of interventions at a school wide level right down to having one or two teachers trained. Finally, there are programmes that have no state support and the training, if needed, is paid for by the school. There was general consensus during Stakeholder interviews
that CPD would be required for the IHC programme, but that it would need to focus more on concepts, selling the programme and advising on how it would fit into their class life. Most felt current teacher training already equipped them to deliver the technical teaching elements of this course:

“I think our teachers are very well equipped to engage with any type of program. They are very well trained” (T010 post-programme interview)

“Teachers don’t need to be told everything. They just need to be given the concepts that are in it” (T002 interview)

“CPD would need to focus the attention on the specific elements that will motivate, the demotivating factors would need to be addressed” (T010 post-programme interview)

“with the nature of the heavy loaded curriculum like, you just need someone to sell it to a school basically” (T012 post-programme interview)

The shortened teacher preparation programme, adjusted in response to feedback, was deemed appropriate by participating teachers:

“If this book is being rolled out of my class on a regular basis, I’ll welcome the CPD hour, or a few hours, just going through it just like we had before we tackled this I suppose, you know?” (T012 post-programme interview)

In total, there were 18 recommendations relating to the teacher preparation programme that arose from the cycle 1 PAR process and these were all implemented (Appendix 4).

4.3.4 Environmental Level– This boat will sink without captains

Involving the Department of Education would help

Some stakeholders felt that successful implementation of this programme nationally would be more likely with Department of Education support. The
national context can have a significant influence on the development direction of schools. The support can take the form of a top-down edict to employ the programme. It could also be a recognition of the programme as strategically significant for addressing a subject or skills shortfall, resulting in support being provided in the form of free printed resources and/or PDST (Professional Development Service for Teachers) CPD (Continuous Professional Development) support:

“obviously you see the program would need to be launched and if it’s launched at national level with backing from the inspectorate and the department.” (T009 interview)

“I think the PDST or the department or the government, some way it has to come from on high, you know if a book lands in a school and some teacher says oh this is a lovely book, will we try this. It will go on a shelf and stay there. So it needs to be like a national program and this happens and maybe from the minister, you know books come, this program, but I think it needs to be really tied down and this needs to be done in term 2, in every school in the country, 4th, 5th and 6th class. And one lesson per week for so many weeks.” (T009 interview)

The participants raised parallels with other, nationally run, behaviour modification programmes:

“many are now are Health Promoting Schools encouraging healthy eating and healthy lifestyle. So this ties in very well there” (T009 interview)

“every school has a healthy school’s/Active Schools’ week: you could definitely bring the program and tie it in with that you know” (T010 interview)
4.4 Conclusion of the Findings

IHC was seen as a valuable resource with a few correctable context issues. Most stakeholders saw clear and practical solutions to address its perceived shortcomings for an Irish classroom. The experience of teachers and students who engaged with the IHC programme was positive. The attitude of participating classroom teachers was improved through engagement. The main obstacle to implementation seems to be at the gatekeeper stage, where a decision maker might undervalue the IHC programme based on the size of the books, its perceived over-prescriptive guidance, or the apparent oversimplicity of the vocabulary. The latter two of these issues are solved by engagement but there needs to be enough motivation to do so. You need something here to summaries the differences between the views of the adults and the children participating in this study.
Chapter 5 - Discussion

5.1 Introduction – Summary of Findings

This chapter will discuss the findings presented in Chapter 5 in order to explore their meaning within the context of the primary school system in Ireland. Using the SEM as a framework to guide the presentation of this discussion, the narrative will also highlight the actions proposed as a result of this study and the suggested contextualisation required in relation to the IHC (this will be developed further in Chapter 6).

5.1.1 Personal level summary

The findings related to the personal Socio-ecological level highlight that stakeholders and students view the IHC programme positively, but that this is sometimes initially curtailed by first impressions of the resources, including that the books are too big, the vocabulary is too simplistic, and the narrative lacks local relevance. These feelings tend to be mitigated by engagement with the content. It was at the personal SEM level that student voice was to be heard, often contradicting the reservations expressed by some adult stakeholders. Students enjoyed the programme as a break from normal lessons, saw the value it brought and made observations for improvement. However, the findings of this study suggest that the main obstacles to implementation of the IHC programme occur before the students ever see it in class.

5.1.2 Interpersonal level summary

At the interpersonal level Socio-Ecological level stakeholders drew attention to the perceived lack of
parental involvement in the IHC programme as active co-learners. They also noted that, under classroom timetabling norms, a less prescriptive approach to planning and a broadening of the curricular branding of IHC would be useful. It also became clear that as the IHC programme does not deliver a core subject, finding time and space for it on the Irish curriculum will be difficult unless it is seen as an integrated thematic programme that delivers elements of several subject areas.

5.1.3 Community/Organisational level summary

Key stakeholders contributing to this data noted that this programme will not enter schools without community/organisational level support (getting past the gatekeepers). The IHC programme’s chance of success will be improved by the structurally sustainable support of in-school management and a positively disposed teaching population.

5.1.4 Environmental level summary

All the adult stakeholders participating in this study noted that a highly significant factor for the success of IHC will be the level of support coming from a national/environmental level (The boat will sink without captains). The greater the level of top-down support that comes from the Department of Education and Skills, the greater the likelihood of successful nationwide implementation. However, the decision makers at this level are likely to experience the same first impression issues as stakeholders in the absence of contextualisation.

The findings seem to point to one encapsulating sense that contextualising the resources to Ireland will improve first impressions, increase initial engagement, and the strengths of the IHC programme become more evident through that engagement.
5.2 Were the Aim and Objectives Achieved?
How each of the objectives of this study were achieved:

<table>
<thead>
<tr>
<th>Objective</th>
<th>How it was achieved</th>
</tr>
</thead>
</table>
| 1. To complete a curricular mapping of the IHC programme onto the Irish Curriculum | - Stakeholder feedback during interviews (pre- and post- programme)  
- Focus Group interviews with students  
- Curricular mapping exercise by researcher                                                                 |
| 2. To identify and respond to key stakeholders views of the IHC program and their experiences of facilitating / participating in the IHC in a primary school setting in Ireland | - Interviews were completed  
- The programme was run in three schools  
- Feedback in relation to IHC was obtained using interviews, focus groups and lesson evaluation forms and responded to with adjustments made to the programme  
- An implementation of the adjusted programme in a school was facilitated and further research in relation to this will be planned |
| 3. To explore the participating stakeholders’ and end-users’ experience of the contextualised programme | - Point worth noting: The implementation of the program following the first PAR Cycle was somewhat curtailed by the Covid19 pandemic  
- One session of non-participant observation of the class was completed.  
- Lesson self-evaluation was conducted by the teacher  
- A semi-structured, post-programme, online video interview took place with the teacher (most of the programme completed in class by the time of the closure of all schools in Ireland) |
| 4. To produce an adjusted version of the IHC programme that is ready for trialling in Irish Schools | - A contextualised version has been prepared and is ready for review in Irish primary schools  
- The teacher preparation programme has been modified based on feedback from the stakeholders  
- Additional supplementary resources and activities for the IHC programme were developed  
- Prototype student books and teacher guide were printed for use in the second PAR cycle of the study  
- Feedback from the second cycle served to reinforce the changes made, with no additional ideas offered |

Table 5.2.2
5.3 The Themes
5.3.1 Try it, you’ll like it.

The findings of this study, reported at the personal level domain of the SE Model, found that participants’ views of the IHC programme in relation to its relevance and effectiveness improved with engagement. The students gave positive feedback about their IHC programme experience and engaged enthusiastically with it in class. The only reservations expressed about this programme came from the adult stakeholders. It is important, therefore, to inspire individual practitioners enough to take those first steps of engagement.

IHC as part of a teacher’s toolbox

When teachers engage in long term planning of their classwork, they select the methods and strategies from their toolbox that will best support the learning objectives (Howard 2013). The IHC programme can form a part of the teacher’s long-term toolbox. This study has established that getting schools and teachers to engage with the IHC programme will raise their views of its value. An important positive recognised at all stages of this study and by all participants was the potential transferability of the skills taught by the IHC programme and its broad curricular base (i.e. that it straddles several curricular areas as more of a thematic approach programme). With the impending shift in the Irish educational system to a thematic approach curricular delivery with a focus on broad skills’ development (National Council for Curriculum and Assessment, 2020), IHC finds itself perfectly placed just ahead of the curve of curricular development in Ireland, with a readymade programme that meets many of the aspirations of the proposed new curricular framework.
If proposing a change to the curriculum or to practice, it is important to be mindful of the cognitive processes that take place at an individual teacher level, particularly in relation to perceptions of risk and benefit of curricular change. In this process, the research shows that more weighting is placed by teachers on the perceived potential benefits (Weber et al, 2002). Some stakeholders in this study expressed initial personal reservations prior to engagement with the programme, centred around the relevance of the IHC programme to the Irish context and its workability in an Irish classroom. Fox and Irwin (1998) state that exposure to the biases of others in judgement of risks may influence bias in individuals. Accordingly, if the reservations expressed by some teachers were translated proportionately to a national scale, then the effect could be to significantly stifle progress of implementation. One of the findings highlighted that, in its pre-contextualised state, for some it can take a while to see the value of the IHC programme. Therefore, teachers who are introduced to the IHC programme need to experience a positive first impression.

Teachers’ response to cultural change in Ireland

The concerns over relevance were generally focussed on narrative, setting, character names and supporting anecdotes/examples. These concerns were either directly (where the stakeholder clearly identified the problem) or indirectly (where their comment indicated their concern without directly naming it) addressed during the interview process. As an example of the indirect commentary, some stakeholders seemed to struggle with naming race and culture as weaknesses of the text, perhaps out of a sense of political correctness, so instead focussed on words such as diversity.
There is a general professional conservativism in education that mitigates against significant change, characterised by the notion that nothing dramatic or unnerving will happen as long as there are no radical new ideas replacing established traditional ones (Jonasson, 2016). Howard (2013) states that, in addition to student learning, teachers’ identities are at stake when they are asked to make significant changes to their teaching practice. Fox and Irwin (1998) highlight that this self-identity, manifested in a set of values and beliefs, is further crystallised through experience and pre-existing expertise in the area. The teachers in this study noted that they were not experienced with the content of IHC claims, particularly after engagement with the programme, and this led to the proposal to change the focus of the teacher training programme element of IHC (moving the focus to an exploration of the content of the Key Concepts of the IHC rather than on methods of teaching).

This state of inertia of the mind is weighed by the teacher against the credibility of the presenter of new information and the quality of associated evidence (Fox and Irwin, 1998). This complex process of the mind, informed by more than just logic, and can be susceptible to non-evidence-based influences (Fox and Irwin, 1998). An example of this commitment to pre-existing norms appeared during this study and often related to language. Issues were raised about the vocabulary, but they were possibly due to a lack of understanding that the definitions used given their original in the field of medical research. Even during the iterative development of the original IHC programme, the guiding hand of the researchers with a medical background may have helped the teachers involved to rationalise the inclusion of what often seem like simplistic definitions. That is to say, the teachers might have accepted the inclusion of some words that would normally have been deemed too simple for the target age because the researchers are likely to have explained the reasoning behind the use of the vocabulary in question. This is an important nuance because most of the words used in the IHC programme are in common use in the classroom. Therefore, when the programme takes
the time and page space to give a starting point definition of these words, some teachers (as experienced by some participants of this study) may misread this as a sign that the vocabulary is too simple and this was reflected in the findings of this study.

This misread may also be extended to commentary in this study on what was considered the unnecessary broadening of some definitions, such as ‘treatment’. The definition of that word takes on a whole different range of meanings in the medical research world. Therefore, where the teacher is uncertain about adopting the IHC programme, their decision will be influenced by context (i.e. there is a need for this programme) and the credibility of the speaker in presenting the case for the decision (Fox and Irwin, 1998).

In relation to the need for positive engagement by teachers with the IHC programme, the possible benefits or risks of an activity or task are often assessed through a combination of rational and affective responses (Howard, 2013). An affective response is the emotional response to a situation, and is thought to have a strong effect on risk perception and decision-making, where people typically fall back upon the old reliable of intuition, and the quality of their intuition can set an upper limit on the quality of the entire decision (Slovic et al., 2000). The influence of affective responses in individuals’ risk perception has been identified as the ‘affect heuristic’, which is comprised of conceptualised and conditioned emotional responses based on previous experiences and perceptions (Howard, 2013, Finucane et al., 2000). Finucane et al. (2000) state that individuals having a positive affective response to an activity are likely to perceive it as less risky and of greater benefit to themselves and their practice. An activity invoking a negative affective response will be seen as threatening and of low benefit. Affective responses are not necessarily based on complete information and are often drawn from past experience and subject to strong bias (Loewenstein et al., 2001). In the case of the IHC programme, it cannot be assumed that teachers will decide to engage based on expected utility alone, which assumes that individuals make decisions in the presence of risk based on an assessment of quantifiable
consequences. Creating a positive introduction to the IHC brand becomes an even more important part of implementation.

Therefore, the overcoming of that inertia of professional identity can happen with a strong, benefits based, argument for the IHC programme, delivered by a credible presenter/facilitator. Presenting IHC in this way could encourage teachers to let go of a more comfortable existing system and take those first steps into the uncertainty of change a strategy suggested by Bialik and Fadel (2017) in relation overcoming system inertia in education reform.

*The need for a toolbox*

A key characteristic observed in all participating classrooms was the use of relevant but non-IHC prescribed in-class strategies and approaches during the delivery of the IHC programme. It is considered best practice for teachers to have a selection of approaches for use in the classroom to meet the varying needs and contexts they encounter (Croll and Hastings, 2012). Accordingly, it was a finding of this study that a toolbox of activities should be developed for inclusion in the contextualised IHC programme. It was evident from observation that this could be useful. Several stakeholders also indicated the need for differentiation exercises as part of that toolbox. Differentiation is as ‘the process by which differences between learners are accommodated so that all students in a group have the best possible chance of learning’ (Bartlett, 2016). This, it could be argued, was a less reasonable request as differentiation is structurally embedded in most classrooms already, with differentiated strategies used every day or most days in 75% of primary school classrooms (Mc Coy et al, 2012). Therefore, the need for the development and the inclusion of a toolbox was included as a recommendation and the potential for using pre-existing in-class differentiation approaches was noted. Both were included for mention in the teacher preparation programme session (see Appendix 4).
5.3.2 Something for everyone – Broadening the appeal

The findings of this study, reported at the interpersonal level domain of the SEM, indicated that stakeholders felt there was scope for encouraging more parental involvement during the running of the IHC programme. While the participants of this study noted that the IHC had the potential to widen its appeal outside the classroom (e.g. include parental involvement) it was also noted that its scope within the national curriculum was wider than stakeholders initially thought. Their first impression was that the IHC programme would contribute to the Social, Personal and Health Education curriculum. However, after further engagement it was suggested that it traverses many subjects and themes of the Irish primary school curriculum.

Home-school link

Much attention was given by stakeholders to the point of contact (or lack thereof) between parent and school during the IHC programme. The notion of a Home-School Link has become deeply ingrained in Irish primary school education and began with the constitution of Ireland which recognises the parent as the primary educator of children in this state (Government of Ireland, 1937). During the 1990’s the status of parental influence on academics became more formally recognised through a series of position papers (Eivers and Creaven, 2013, pg. 105-106). The current national curriculum makes explicit reference to the importance of the home-school link and the need to nurture the cooperative relationship between parents and schools (Government of Ireland, 1999a). The stakeholders in this study held great value in a structured and inbuilt link to the home for programmes like this, with the need for a home-school link mentioned in the 7 out of the 12 interviews.

Home-school links have a moderately positive effect on academic outcomes but only if the parents have aspirational intent for their children and, therefore, the success of this type of intervention is dependent on parental ambition.
(Jeynes, 2005, Education Endowment Foundation, 2020). This seems to be reflected in studies focused on disadvantaged areas with more diminished returns for Home-School links activities (Education Endowment Foundation, 2020). The literature supports the notion that parental involvement works best for children’s reading when the engagement period is more than six weeks and is more interactive than just correcting or checking homework (Nye et al, 2006). In relation to the IHC programme, this would imply that a structured home-school link, spanning the duration of the course, would be beneficial and serve to reinforce the learning. A caveat, however, is that engagement with it may vary from one family to another and could possibly fall along socio-economic lines as this has been the experience with other interventions (Education Endowment Foundation, 2020). This was reflected in the experience of the third school in this study, a disadvantaged school with a high level of EAL (English as an additional language) students, where the participating teacher reported that the Home-School link exercises provided in the contextualised IHC programme were not actively pursued.

**Thematic approach**

Fitting this programme into a crowded curriculum has been a core activity of this study as it was a significant concern raised by most stakeholders. This concern seems to be replicated in other jurisdictions too (Mugisha, 2016; Nsangi, 2019). The general consensus from stakeholders, after they engaged with the programme, was that the IHC aligns mostly with the Social Personal and Health Education (SPHE) curriculum. However, the ½ hour per week allocated to this subject immediately causes a problem for the IHC programme which requires 60 minutes or more per lesson to complete. As other subjects were mentioned by stakeholders, it became necessary to conduct a curricular mapping exercise to find any overlapping learning objectives between those of subjects in the Irish primary school curriculum and IHC. The mapping exercise revealed overlaps in three subjects from the Irish curriculum. The IHC could be viewed as a transdisciplinary integrated curriculum programme. This is where several traditional learning disciplines
are mixed up together in addressing an important real-world problem or question (Bacon, 2018). It is clear that children’s experiences, outside of the classroom, are generally not compartmentalizable by subject and this has implications for how they might best learn (Bacon, 2018). Rather than approaching knowledge through distinct subject areas, their learning benefits from starting in real world situations and making meaningful connections between units of subject matter (Jensen, 2005). This approach does seem to be mirrored by the proposed new structure of the National Curriculum, as laid out by the National Council for Curriculum and Assessment (NCCA, 2020). In their proposed restructuring, traditional subjects are categorised and regrouped in relation to their relevance to a list of key competencies for life that become, in effect the new aims of the proposed curriculum.

Given the broad definition the integrated curriculum implies (i.e. a combination of any two or more subject areas), it may be more helpful to review the intentions of the IHC programme through the lens of an integrated curriculum programme. Through narrative and discussion, the IHC programme develops the vocabulary of the students (and teacher) to be able to engage with and understand the core concepts it wishes to teach. A concept differentiates itself from a subject or a skill in that it can reach out and touch many curricular areas and contexts (Bacon, 2018). Accepting that this is a health literacy programme, the approaches used clearly make it a language programme too, making use of approaches and objectives common to first language learning (such as narrative, discussion and debate, and environmental text, etc). Recognising the value of the language elements of the IHC, and the approaches seen during classroom observations during this study indicated that much of it was delivered like a language programme (with vocabulary development, use of flashcards and word walls and referral back to the terminology during other lessons), allows the teacher as planner to rationalise the extra time allocated to this programme (in addition to the ½ hour per week allowed for SPHE) on the grounds of language learning. Viewing IHC in the light of an integrated curriculum approach makes its successful completion more achievable for teachers. Listing language as being part of that offering affords up to an additional 4.5 hours per week
available for timetabling the IHC programme (Government of Ireland, 1999a). In fact, an effect in Ireland of the Numeracy and Literacy Strategy, (2011), was to increase the pressure on teachers to focus more time on language and mathematics. Therefore, one of the only ways to effectively cover other subject areas was to double them up as a language lesson (McCoy et al, 2012). This approach holds true for IHC, and SPHE, Science and Language programme.

5.3.3 Getting past the gatekeepers.

*The importance of local leadership*

Middle management in Irish primary schools, with its origins in the early 1970’s, had been little more than an often-ineffectual seniority-based rite of passage for teachers until the turn of the century (Ryng, 2000). The last 20 years have seen the evolution of the appointment process away from disproportionate reliance on seniority to one which now also gives equivalent weight to the needs of the school and the abilities of the candidates (DES, 2003, 2010, 2016, 2017, 2018, 2019). The importance and influence of school leadership is second only to teacher quality in how it impacts on pupil achievement (Pricewaterhousecoopers, 2009). Leadership and staff selection play a key role in the level of success of implementing a new programme (Ingemarson et al, 2014). Teachers can take leadership roles in curricular and organisational areas (Darmody and Smith, 2016). For IHC, therefore, the way into schools is through these leaders, particularly given the increasing relevance of middle managers in Irish primary schools. References made by stakeholders in this study, indicating the need for an in-house ‘driver’ to advocate for the IHC
programme, would seem to support this. Therefore, the teacher preparation programme should invite the 5th class teacher(s) and a relevant member of management with duties that could overlap with IHC (if they are not the same person).

Short course, face to face teacher preparation programme delivery

The findings of this study imply that the teacher preparation programme model of delivery will play a significant role in the success or failure of the IHC programme in Irish schools. The preferred line of delivery mentioned by stakeholders was by means of a course/workshop where there would be direct engagement between a course facilitator and the practitioners in the school (i.e. the middle management leader and/or the implementing teachers). This form of CPD is generally perceived by teachers as a useful method of CPD delivery and also has a high participation rate (OECD, 2009). There is a pre-existing structure in the Irish Primary landscape for delivering this mode of CPD. In most cases, this is facilitated through the Professional Development Service for Teachers (PDST) and teacher engagement with CPD is voluntary, except where CPD is offered to support implementation of Government initiatives/programmes (de Paor & Murphy, 2018). The form of short course, face to face delivery envisaged by this study is seen as beneficial or very beneficial by 93% of teachers in Irish schools (de Paor & Murphy, 2018). In teachers’ experience, the CPD that most (45%) found to be the most effective was where it had relevance at a curricular or practice level (de Paor & Murphy 2018), which reinforces the point that curricular placement should be also emphasised at CPD level. The form of CPD proposed sits within National CPD policy guidelines (Teaching Council, 2011, pp19-21). The original IHC teacher preparation programme was a two day course. The redesigned teacher preparation programme for this study, a response to stakeholder feedback, provides a contextualised CPD solution that reflects best practice and the will of the teachers. It is shorter, relates the subject matter to the curriculum and deals with the content at a practice level (i.e. focussing on professional practice rather than spending a lot of time reading the narrative content).
5.3.4 This boat will sink without captains.

Most long-established systems, and education is no exception, tend to be conservative and inert in their nature (Hayes, 2000). At a national level, there is a significant amount of curricular pressure perceived by teachers and this has led to a resistance to engagement with additional programmes such as the Health Promoting School Award (Bennett et al., 2016). Add the increasing external pressures for performance cultures through higher accountability expectations, application of best practice and standardised approaches, teachers have become more conservative and risk averse in their curricular decisions (Sachs, 2016). Some stakeholders drew attention to the need for a nationwide implementation model for IHC. The findings discussed in this section shed further light on these issues.

*Involving the Department of Education in the delivery of IHC – Cascade Model*

Stakeholders in this study generally agreed that implementation mechanism most likely to succeed would be one launched at a national level by the Department of Education. Primary teachers in Ireland have a high level of regard for top-down curricular CPD by means of a face to face course, with over 80% viewing it as desirable and a similar percentage who make use of this means (de Paor & Murphy, 2018). The model teacher preparation arrived at as a recommendation in this study is not dissimilar to the Cascade model, where CPD is provided from a top-down perspective, with facilitators being trained who then deliver the training to practitioners (Hayes, 2000). Although a long-established model for large scale curricular change delivery in many countries (OECD, 1998), there have been concerns raised about the quality of knowledge transfer from expert to practitioner, particularly if there is room for interpretation as the information moves from one layer of expertise to the next (Dichaba & Mokhele, 2012). However, the cascade system has somewhat evolved in Ireland, involving close contact between management
and facilitators (PDST, 2019), and also between facilitators and teachers. This greater emphasis on communication and mentoring between the levels of expertise serves to mitigate the dilution effect on knowledge transfer seen in other cascade models (Turner et al, 2017). In operation, the IHC would provide a train the trainer service to PDST facilitators and provide ongoing support to them during the teacher training phase. These facilitators would then deliver the training to leaders and practitioners from the participating schools and provide ongoing support during the implementation phase. This would meet the intentions of stakeholders who called for a top-down CPD solution.

*How the IHC cascade model might look*

Figure 5.3.4 graphically represents the form of CPD envisaged by a top-down cascade model with opportunities for feedback and reciprocal communication. Following the process from left to right, the IHC would initiate the training of PDST facilitators and provide them with support as they begin their delivery of the programme to leaders and relevant teachers in schools. The facilitators would provide a level of support to those who have attended the teacher preparation programme days. During and post implementation in classrooms, schools would be able to contact the PDST for further support if deemed necessary:
Without this level of Department of Education support behind it, however, the path to ubiquitous implementation could be a long and slow one.

_Covid 19 as a Cultural Flashpoint_

On the question of whether the Irish Education System is receptive to a curricular change such as the IHC programme, some recent experiences in Ireland in relation to the Covid19 pandemic may have done more than just softened people’s views on the rigidity of definitions (‘Social distancing’ and ‘Cocooning’ have entered the vernacular as preventative treatments). Indeed, the recent traumatic experiences in Ireland and worldwide have served to highlight the need for a programme such as IHC. A set of extreme conditions that lead to an environment conducive to great change has been referred to as a cultural flashpoint (O’Sullivan, 2005). This can happen in education, or indeed other social arenas, laying bare fundamental assumptions, rendering worldviews, norms, and values more visible (Conway, 2013). Also referred to as a ‘perfect storm’ in education circles, the last time such an event occurred in Ireland was the combination of a worldwide recession and the 2009 Programme for International Student Assessment results (OECD, 2010). It
led to the production of a national numeracy and literacy plan with immediate implications for educational practice (Dep of Education, 2011). In a world where the lack of basic health literacy training at an appropriate age has resulted in the unfettered worldwide proliferation of misinformation, the need for change in this regard may become an irresistible force. It is precisely this kind of scenario that can lead to an effective mechanism for change, that being the political top-down application of change to the system (Bialik & Fadel, 2017)

5.4 Interprofessional Collaboration

5.4.1 What is it and why engage in one?

An interesting feature of this study is the origin sector (IHC was developed by experts from the health sector) and the intended beneficiary sector (the end-users are teachers and students in the primary education sector) are different. The development of the IHC programme was led, initially, by medical researchers to be implemented in primary schools by teachers for the benefit of their students. The drawing together of researchers from different professional sectors to work together on a research study is an example of an Interprofessional Collaboration (as is defined by the World Health Organisation, 1988). The genesis of this PAR study was under the umbrella of the Health Research Board – Trials Methodology Research Network (HRB-TMRN), with their mission to strengthen the methodology and reporting of trials in health and social care on the island of Ireland. This is done so that the work may become more relevant, accessible and influential for patients and other service users, practitioners, policy makers and the public (www.hrb-tmrn.ie, 2020). The intended end-users of the product of this study are the students in the care of the Department of Education and Skills. The IHC programme was developed by a similar collaboration between health researchers and teachers (Nsangi, 2017, 2020b). Collaboration is a term commonly used in research, clinical practice, and health professions
education. It is a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve common goals (Green and Johnson, 2015). Interprofessional and interorganizational collaboration have become important components of a well-functioning healthcare system (Karam et al, 2018). Given that today we are largely defined in relation to our profession, it is necessary to use those mechanisms of cooperation and communication in the professional environment, which leads to efficient and interprofessional teams (Alexandru, 2018). The World Health Organization (1988) also stated that interprofessional collaboration can promote interprofessional research, permit collective consideration of resource allocation according to need and ensure consistency in curriculum design (WHO, 1988, p. 16 – 17). Some of the findings, such as the differing understandings of definitions and perspectives of appropriate in-class activities, reflected the overlap points between two different professions. The differing perspectives mostly served to improve the learning experience, with both sides gaining valuable insights into how the other viewed the same thing.

5.4.2 The clash of parallel universes

Interprofessional collaborations are not without pitfalls though, with studies showing that working together can create ambiguous overlaps into who does what, and who is responsible for what (Schot et al, 2019). Schot et al (2019) outline best practice for managing the professional collaboration relationship with three characteristics appearing important in their systematic review:

- Participants actively engage in bridging professional, social and communication gaps. Being aware and taking account of these during interactions was seen as important.
- Where overlaps of duties and/or expertise occur, the responsibilities are negotiated between participants.
- Working together provides the need for professionals to organize the necessary space for interacting. It can be seen as facilitative to the first two items in this list.
The ability to communicate and cooperate was an evolutionary development in humans that gave them a competitive edge in the struggle for survival, and since then, the greatest achievements of mankind have been gained in teams (Alexandru, 2018). The sharing of professional space and the understanding of the gaps between the professions involved in this study was key to the effective delivery of its aim and objectives. Reflecting on the IHC textbooks, some of the time was spent relearning the meaning of words to develop health literacy vocabulary. The journey taken during this study has involved an interesting side quest of reassessing the researcher’s understanding of his own respective professional parallel universe through the lens of someone else’s. On reflection it has been fascinating to discover that, like a box of Lego blocks, even the simplest of words and phrases can be used to make very different meanings by different professions. Considering that people’s life experiences are not compartmentalised in the same way as the professions (e.g. school and health experiences bleed into each other and are not mutually exclusive), the professionals should be aware that their customers and practitioners from other professions may have quite a different understanding of language.

5.5 What Interests Does Public Education Now Serve?

Public education in Ireland, since its inception in the 1830’s, has been the site of a culture war where the competing national and religious interests struggled for dominance over the minds of the young (O'Donoghue, 2019). As discussed in Chapter 2, some subjects such as health literacy related ones (e.g. cooking, cleaning, self-care) found themselves incidental additions to the curriculum (Nolan, 2008; Walsh, 2016a). The 1971 and 1999 national curricula represented a shift from an internal struggle for self-identity to a more outward looking, holistic view of the child, with education focussed more on their interests rather than that of the state (Walsh 2016b; Government of Ireland, 1999a). There has always been a link between education and the
economic well-being of the population with progress through the secondary and tertiary levels being matched by progressive levels of employability and earnings (Barry, 2014). However, there has been a resurgence of a culture war of sorts in the last two decades in Ireland, with the attempt to reclaim education as a secular operation (Coolahan et al, 2012, pg. 105; O’Toole, 2015). There has also been a rise in the influence of economists over education systems through the proliferation of an international comparison culture, leading to an academic arms race between countries (Sellar & Lindgard, 2013). There has been a marked change in educational ideology to make policy decisions by the numbers, chasing the intangible and hard to prove rewards of climbing a few places on the global leader board (Ball, 2015). Given that the education agenda of most governments now equates the greater good with better international comparisons, and the Irish system currently finds itself in a state of cultural and curricular flux (Walsh, 2016a; National Council for Curriculum and Assessment, 2020) and is therefore open to change, the IHC must present in a way that fits into this landscape. The IHC programme is a public good that can provide quantifiable, evidence-based, internationally comparable results (Austvoll-Dahlgren et al, 2016a). It provides numbers and evidence and new learning. As per the Socio-Ecological model, the argument for inclusion of IHC in the national curriculum must be won at the personal, interpersonal, organisational and environmental level. Public education can sometimes miss the mark in its attempt to serve the public interest, but IHC is a programme that has the potential to serve the interests at all Socio-Ecological model levels.

5.6 The Cost-Benefit Question of IHC

The findings of this study have suggested that a top-down, Department of Education-led, Cascade model of CPD would be the method of implementation most likely to result in nationwide delivery. However, the most immediate concern for a government decision maker, once the academic and health literacy value of the IHC programme is established, would be the cost. A simplistic cost-benefit analysis will shed some light on the possible
net benefit to the country. Based on the quote received to provide 35X80pg A4 IHC student booklets, the projected cost to set up the IHC programme per classroom of 27 children would be €250 in resource acquisition. This is a once-off investment, as there is no writing in the books, and any future costs would be attributable to wear and tear. The cost of delivering a one day course to fifteen classrooms (30 attendees), including substitution, room hire and facilitator salary, would cost approximately €333 per classroom (with two people from that school trained).

Estimated cost of IHC Teacher Preparation Programme

<table>
<thead>
<tr>
<th>Student books</th>
<th>€8 X 27 =</th>
<th>€216</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teacher Guide</td>
<td></td>
<td>€34</td>
</tr>
<tr>
<td>Ancillary materials</td>
<td></td>
<td>€250</td>
</tr>
<tr>
<td>Substitute cover</td>
<td>30 x €150=</td>
<td>€4,500</td>
</tr>
<tr>
<td>Facilitator salary</td>
<td></td>
<td>€150</td>
</tr>
<tr>
<td>Room Rental</td>
<td></td>
<td>€50</td>
</tr>
<tr>
<td>Lunch</td>
<td>30 x €10 =</td>
<td>€300</td>
</tr>
<tr>
<td>Course Cost</td>
<td></td>
<td>€5000 total (€333 Per class)</td>
</tr>
</tbody>
</table>

Table 5.1

The cost of delivering this programme is estimated to be just short of €600 per class in year 1. A nationwide delivery, for a total of 3,500 schools, would cost around €2.1 million euro. This seems like a lot of money. Consider, however, that little or no resourcing or training will be needed in subsequent
years. Then consider what the cost of poor health literacy in the general population might be, with ill-informed choices made by the citizenry due to a lack of knowledge and understanding in this area. A figure can be attributed to this. Switzerland (a country comparable in size to Ireland), based on their own data, established that figure 10 years ago as 1.5 billion Swiss francs annually (1.4 billion Euro) (Kickbusch, 2009). Even if the cost of poor health literacy was a half or a third of that in Ireland, the investment in IHC remains tiny by comparison. At 1/3 of that cost cited by Kickbusch (2009), the cost in Ireland of poor health literacy would roughly translate to €90 per citizen. In a classroom of 27 citizens, providing the evidence based IHC programme costs just over €20 in the first year (with the cost dropping to a fraction of that in subsequent years with little or no resourcing needed for quite some time). The implication of this is that an Irish population, with IHC programme training, could be equipped to make better health decisions saving the government millions of euro in annual health expenditure.

5.7 From Knowledge to Behaviour Modification – Concluding Thoughts

The intended outcome of the IHC programme is that the students, with the knowledge and skills they have learned during the programme, will make more informed decisions about their health. The evidence is there that the students gain applicable knowledge from the IHC programme and that this effect continues for at least one year (Nsangi, 2020). It will be some time before it can be established if that knowledge translates into desired behaviour in adulthood. The transfer of knowledge into behaviours through health literacy programmes does occur. In their systematic review of 49 studies, Dudley et al (2015) found that most teaching strategies in relation to nutrition led to improved knowledge and behaviour. Dudley et al (2015) also found the most effective teaching strategies to be:

- enhanced curriculum (going beyond any existing health curriculum in the school, something that IHC does)
- experiential learning (engaging with real life examples, something that IHC achieves through case studies and relating to the students’ own life experience)
- cross-curricular learning (something, this study argues, IHC is in its nature).

School is a place where children should acquire health literacy skills and knowledge that they will be able to apply throughout their lives (Paakari et al, 2019). Health literacy in schools is a growing area of interest and is now seen as a vital point of contact to address the low health literacy levels found in all countries including wealthy ones (Vamos et al, 2020). The improvement of health literacy in children has been shown to lead to benefits at the personal, community and society level (Broder et al, 2017). In summary, all forms of targeted health literacy programmes have beneficial knowledge and behaviour effects and schools are an ideal place and time for this to happen. IHC makes use of the three most effective health literacy approaches and the benefits of implementing a programme like IHC occur at an personal, community and societal level.

5.8 What This Study Has Achieved

Since the late 1980’s humans are living in an ever more globalised world, where the barriers to the flow of trade, people and ideas have been chipped away (Mc Cann, 2018). An increasing number of events are experienced worldwide, such as global recession, global warming, global pandemics, and over relatively short periods of time (Ferguson et al, 2013). However, we still react and engage with those events on a local level. Tax and cut or borrow and spend? Cut emissions or develop new technologies? Slow the spread of disease or chase herd immunity?

Health is a global experience, as it has a universality in that everyone experiences good and/or bad health. With globalisation and the melting of
barriers, medicines can be more readily shared, medical tourism occurs, the spread of pandemics is facilitated (Cohen, 2013). The consequences of good and bad health are universal. The consequences of good and bad health decisions are universal. Yet our engagement with health is often individual and subject to our own bias and local/national influence. The Covid19 pandemic of 2020 is the epitome of this. A global experience reacted to differently in quality and speed by governments and citizens. At the time of writing this, governments and citizens who made health literacy informed decisions, such as South Korea and New Zealand, seemed to have better outcomes than those that did not, such as Brazil, USA and the UK.

The IHC programme recognises the universality of health literacy. It takes a set of globally useful skills (Key Concepts) and teaches them to primary school children. The IHC programme works and implementing it into every classroom in Ireland would be a well-informed decision. However, the IHC group recognises that decisions are not yet globally taken and this recognition is evident in the translating and contextualisation guides they now provide on their website (Rosenbaum et al, 2019a & 2019b).

This study has recognised that engagement with health literacy is still individually and locally driven. It explored the nature and quality of the IHC programme experience at an individual and local level in Ireland. It found ways and means to contextualise that experience with a view to improving engagement with and implementation of the resources. Finally, it applied most of the changes arising from those findings and provided a roadmap for future successful engagement in Ireland (see Recommendations, Chapter 6).
Chapter 6 - Recommendations and Conclusion

6.1 Introduction

The recommendations presented here have their origins in the findings from Chapter 4 and their rationale from Chapter 5 (Discussion). In this chapter the recommendations are described, and this description extends to include the practicalities of implementation and any implications for future practice. They are presented within the domains of the SEM. Many of these recommendations were implemented during the study to be explored in the final PAR cycle (this will be revisited in future work). Others also remain for future consideration. The proposed contextualised IHC as outlined in these recommendations has been presented to 3 participants of this study. All have agreed that the recommendations represent their views and suggest that further exploration within other schools in Ireland is required.

6.2 Recommendations (Actions as a result of PAR Cycles 1 and 2)
6.2.1 Personal - Try it, you’ll like it

The findings of this study indicate that most people liked the books but felt that they needed contextualisation.

It is recommended that:

- No adjustments be made to the aesthetics or the comic strip format and any changes, arising out of other recommendations, should try to have minimum impact on aesthetics.
- The names of some characters in the Student Textbook should be changed to more easily pronounced and Western ones to increase familiarity.
• The possibility should be considered that concerns expressed by teachers/stakeholders in relation to children finding the context/setting too alien might be unfounded and that not every change suggested is necessary in practice.

The Teacher Guide and Student Book are considered by stakeholders to be too big

**It is recommended to:**

• Adjust or edit content to reduce the amount of empty space.
• Explore a switch to a glossy A4 format, in line with the most common format for this kind of programme in Ireland, for the Children’s Book.
• Explore the possibility of an additional midway review chapter to create a 2-year cycle of 2X5 chapters.
• Reduce the level of prescription and detail in lesson outlines in the Teacher’s Guide.
• Provide a clear and succinct description of how the book was developed in the Teacher’s Guide.
• Reduce the amount of Children’s Book embedded in the Teacher’s Guide to key points in the lesson.

Findings suggest that it takes a while to see value in the programme.

**Associated recommendations:**

• The teacher training programme should be amended/adapted to include a session on the benefits of the IHC programme and resources within the Irish primary school setting.
• Incorporate positive end-user feedback quotes/data in the Teacher Training Programme presentation to highlight the positive experiences of those who have implemented the IHC programme.
The findings reveal a misunderstanding of the approach of this programme in relation to vocabulary and its function

**It is therefore recommended that:**

- The Teacher Training Programme needs to be adapted to include a section on the importance of broadening the definition of the word ‘Treatment’ in-class with the students. A reminder of this should also be included in the Teacher Guide.
- The Teacher Training Programme should include a focus on the glossary and the importance of the concept building approach (i.e. how the IHC programme uses simple words and definitions early in the book to create a solid foundation of understanding, which are later used as the building blocks for more complex concept building in the later chapters).
- Printable flashcards of the vocabulary should be provided in an digital format to the teachers.

The findings indicate that additional resources to supplement the IHC programme, including Irish specific examples, would be useful.

**Additional resources should be available to the teachers and these should include:**

- A list of additional Irish/Western narrative examples for improving relevance at stopping points such as discussions/activities/exercises.
- Ideas for linkage projects to other areas of the curriculum.
- A toolbox of methods for optional use throughout the Teacher Guide (A list of established in class approaches already known to teachers, such as the use of Environmental Text or the drama technique of ‘hot-seating’, that may work well with IHC).
- Additional printable posters for display during the weeks of the programme.
• Supporting resources that are made available online and in the Teacher Guide where feasible.

Skills transferability is seen as a key bonus to the content being taught

**Therefore, it is recommended that:**

• The Curricular map (see Findings Chapter) should include a transferable skills list that gives a similar visual overview of skill sets being developed by this programme (e.g. problem solving, critical thinking).
• The Teacher Training Programme needs to be adapted to ensure teachers become aware that although the topics covered are narrow and focused, the skills learned are transferable and lifelong.
• The Teacher Training Programme needs to be adapted to emphasise the need for the use of discussion as a learning tool.

6.2.2 Interpersonal – Something for everyone – Broadening the appeal

The findings highlight the lack of a structured Home-School link within the text

**It is recommended to:**

• Suggest to schools that they invite parents a talk about the IHC programme (e.g. by the class teacher) or have video clips online to introduce the programme (site location included in the letter home).
• Include a home-school link element/exercise within each lesson (e.g. a possible alternative use for some of the green boxes where translations may be removed).
• Produce an accompanying information sheet for distribution to parents in advance of the IHC programme in their child’s class.
The findings point toward a sense that the instructions and timetabling are overly prescriptive and that a greater recognition of teacher autonomy is needed.

**Associated recommendations:**

- The Teacher Training Programme needs to focus on the skills the teacher already uses in the classroom and to encourage teachers to be flexible and creative in their delivery of the IHC programme.
- The Teacher Guidelines and Teacher Training Programme should include a recognition of the need for differentiation.
- The Teacher Guide and Teacher Training Programme need to explicitly recognise and encourage Teacher autonomy (e.g. in choosing additional stopping points for discussion during a lesson).
- The Teacher Guide and Teacher Training Programme should advise the use of pre-existing methods for providing differentiation (e.g. Drop Everything And Read, or DEAR, where children who finish early can take out a book and silently read until the other students catch up). This could be included in the afore-mentioned toolbox of methods.

The findings suggest a curricular placement within SPHE but with a strong argument for viewing this programme as a cross-curricular thematic one.

**It is recommended that:**

- A curricular map should be developed to justify time taken from SPHE and other subject areas.
- The IHC should be re-branded in Ireland as an integrated learning theme programme rather than aligning it with any one subject.
6.2.3 Organisational – Getting past the gatekeepers

Findings indicate that how schools are engaged professionally with this programme will strongly influence its success and sustainability

Accordingly, it is recommended that:

- The Teacher Training Programme should include a module on practical issues for school implementation (i.e. describe a subject and a programme coordinator driven implementation structure).
- The Teacher Training Programme should be up to one school day in duration (4-5 hours of contact time).
- The Teacher Training Programme should be conducted face to face with every participating teacher present (i.e. all participating teachers should attend for training and not just a representative sample).

6.2.4 Environmental – This boat will sink without captains

Findings suggest that involving the Department of Education would be beneficial to the IHC programme

The following recommendations should be considered as system measures, presented in order of preference, to support the introduction and implementation of the IHC programme into Irish schools:

- Explore how the IHC programme can be included for consideration during the development of the next SPHE curriculum or National Curriculum Framework in a cascade model delivery.
  If not, then
- Explore with wider key stakeholders, the possibility of becoming a programme sanctioned/endorsed by the Department of Education and available to all schools (like Walk Tall, Blue Star Programme). One should also consider the possibility of endorsement by the Department of Health as an addition or an alternative.
  If not, then
• Provide a PDST style (Professional Development Service for Teachers) structural support for schools to opt in to. This is an established system in Ireland where a PDST facilitator with a curricular expertise may be booked for a visit to the school. During the visit, the facilitator can offer to discuss the IHC programme with individuals, groups or the whole school as well as modelling lessons and answering any questions.

The proposed contextualised IHC programme has been presented to 3 participants of this study. No further feedback was offered in relation to the recommendations suggested.
### 6.3 Summary Table of Recommendations

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Completed?</th>
<th>Further Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>No adjustments should be made to the aesthetics or the comic strip format and</td>
<td>Yes</td>
<td>This was applied as a guiding metric for other proposed changes.</td>
</tr>
<tr>
<td>any changes, arising out of other recommendations, should try to have minimum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>impact on aesthetics.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The possibility should be considered that concerns expressed by teachers/stakeholders in relation to children finding the context/setting too alien might be unfounded and that not every change suggested is necessary in practice.</td>
<td>Yes</td>
<td>The post-programme interviews with teachers and students supported this.</td>
</tr>
<tr>
<td>Change names of some characters in the Student Textbook to more easily</td>
<td>Yes</td>
<td>The more difficult to pronounce African names were changed to Irish or Western names in the Children’s Book.</td>
</tr>
<tr>
<td>pronounced and Western ones to increase familiarity.</td>
<td></td>
<td>Appendix 8</td>
</tr>
<tr>
<td>Adjust/Edit content to reduce the amount of empty space</td>
<td>Yes</td>
<td>As part of a restructuring of the Children’s Book.</td>
</tr>
<tr>
<td>Explore a switch to a glossy A4 format, in line with the most common format for</td>
<td>Yes</td>
<td>As part of a restructuring of the Children’s Book.</td>
</tr>
<tr>
<td>this kind of programme in Ireland, for the Children’s Book.</td>
<td></td>
<td>Appendix 8</td>
</tr>
<tr>
<td>Explore the possibility of an additional midway review chapter to create a 2-year</td>
<td>No</td>
<td>This will be explored in the next cycle of work (deferred due to the limitations imposed by COVID-19 and primary school closure).</td>
</tr>
<tr>
<td>cycle of 2X5 chapters.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the level of prescription and detail in lesson outlines in the Teacher’s</td>
<td>Yes</td>
<td>These were reduced significantly during the reworking of the Teacher’s Guide.</td>
</tr>
<tr>
<td>Guide.</td>
<td></td>
<td>Appendix 9</td>
</tr>
<tr>
<td>Provide a clear and succinct description of how the book was developed in the</td>
<td>Yes</td>
<td>Completed as part of providing a series of additional contextualised resources.</td>
</tr>
<tr>
<td>Teacher’s Guide.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduce the amount of Children’s Book embedded in the Teacher’s Guide to key</td>
<td>Yes</td>
<td>This was reduced significantly during the reworking of the Teacher’s Guide.</td>
</tr>
<tr>
<td>points in the lesson.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The teacher training programme should be amended/adapted to include a session on the benefits of the IHC programme and resources within the Irish primary school setting.</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Incorporate positive end-user feedback quotes/data in the Teacher Training Programme presentation to highlight the positive experiences of those that have implemented the IHC programme.</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Training Programme needs to be adapted to include a section on the importance of broadening the definition of the word ‘Treatment’ in class with the students. A reminder of this should also be included in the Teacher Guide.</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Training Programme should include a focus on the glossary and the importance of the concept-building approach (i.e. how the IHC programme uses simple words and definitions early in the book to create a solid foundation of understanding, which are later used as the building blocks for more complex concept-building in the later chapters).</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>Printable flashcards of the vocabulary should be provided in an online format to the teachers.</td>
<td>Yes</td>
<td>Provided printed flashcards for Cycle 2 but a pdf is included with the additional contextualised resources. Appendix 10</td>
</tr>
<tr>
<td>Teacher Guidelines to provide a list of additional Irish/Western narrative examples for improving relevance at stopping points such as discussions/activities/exercises.</td>
<td>Yes</td>
<td>Completed as part of providing a series of additional contextualised resources. Appendix 10</td>
</tr>
<tr>
<td>It is recommended that these supporting resources should be made available online and in the Teacher Guide where feasible.</td>
<td>Yes (by IHC) online</td>
<td><a href="https://www.informedhealthchoices.org/">https://www.informedhealthchoices.org/</a> already provides some online resources associated with the IHC programme. Additional resources developed during this study can be added to the already existing online platform.</td>
</tr>
<tr>
<td>Ideas for linkage projects to other areas of the curriculum.</td>
<td>No</td>
<td>This will be explored in the next cycle of work (deferred at present due to the limitations imposed by COVID-19 and primary school closure).</td>
</tr>
<tr>
<td>Task Description</td>
<td>Action</td>
<td>Status</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------------</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>A toolbox of methods (A list of established in class approaches already known to teachers, such the use of Environmental Text or the drama technique of ‘hot seating’, that may work well with IHC) for optional use throughout the Teacher Guide.</td>
<td>No</td>
<td>This will be explored in the next cycle of work (deferred at present due to the limitations imposed by COVID-19 and primary school closure).</td>
</tr>
<tr>
<td>Additional printable posters for display during the weeks of the IHC programme.</td>
<td>Yes</td>
<td>Completed as part of providing a series of additional contextualised resources. Appendix 10</td>
</tr>
<tr>
<td>The Curricular map (see Findings Chapter) should include a transferable skills list that gives a similar visual overview of skill sets being developed by this programme (e.g. problem solving, critical thinking).</td>
<td>No</td>
<td>This will be explored in the next cycle of work (deferred at present due to the limitations imposed by COVID-19 and primary school closure).</td>
</tr>
<tr>
<td>The Teacher Training Programme needs to be adapted to ensure teachers become aware that although the topics covered are narrow and focused, the skills learned are transferable and lifelong.</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Training Programme needs to be adapted to emphasise the need for the use of discussion as a learning tool.</td>
<td>Yes</td>
<td>Completed as part of the redevelopment of the Teacher Training Session for Cycle 2. Appendix 4</td>
</tr>
<tr>
<td>Suggest to schools that they invite parents in to hear a speaker on the IHC programme (e.g. class teacher) or have video clips online to introduce the programme (site location included in the letter home).</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>Include a Home-School link element/exercise within each lesson (e.g. a possible alternative use for some of the green boxes where translations may be removed).</td>
<td>Yes</td>
<td>As part of a restructuring of the Children’s Book. Appendix 8</td>
</tr>
<tr>
<td>Produce an accompanying information sheet for distribution to parents in advance of the programme in their child’s class.</td>
<td>No</td>
<td>This will be explored in the next cycle of work (deferred at present due to the limitations imposed by COVID-19 and primary school closure).</td>
</tr>
<tr>
<td>The Teacher Training Programme needs to focus on the skills the teacher already uses in the classroom and to encourage teachers to be flexible and creative in their delivery of the IHC programme.</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>Suggestion</td>
<td>Yes/No</td>
<td>Notes</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>--------</td>
<td>-----------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>The Teacher Guidelines and Teacher Training Programme should include a recognition of the need for differentiation.</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Guide and Teacher Training Programme need to explicitly recognise and encourage Teacher autonomy (e.g. in choosing additional stopping points for discussion during a lesson).</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Guide and Teacher Training Programme should advise the use of pre-existing methods for providing differentiation (e.g. Drop Everything And Read, or DEAR, where children who finish early can take out a book and silently read until the other students catch up). This could be included in the aforementioned toolbox of methods.</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>A curricular map should be developed to justify time taken from SPHE and other subject areas.</td>
<td>Yes</td>
<td>Completed as part of providing a series of additional contextualised resources. See Findings Chapter (Section 4.3.2)</td>
</tr>
<tr>
<td>The IHC should be re-branded in Ireland as an integrated learning theme programme rather than aligning it with any one subject.</td>
<td>No</td>
<td>This is an implication for future practice.</td>
</tr>
<tr>
<td>The Teacher Training Programme should include a module on practical issues for school implementation (i.e. describe a subject and a programme coordinator driven implementation structure).</td>
<td>Yes</td>
<td>Included in the Teacher Training Session. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Training Programme should be up to one school day in duration (4-5 hours of contact time).</td>
<td>Yes</td>
<td>The redeveloped Teacher Training Session is under 1 day. Appendix 4</td>
</tr>
<tr>
<td>The Teacher Training Programme should be conducted face to face with every participating teacher present (i.e. all participating teachers should attend for training and not just a representative sample).</td>
<td>Yes</td>
<td>This is required for the Teacher Training Session.</td>
</tr>
<tr>
<td>Explore how the IHC programme can be included for consideration during the development of the next SPHE curriculum or the new National Curriculum Framework.</td>
<td>No</td>
<td>This is an implication for future practice.</td>
</tr>
</tbody>
</table>
Explore, with wider key stakeholders, becoming a programme sanctioned or endorsed by the Department of Education and available to all schools (like Walk Tall, Blue Star Programme). One should also consider the possibility of endorsement by the Department of Health as an addition or alternative.

<table>
<thead>
<tr>
<th></th>
<th>No</th>
<th>This is an implication for future practice.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide a PDST style (Professional Development Service for Teachers) structural support for schools to opt in to. This is an established system in Ireland where a PDST facilitator with a curricular expertise may be booked for a visit to the school. During the visit, the facilitator can offer to discuss the IHC programme with individuals, groups or the whole school as well as modelling lessons and answering any questions.</td>
<td>No</td>
<td>This is an implication for future practice.</td>
</tr>
</tbody>
</table>
6.4 Limitations of this study

As with any research in the real world there are several limitations associated with this work and they must be acknowledged.

The number of participants were small and the schools although socioeconomically diverse were not geographically spread across Ireland, and while in keeping with the tenants of qualitative research underpinning the PAR, it must be noted as a consequence of this that the actions arising within the cycles require further and wider exploration.

As has been recorded in this dissertation the COVID-19 pandemic and the subsequent closure of schools impacted on the 2nd Cycle of this study. While every effort was made to plan and re-plan in relation to the disruption in fieldwork, schools did not open for the remainder of the academic year. As a result, all Actions (Implications) arising from Cycle 1 (and Cycle 2) will require further exploration in the research field.

The Actions of this study focus, for the most part, on the data provided by the adult stakeholders. The children offered less insights into changes they deemed vital. This may be reflective of the particular participants of the study or indeed perhaps is normal within the culture of classrooms in Ireland where children accept the programs presented to them. However, it is vital to acknowledge that further exploration of children’s views and experiences are required.

6.5 Conclusions and Implications for Future Practice

Positionality of the researcher after the study

Seeing the IHC programme in action in Irish schools has further confirmed the importance of Health Literacy education in the researcher’s mind. It seems to serve multiple purposes that are individually important (e.g.
language development, scientific method, analysis) but also add up to a greater good (e.g. confidence, critical thinking, engagement). The IHC is like a sandbox, where children engage with these skills and competencies within the safety of a structured programme. Any or all of these skills and competencies can be taken with them out into the real world. Children and teachers who fully engage with this programme also seem to develop a deep understanding of the need for, and usefulness of, RCT. It is truly a worthwhile programme that should be promoted and spread throughout Ireland.

Rebranding

The IHC programme has been contextualised to the Irish Primary context and is ready for further development and inclusion as part of a trail in line with the work being done in other countries. Although there may be further modifications required to the IHC programme, the core focus in the future will centre on the mechanisms used to ease this programme into common use. Key to the success of this will be the re-branding of the IHC programme so that it will be seen as much more than just a health literacy programme by teachers. In this regard, the diversity of setting and narrative can be used as a strength providing the teacher with integration and linkage opportunities with other areas of the curriculum.

From the perspective of policy makers, the current Covid19 crisis has probably prepared the ground for a programme like IHC. There has been a wave of misinformation following the virus around the globe with ordinary citizens, including children, parents and teachers, having to decide what to believe. The skills taught by the IHC programme would improve their chances of making better decisions in that regard. Accordingly, this programme can be presented to them with the emphasis on the health literacy benefits. A positive decision is made easier by having a ready-made, evidence-based programme that has the added benefits of being cross-curricular and is already contextualised for the Irish primary school.
The IHC programme has been reviewed by stakeholders and adapted for a better fit to the Irish primary school landscape. Given how well the IHC programme was received by teachers and students, both before and after contextualisation, part of any future development should include a consideration for inclusion as an obligatory programme in the next Irish primary curriculum. This would be the most effective means of getting into Irish classrooms. The implications of making good health choices are wide ranging from ensuring personal health to the promotion of the economic interests of a nation. A health literate population should be made a high priority of the Irish government and the IHC programme provides an effective evidence-based first step in that regard. Embedding the contextualised IHC programme in the national curriculum would provide a sustainable structural support and the positive effects would linger for generations to come. This route could see IHC in every classroom within five years.

In the absence of getting a directive from the Department of Education, an endorsement for the IHC should be sought as a programme that fits the intentions of the National Curriculum. This could be done through the promotion of the IHC programme by NEPS (National Educational Psychology Service) or the PDST (Professional Development Service for Teachers), both of which are government-funded organisations. It would not guarantee saturation, but it would set the IHC programme up as a best practice option for schools. Under these conditions, the growth in use of the IHC programme would be accelerated over no intervention. This route could see the IHC programme in most schools in 5-10 years.

The final option is to release the IHC programme without any stated or structural support from the government. This would involve making it freely available and promoting it through media and at conferences. This would be the least effective route and it would be hard to predict how long this might take. It should be considered as an option if the previously mentioned avenues
are unsuccessful. It faces the most risk, requiring the IHC programme to take root in a crowded and competitive market, that of the curricular-overloaded Irish classroom.

Importance of the IHC during a Global Pandemic – Personal Reflection

Ireland was fortunate during the onset of the Covid19 pandemic to have a medical doctor in the position of Taoiseach (Prime Minister). Accordingly, decisions were strongly influenced by health research and advice. Not every world leader has medical training, but it could be argued that some other countries might have made better decisions if their leaders had completed an IHC-like programme when they were children. Whether on a national or individual level, the pandemic exposed the dangerous gap in learning that a programme such as IHC could have bridged. The virus of health misinformation has possibly circled the globe more times than Covid 19. The World Health Organisation was compelled to address and debunk over 20 of the most pervasive and dangerous claims associated with Covid19 (WHO, 2020). In Ireland, the iHealthFacts website was developed by the HRB-TMRN, Evidence Synthesis Ireland and Cochrane Ireland to enable the public to verify the reliability and current evidence of health claims (www.ihealthfacts.ie, last accessed 26/07/20). We have all been repeatedly exposed to claims during this crisis ranging from washing our grocery shopping, through the wearing of masks and gloves, to the more sinister ingestion of disinfectant. This kind of pandemic was always a possibility and a programme like IHC would have helped equip people with the skills to recognise claims with a bad basis. In the face of our shared experience (that of the decision-makers and the citizenry alike) during the first half of 2020, the value of this kind of evidence-based programme has vastly increased. The time is right for the contextualised IHC programme in Ireland.
References


Careersportal.ie (accessed 24/11/19) Points required for Education – Primary Teaching in Mary Immaculate College.


Department of Education, (2011) Literacy and Numeracy for Learning and Life. Published by Department of Education and Skills.


Government of Ireland, (1937) Bunreacht na hÉireann. Article 42.1.


About iHealthFacts. www.ihealthfacts.ie/about-us/ (last accessed 26/07/20)


Mc Daid, D., (2016) POLICY BRIEF 19 - Investing in health literacy: What do we know about the co-benefits to the education sector of actions targeted at children and young people? Published by the World Health Organization, Denmark.


NCSE - National Council for Special Education (2019) Policy Advice on Special on Special Schools and Classes – An Inclusive Education for and Inclusive Society?


National Principals’ Forum (last accessed 24/11/19) Results of 2018 Survey of Principals.


OECD (2010), PISA 2009 Results: Executive Summary.


Sorenson, K., Van Der Broucke, S., Fullam, J., Doyle, G., Pelikan, J., Slonska, Z., Brand, H., for (HLS-EU) Consortium Health Literacy Project


Unesco website with statistics for primary school children numbers (accessed 20/7/19).


Appendices
Appendix 1 – Overview of the IHC Key Concepts

1. Claims
Claims about effects that are not supported by evidence from fair comparisons are not necessarily wrong, but there is an insufficient basis for believing them.

1.1 It should not be assumed that treatments are safe or effective - or that they are not.
a) Treatments can cause harms as well as benefits.
b) Large, dramatic effects are rare.
c) It is rarely possible to be certain about the effects of treatments.

1.2 Seemingly logical assumptions are not a sufficient basis for claims.
a) Treatment may not be needed.
b) Beliefs alone about how treatments work are not reliable predictors of the presence or size of effects.
c) Assumptions that fair comparisons of treatments in research are not applicable in practice can be misleading.
d) An outcome may be associated with a treatment but not caused by it.
e) More data is not necessarily better data.
f) Identifying effects of treatments depends on making comparisons.
g) The results of one study considered in isolation can be misleading.
h) Widely used treatments or those that have been

2. Comparisons
Studies should make fair comparisons, designed to minimize the risk of systematic errors (biases) and random errors (the play of chance).

2.1 Comparisons of treatments should be fair.
a) Comparison groups should be as similar as possible.
b) Indirect comparisons of treatments across different studies can be misleading.
c) The people being compared should be cared for similarly apart from the treatments being studied.
d) If possible, people should not know which of the treatments being compared they are receiving.
e) Outcomes should be assessed in the same way in all the groups being compared.
f) Outcomes should be assessed using methods that have been shown to be reliable.
g) It is important to assess outcomes in all (or nearly all) the people in a study.
h) People’s outcomes should be counted in the group to which they were allocated.

2.2 Syntheses of studies need to be reliable.
a) Reviews of studies comparing treatments should use systematic methods.

3. Choices
What to do depends on judgements about a problem, the relevance of the evidence available, and the balance of expected benefits, harms, and costs.

3.1 Problems and options should be clear.
a) Be clear about what the problem or goal is and what the options are.

3.2 Evidence should be relevant.
a) Attention should focus on all important effects of treatments, and not surrogate outcomes.
b) Fair comparisons of treatments in animals or highly selected groups of people may not be relevant.
c) The treatments compared should be similar to those of interest.
d) There should not be important differences between the circumstances in which the treatments were compared and those of interest.

3.3 Expected advantages should outweigh expected disadvantages.
a) Weigh the benefits and savings
used for decades are not necessarily beneficial or safe.

i) Treatments that are new or technologically impressive may not be better than available alternatives.

j) Increasing the amount of a treatment does not necessarily increase its benefits and may cause harm.

k) Earlier detection of ‘disease’ is not necessarily better.

l) It is rarely possible to know in advance who will benefit, who will not, and who will be harmed by using a treatment.

1.3 Trust in a source alone is not a sufficient basis for believing a claim.

a) Your existing beliefs may be wrong.

b) Competing interests may result in misleading claims.

c) Personal experiences or anecdotes alone are an unreliable basis for most claims.

d) Opinions alone are not a reliable basis for claims.

Peer review and publication by a journal do not guarantee that comparisons have been fair.

b) Failure to consider unpublished results of fair comparisons may result in estimates of effects that are misleading.

c) Treatment claims based on models may be sensitive to underlying assumptions.

2.3 Descriptions should clearly reflect the size of effects and the risk of being misled by the play of chance.

a) Verbal descriptions of the size of effects alone can be misleading.

b) Relative effects of treatments alone can be misleading.

c) Average differences between treatments alone can be misleading.

d) Small studies may be misleading.

e) Results for a selected group of people within a study can be misleading.

f) The use of p-values may be misleading; confidence intervals are more informative.

g) Deeming results to be “statistically significant” or “nonsignificant” can be misleading.

h) Lack of evidence of a difference is not the same as evidence of “no difference”.

against the harms and costs of acting or not.

b) Consider the baseline risk or the severity of the symptoms when estimating the size of expected effects.

c) Consider how important each advantage and disadvantage is when weighing the pros and cons.

d) Consider how certain you can be about each advantage and disadvantage.

Important uncertainties about the effects of treatments should be addressed in further fair comparisons

---

The Informed Health Choices Group (2019)
Appendix 2 – Information Packs
Letter of introduction to stakeholders:

Health Research Board-Trials Methodology Research Network
School of Nursing & Midwifery, 
NUI Galway

Date: 18/06/2018

Dear Stakeholder,

My name is Dara Glynn. I am a MPhil Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis.

I would like to invite you to participate in a study contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System.

Before you decide whether you want to take part please read the included Participant Information Leaflet and Consent Form. I am happy to provide more information to answer any questions you may have.

Looking forward to hearing from you and thank you for taking time to consider my request.

__________________________
Dara Glynn
Letter of introduction to parents:

Health Research Board-Trials Methodology Research Network
School of Nursing & Midwifery,
NUI Galway

Date: 10/01/2020

Dear Parent / Guardian,

My name is Dara Glynn. I am a MPhil Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis.

I would like to invite your child to participate in a study contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System.

Before you decide whether you would like your child to take part please read the included Participant Information Leaflet and Consent Form. I am happy to provide more information to answer any questions you may have.

Looking forward to hearing from you and thank you for taking time to consider my request.

__________________________

Dara Glynn
Letter of introduction to students:
Health Research Board-Trials Methodology Research Network
School of Nursing & Midwifery,
NUI Galway

Date: 10/01/2020

Dear Member of 5th Class,

My name is Dara Glynn. I am a MPhil Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis.

I would like to invite you to take part in a study about a school programme called Informed Health Choices.

I’ve included some more information for you and for your parent / guardian. Read it together and I am happy to provide more information to answer any questions ye may have.

Looking forward to hearing from you!

__________________________
Dara Glynn
Informed Health Choices

Thank You!

ADAPTING THE RESOURCE FOR USE IN IRISH SCHOOLS
Hi there!

My name is Dara Glynn. I am a Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis.

I would like to invite you to take part in a study about the Informed Health Choices (IHC) programme.

Before you decide if you’d like to take part I would like to tell you why this research is being done and what you can expect if you take part.

**What is the purpose of this study?** This study wants to give you the chance to take part in the IHC programme which has been run in a number of other countries but you would be the first Irish students to try it out. With your help, we want to see if the IHC programme would be good for more Irish schools to try out.

**Why have I been invited to participate?** Because you are in an Irish school! Also, because the researcher works in a school not too far from your own.

**Do I have to take part?** No, it is your choice. I have also sent information to your parent / guardian to get their permission for you to take part.

**What is involved with taking part?** I would like to talk to you, with a group of your class mates (no more than 6) about the IHC programme while you’re doing it and after you finish it. I will ask you about what you think and if there’s anything that can be done to improve it. You will also have a questionnaire to complete at the end of the programme. I will also be in the classroom with another researcher for some of the lessons to see the programme in action.

**What will the interview be like?**

The interview will be a bit like a group chat but it will be tape recorded. Everyone will get a chance to talk and we will listen to what everyone has to say. We can stop or you can leave the group interview at any time and return to your classroom.

**Any reason why I can’t take part?**

As well as yourself, your parent / guardian needs to sign that it is ok for you take part in this study.

**Will anyone know that I have taken part in this study?**

No one (outside your parents and teacher) will know what schools or what students took part in this study.
**Will anyone know that I have taken part in this study?**

No, your identity will remain confidential; your name will not be published and will not be given to anyone outside the research team. All information will be stored in accordance with the Data Protection Act. However, you are free to discuss your participation with others if you choose.

**Is there any compensation associated with this study?**

No, nothing in this document restricts or curtails your rights. Your school will be offered the cost of two days of substitute cover, one to allow you to attend CPD in the delivery of the contextualised programme and one day for you to plan the implementation of the programme.

**Stopping the Study**

The likelihood of the researchers stopping the study, or your participation in it, is very low.

**Who has reviewed this study?**

The protocol for this study has been peer reviewed by researchers in another university. This study has received ethical approval from the Research Ethics Committee at NUI Galway.

**Where can I get more information?**

You can get more information or answers to your questions about this study, your participation in this study from Dara Glynn who can be telephoned at 085 7624724 and emailed at d.glynn.16@nuigalway.ie

If the research team learns of important new information that may affect your desire to remain in the study you will be informed at once.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie

You may also contact the research supervisor for this study, Dr. Linda Bierly, by email at linda.bierly@nuigalway.ie
My name is Dara Glynn.

I am an MPhil Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis. I would like to invite you to participate in a study contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System. Before you decide whether you want to take part I would like to tell you why this research is being done and what you can expect if you take part.

What is the purpose of this study? We are all regularly bombarded with advertisements and circulars about the benefits of a variety of treatments. Even as adults, we find it difficult to separate the truth from the fiction. Informed Health Choices (IHC) is a free, evidence-based school programme that equips primary school children with skills to critically appraise health claims made by individuals or companies. We want to fine-tune the content and/or delivery of this programme for the Irish Primary School System.

Why have I been invited to participate? Your school was chosen as a typical example of a primary school in Ireland.

Do I have to take part? No, it is your choice whether you take part or not. If you decide to take part, you will be asked to sign a consent form, and you are still free to withdraw from the study at any time without giving a reason.

What is involved with taking part? Please contact me and I will answer any outstanding questions you have about this research study. I will contact you, no sooner than a week after you receive this information, and if you are willing to participate we can make the necessary arrangements. You will be given a digital copy of the student book, teachers’ manual and associated IHC resources and are asked to join a focus group, meeting as a group or for individual interview no more than 5 times over the 18 months of this study. You will be asked for feedback on the content and delivery of the programme and then on that of the contextualised programme. If your class is running the programme, then there will also be some non-participatory observation by the researchers so that they can see the programme in action on the ground.

What will the interviews be like? The interview will be a bit like a conversation but it will be tape recorded. I will ask you to talk freely of your opinions and later on your experiences of participating in the IHC programme, what is good about the experience, what could be different, the learning that has occurred. You can bring to the interview anything that helps you describe how you have responded to the IHC programme. The time it takes for an interview varies and will be influenced by how much you would like to say. You are free to stop/ withdraw from the interview at any point.

How will the information from the interview be used? The experiences and discussions which emerge from the interviews will be analysed and will inform the findings and actions of this study. The study will be written up and a report will be issued to the HPB, TNBH and to the School of Nursing & Midwifery at NUI Galway. There may also be publications in peer reviewed journals and conference presentations. The report, publications and presentations will include summaries and anonymised quotes for some interviews. You may, if you wish, ask for a summary of the findings.

Are there any benefits associated with participating in this study? The aim of the IHC programme is to equip the children with really useful critical thinking skills and help them to make more informed choices about treatments. Participating in this study will help us maximise the benefits of this programme for Irish children who complete it. The students in your class will be the first Irish students to benefit from this contextualised programme.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participating? You cannot participate in this study if any of the following are true:

- You have not consented to participate in this research study.
Parent Information Leaflet

Will anyone know that my child has taken part in this study? No. Your child’s identity will remain confidential; his / her name will not be published and will not be given to anyone outside the research team. All information will be stored in accordance with the Data Protection Act. However, you are free to discuss your child’s participation with other if you choose.

Is there any compensation associated with this study? No, nothing in this document restricts or curtails your child’s rights.

Stopping the Study: The likelihood of the researchers stopping the study, or your participation in it, is very low.

Who has reviewed this study? The protocol for this study has been peer reviewed by researchers in another university. This study has received ethical approval from the Research Ethics Committee at NUI Galway.

Where can I get more information? You can get more information or answers to your questions about this study, your participation in this study from Dara Glynn who can be telephoned at 085 7624724 and emailed at d.glynn16@nuigalway.ie

If the research team learns of important new information that may affect your desire to remain in the study you will be informed at once.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie

You may also contact the research supervisor for this study, Dr. Linda Biesty, by email at linda.biesty@nuigalway.ie

Informed Health Choices

ADAPTING THE RESOURCE FOR USE IN IRISH SCHOOLS
My name is Dara Glynn.

I am a MPhil Student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis. I would like to invite you to participate in a study contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System. Before you decide whether you want to take part I would like to tell you why this research is being done and what you can expect if you take part.

What is the purpose of this study? We are all regularly bombarded with advertisements and advertorials about the benefits of a variety of treatments. Even as adults, we find it difficult to separate the truth from the fiction. Informed Health Choices (IHC) is a free, evidence-based school programme that equips primary school children with skills to critically appraise health claims made by individuals or companies. We want to fine-tune the content and/or delivery of this programme for the Irish Primary School System.

Why has my child been invited to participate? Your school was chosen as a typical example of an Irish Primary School and is within a short driving distance from my place of work.

Does my child have to take part? No, it is your choice whether your child takes part or not. If you decide it is ok for him/her to take part you will be asked to sign a consent form, you are still free at any time to withdraw your consent from the study without giving a reason.

What is involved with taking part? Please contact me and I will answer any outstanding questions you have about this research study. I will contact you, no sooner than a week after you receive this information, and if you are willing to participate we can make the necessary arrangements with the school. I would like to ask your child, in a group interview (called a focus group) with up to 6 other children, about their experiences of participating in the IHC programme. To gain an insight into their experiences I would like to do a group interview on 3 occasions during the course of the programme. The research team will link in with the school in relation to the dates and times of these interviews. There will also be some non-participatory observation by the researchers so that they can see the programme in action on the ground.

What will the interview be like? The interview will be a bit like a group conversation but it will be tape recorded. I will ask everyone to talk freely of their experiences of participating in the IHC programme, what is good about the experience, what could be different, the learning that has occurred.

The time it takes for an interview varies and will be influenced by how much the group would like to say. Anyone is free to stop/withdraw from the interview at any point. A researcher will conduct the focus group interview, the other researcher will observe the group and ensure that the children participating in the group are comfortable.

How will the information from the interview be used? The experiences and discussions which emerge from the interviews will be analysed and will inform the findings and actions of this study. The study will be written up and a report will be issued to the HSE-TMRN and to the School of Nursing & Midwifery at NUI Galway. There may also be publications in peer reviewed journals and conference presentations. The report, publications and presentations will include summaries and anonymised quotations for some interviews. You may, if you wish, ask for a summary of the findings.

Are there any benefits associated with participating in this study? The aim of the IHC programme is to equip the children with really useful critical thinking skills and help them to make more informed choices about treatments. Participating in this study will help us maximise the benefits of this programme for Irish children who complete the programme. The students in your child’s class will be the first Irish students to benefit from this contextualized programme.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participating? Your child cannot participate in this study if:

- Your child has not consented to participate in this research study
- You as a parent/guardian have not consented for them to participate in this research study
Will anyone know that I have taken part in this study?

No. Your identity will remain confidential; your name will not be published and will not be given to anyone outside the research team. All information will be stored in accordance with the Data Protection Act. However, you are free to discuss your participation with others if you choose.

Is there any compensation associated with this study?

No, nothing in this document restricts or curtails your rights.

Stopping the Study

The likelihood of the researchers stopping the study, or your participation in it, is very low.

Who has reviewed this study?

The protocol for this study has been peer reviewed by researchers in another university. This study has received ethical approval from the Research Ethics Committee at NUI Galway.

Where can I get more information?

You can get more information or answers to your questions about this study, your participation in this study from Dara Gynn who can be telephoned at 085 7624724 and emailed at d.gynn16@nuigalway.ie

If the research team learns of important new information that may affect your desire to remain in the study you will be informed at once.

If you have any concerns about this study and wish to contact someone independent and in confidence, you may contact the Chairperson of the NUI Galway Research Ethics Committee, c/o Office of the Vice President for Research, NUI Galway, ethics@nuigalway.ie

You may also contact the research supervisor for this study, Dr. Linda Blesky, by email at linda.blesky@nuigalway.ie
My name is Dara Ginn.

I am a MPhil student at the School of Nursing & Midwifery in NUI Galway. I am also the Principal of CBS Primary in Ennis. I would like to invite you to participate in a study contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System. Before you decide whether you want to take part I would like to tell you why this research is being done and what you can expect if you take part.

What is the purpose of this study? We are all regularly bombarded with advertisements and adversitement about the benefits of a variety of treatments. Even as adults, we find it difficult to separate the truth from the fiction. Informed Health Choices (IHC) is a free, evidence-based school programme that equips primary school children with skills to critically appraise health claims made by individuals or companies. We want to fine-tune the content and/or delivery of this programme for the Irish Primary School System.

Why have I been invited to participate? You have been asked as a stakeholder and as part of a representative sample of the Irish Primary School System.

Do I have to take part? No, it is your choice whether you take part or not. If you decide to take part you will be asked to sign a consent form, you are still free at any time to withdraw from the study without giving a reason.

What is involved with taking part? Please contact me and I will answer any outstanding questions you have about this research study. I will contact you no sooner than a week after you receive this information, and if you are willing to participate we can make the necessary arrangements. You will be given a digital copy of the student book, teacher’s manual and associated IHC resources and are asked to join a focus group meeting as a group or for individual interviews no more than 5 times over the 18 months of this study. You will be asked for your feedback on the content and delivery of the programme and then on that of the contextualised programme. If your class is running the programme, then there will also be some non-participatory observation by the researchers so that they can see the programme in action on the ground.

What will the interviews be like? The interview will be a bit like a conversation but it will be tape recorded. I will ask you to talk freely of your opinions.

The time it takes for an interview varies and will be influenced by how much you would like to say. You are free to stop/withdraw from the interview at any point.

How will the information from the interview be used? The experiences and discussions which emerge from the interviews will be analysed and will inform the findings and actions of this study. The study will be written up and a report will be issued to the FHR-TMRN and to the School of Nursing & Midwifery at NUI Galway. There may also be publications in peer-reviewed journals and conference presentations. The report, publications and presentations will include summaries and anonymised quotations for some interviews. You may, if you wish, ask for a summary of the findings.

Are there any benefits associated with participating in this study? The aim of the IHC programme is to equip the children with really useful critical thinking skills and help them to make more informed choices about treatments. Participating in this study will help us maximise the benefits of this programme for Irish children who complete it. The students in the participating classes will be the first Irish students to benefit from this contextualised programme.

Are there any risks associated with participating in this study? None anticipated.

Who is excluded from participating? You cannot participate in this study if any of the following are true:

- You have not consented to participate in this research study
Consent Form for Teachers Participating in Interviews

Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System

Principal Researcher: Dara Glynn

Declaration (Please read and tick if you agree):

I have read the study information leaflet

I have read and understand this consent form

I have had the opportunity to ask questions

All my questions have been answered to my satisfaction

I understand that taking part in this research involves focus group and/or 1:1 recorded interviews and non-participatory observation of some lessons by the researchers

I understand that that I can access my interview transcripts

I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential

I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights

I have received a copy of this agreement and I understand that the results of this research study will be published

I understand that if the researchers witnesses any harm occurring to children they are professionally obliged to report such harm to the relevant authorities without my consent

I understand that I may withdraw from this study at any time

Participant’s Signature

Date:

Researcher’s Signature:

Date:

Signature of person taking consent:

Date:

1 copy for the participant, 1 copy for the researcher, 1 copy to be kept with research notes
Consent Form for Stakeholders Participating in Interviews

Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System

Principal Researcher: Dara Glynn

Declaration (Please read and tick if you agree):

I have read the study information leaflet ( )
I have read and understand this consent form ( )
I have had the opportunity to ask questions ( )
All my questions have been answered to my satisfaction ( )
I understand that taking part in this research involves focus group and/or 1:1 recorded interviews ( )
I understand that I can access my interview transcripts ( )
I understand that all information collected in this study will be treated as confidential and that my identity will remain confidential ( )
I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights ( )
I have received a copy of this agreement and I understand that the results of this research study will be published ( )
I understand that if the researchers witnesses any harm occurring to children they are professionally obliged to report such harm to the relevant authorities without my consent( )
I understand that I may withdraw from this study at any time ( )

Participant’s Signature Date:

Researcher’s Signature: Date:

Signature of person taking consent: Date:

1 copy for the participant, 1 copy for the researcher, 1 copy to be kept with research notes
Consent Form for Parent / Guardian of Students Participating in Interviews
Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System
Principal Researcher: Dara Glynn

Declaration (Please read and tick if you agree):

I have read the study information leaflet
(
)

I have read and understand this consent form
(
)

I have had the opportunity to ask questions
(
)

All my questions have been answered to my satisfaction
(
)

I understand that taking part in this research involves a recorded focus group interview and non-participatory observation of some lessons by the researchers
(
)

I understand that all information collected in this study will be treated as confidential and that the participants’ identity will remain confidential
(
)

I freely and voluntarily agree for my child to be part of this research study, though without prejudice to his/her legal and ethical rights
(
)

I have received a copy of this agreement and I understand that the results of this research study will be published
(
)

I understand that if the researchers witnesses any harm occurring to children they are professionally obliged to report such harm to the relevant authorities without my consent
(
)

I understand that my child may withdraw from this study at any time
(
)

Parent / Guardian Signature
Date:

Researcher’s Signature:
Date:

Signature of person taking consent:
Date:

1 copy for the parent/guardian, 1 copy for the researcher, 1 copy to be kept with research notes
Consent Form for Students Participating in Interviews

Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System

Principal Researcher: Dara Glynn

Declaration (Please read and tick if you agree):

I have read / have had read to me the study information leaflet ( )

I understand this consent form ( )

I have had the chance to ask questions ( )

All my questions have been answered ( )

I understand that taking part in this research involves a recorded focus group interview and that the researchers will be present for some of the lessons ( )

I understand that the researchers will not use my name when talking or writing about this study ( )

I freely agree to be part of this research study ( )

I understand that I may leave this study at any time ( )

Participant’s Signature Date:

Researcher’s Signature: Date:

Signature of person taking consent: Date:

Signature of the reader: Date:

1 copy for the participant, 1 copy for the researcher, 1 copy to be kept with research notes, 1 copy to be kept with research notes.
Appendix 3 – Reflections on implementation of the unaltered IHC programme in researcher’s own school prior to PAR cycles

This document was an amalgamation of notes and impressions taken during the initial familiarisation phase of this programme, where I ran the unaltered programme in a 5th class in my own school.

Overall impressions of the course

- Simple language/vocabulary used to explain complex critical thinking skills
- Lots of appropriately pitched repetition during the delivery of each lesson
- Unnecessary and exhaustive repetition in the written questions following each lesson
- I have little or no concerns about cultural context. Any perceived deviation/difference from the Irish context is a good starting point for contextualising in-class discussion.
- The children enjoyed the course and were mostly engaged throughout.
- There were plenty of things in the teacher’s manual and some things in the student manual that I ignored.
- The narrow focus on health claims has a positive effect on the learning of some difficult critical thinking skills.
- The lesson outline is useful, but the time expectation is a little high.
- The Review Last Lesson page, with a list of review questions, was very good for reinforcement and for getting everyone up to the same starting point in the new lesson.
- I’ve picked up the language of IHC over the course of implementation which would make the delivery of the lessons more effective the next time.
- It addresses some of the more inaccessible elements of the SPHE curriculum.
- It opens at least three possible lines of further development:
  o A second IHC programme to address more of the original core concepts
  o Involvement in START from a more advanced starting point in terms of understanding
  o Transferability of the skill set to other or more general applications for critical thinking skills (e.g. Debating, science, advertising, fake news testing)

Lesson 1

- I had initial concerns that the language was too simple for the age range and ability level in this class. This could lead to loss of interest and the danger of losing the class to disciplinary intervention.
- Some mild concern about the picture on pg 10.
- Unnecessary explanation about the rules/structure of comic book narrative
- Children were politely engaged and even though the book set a low bar as a starting point, it has effectively ensured that everyone is at the same starting point.
Lesson 2
- Very good chapter to introduce the vocabulary and it was right to limit the core concept taught to one.
- The translations into Luganda and Kishwali are surplus to requirement
- It was more effective to relate the content to the children’s own personal experience and examples came thick and fast from the kids themselves.
- Most children seemed to pick up the vocabulary very quickly

Lesson 3
- Good lesson and it was appropriate that four concepts (grouped into two statements) were taught in this lesson.
- A lot of good discussion about children’s personal experiences of these claims.
- Some fun had with the children beginning to challenge each other using the appropriate language

Lesson 4
- An interesting lesson and, again, it was appropriate that this only covered one core concept.
- It was difficult for some to accept that an expert could be wrong
- Some stories began to emerge of children challenging claims made by family members at home. Use of the skillset outside of the class context.
- Children were beginning to see potential application of the skills in areas outside of the IHC content (adverts on telly, online).
- The issue was raised by one child that we were running out of good sources of information in our lives and ‘when were we going to learn about a good basis for a claim’

Lesson 5
- Again, an appropriately timed change in content
- The children understood the concept of comparison well and the need, for the purposes of research, to develop a research question in a useful (preferably ‘yes’ ‘no’ or similar format)
- Stories about vets, dentists and doctors being challenged/questioned about their bases for a claim.

Lesson 6
- Fair comparison test is a tricky concept but this lesson dealt with it quite well
- Repetition of the criteria and the simplicity of the question made the learning more effective.
- The flaw in the process (limited numbers) became evident to the children before it was mentioned in the test (due to the earlier understanding that everyone has a slightly different reaction to a treatment).
Lesson 7

- An effective lesson for dealing demonstrating the need for larger sample sizes.
- The emergent pattern in the larger sample size clarified the advantage of the process and the children understood well why the small sample size failed to deliver.
- The children started talking about the kinds of research questions they would love to address (e.g. whether breaking mirrors gave you bad luck)

Lesson 8

- A good chapter but the weakest in delivering the desired learning outcomes. There might be a better wording for weighing up the advantages and disadvantages when making a health choice.
- It took a couple of concept fly overs to internalise that making a choice about which was more important to you meant that either decision (take the treatment, don’t take the treatment) could be right. Returning to one of the earliest learnings (i.e. that treatments can have a different effect on different people) helped them understand that this could mean that they did have a genuine option of not taking a suggested treatment.
- The process of asking the doctor/dentist/vet about the advantages and disadvantages, and what to do with that information, became more relevant to them then.

Lesson 9

- Flew through this
- Children really seem to have understood most of this book
- Looking forward to reviewing the CLAIM test results
Appendix 4 – Teacher preparation programme for IHC

Original IHC Teacher Training

Informed healthcare choices - Teacher training workshop

Objectives

- Introduce the Informed Healthcare Choices (IHC) school materials and discuss
  - What this project is about and why is it important
  - How the materials were developed and how they are being tested
  - What is expected of the teachers and what they can expect of the project team
- Review and ensure a shared understanding of how to use the materials
- Discuss questions and suggestions about how best to use the materials
- Discuss each concept

DAY ONE

<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>08:00-08:15</td>
<td>Welcome and introductions</td>
</tr>
<tr>
<td>08:15-08:20</td>
<td>Welcome and practical information</td>
</tr>
<tr>
<td>08:20-09:30</td>
<td>IHC Project Introduction</td>
</tr>
<tr>
<td>09:30-09:45</td>
<td>Questions</td>
</tr>
<tr>
<td>09:45-10:30</td>
<td>Introduction to Study procedures [FOR YOUR PILOT STUDY]</td>
</tr>
<tr>
<td>10:30-11:00</td>
<td>Break</td>
</tr>
<tr>
<td>11:00-11:45</td>
<td>Introduction of the IHC learning resources</td>
</tr>
<tr>
<td></td>
<td>[samples will be shown]</td>
</tr>
<tr>
<td>11:45-12:45</td>
<td>Delivery of the lesson</td>
</tr>
<tr>
<td></td>
<td>[DONE BY A TEACHER OR BY YOU]</td>
</tr>
<tr>
<td></td>
<td>Activities</td>
</tr>
</tbody>
</table>

205
- Lesson preparation forms (semester plans, chapter summaries)
- Lesson wrap up forms (evaluation forms)

12:45 - 01:00 Questions, feedback and discussion
01:00 – 1:45 Lunch

01:45- 2:30 Lesson One *(Health treatments and effects of treatments)*
- Teachers read the chapter and follow instructions as laid out.

2:30-2:45 Questions about lesson one

02:45 - 3:30 Lesson Two *(Claims based on someone’s personal experience using a treatment)*
- Teachers read the chapter and follow instructions as laid out.
3:30-3:45 Questions about lesson two
03:45-4:00 Break

4:00-4:15 Re-cap of Day’s work!
4:15-4:45 General questions about the study
4:45- 5:00 Evaluation of the workshop

**DAY TWO**

08:00 - 08:15 Welcome
08:15 - 08:25 Recap (questions)

08:25- 09:10 Lesson Three *(Other bases for claims about treatments - Part-1)*
- Teachers read the chapter and follow instructions as laid out.
09:10-9:25 Questions about lesson three.

09:25 - 10:10 Lesson Four *(Other bad bases for claims about treatments (Part-2)*
- Teachers read the chapter and follow instructions as laid out.
10:10-10:30 Questions about lesson four
10:30-10:45 Break

10:45 – 11:30 Lesson Five *(Comparison of treatments)*
- Teachers read the chapter and follow instructions as laid out.
11:30-11:45 Questions about lesson five

11:45- 12:30 Lesson Six *(Fair comparison of treatments)*
- Teachers read the chapter and follow instructions as laid out.
12:30-12:45 Questions about lesson six
12:45- 1:00 General questions
<table>
<thead>
<tr>
<th>Time</th>
<th>Activity</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1:00-1:45</td>
<td><strong>Lunch</strong></td>
<td></td>
</tr>
<tr>
<td>1:45-2:30</td>
<td><strong>Lesson seven</strong> (<em>Fair comparison with many people</em>)&lt;br&gt;▪ Teachers read the chapter and follow instructions as laid out.</td>
<td></td>
</tr>
<tr>
<td>2:30-2:45</td>
<td>Questions about lesson seven</td>
<td></td>
</tr>
<tr>
<td>2:45-3:15</td>
<td>Activity for chapter seven</td>
<td></td>
</tr>
<tr>
<td>3:15-4:00</td>
<td><strong>Lesson eight</strong> (<em>Advantages and disadvantages of treatment</em>)&lt;br&gt;▪ Teachers read the chapter and follow instructions as laid out.</td>
<td></td>
</tr>
<tr>
<td>4:00-4:15</td>
<td>Questions about lesson eight</td>
<td></td>
</tr>
<tr>
<td>4:15-5:00</td>
<td><strong>Lesson nine</strong> (<em>What is most important to remember from this book</em>)&lt;br&gt;▪ Teachers read the chapter and follow instructions as laid out.</td>
<td></td>
</tr>
<tr>
<td>5:00-5:15</td>
<td>Questions about lesson nine</td>
<td></td>
</tr>
<tr>
<td>5:15-5:30</td>
<td><strong>General questions and evaluation of the workshop</strong></td>
<td></td>
</tr>
</tbody>
</table>
Informed Healthcare Choices - Teacher training workshop – Irish edition

Resources used
- Teacher’s Guide (TG)
- Children’s Book (CB)
- Posters (P)
- Cards (C)
- Presentation

Objectives
- Introduce the Informed Healthcare Choices (IHC) school materials and discuss what this project is about and why is it important
- Review and ensure a shared understanding of how to use the materials
- Discuss questions and suggestions about how best to use the materials
- Discuss each concept and associated teaching methodologies

Teaching Strategy
- PowerPoint demonstration.
- Facilitator led discussion with ongoing reference to specific pages in the resource materials.
- Question and answer session

Rationale for this contextualized programme
The IHC teacher training programme is a comprehensive and extensive workshop introducing the resources and content. However, the methodologies (including the reading approaches, form of narrative, activities and exercises) are already familiar to Irish trained teacher (National Curriculum, 1998) This programme maps well in onto the outcomes of the Social Personal and Health Education (SPHE) in the Irish curriculum but should be primarily used as a thematic approach programme with integration and linkage opportunities to Language, Science, Maths, Geography, History, Religion, PE and Drama.

The teachers will bring their own experience, training and expertise to the programme. The high quality of training in the primary education sector and feedback from stakeholders who have reviewed the programme and end-users is such that a 1 day (5 hours of contact time) CPD session is needed to be ready to run the programme.

Outline
Session 1 – 1 hour
Break – 15 minutes
Session 2 – 2 hours
Lunch – 1 hour
Session 3 – 2 hours
Finish

(* these refer to the recommendation number addressed – list at the end of this appendix)

Content

Session 1 – Introduction

Learning Outcomes

a. Teacher will become aware of the Global Landscape of Health Literacy and of Critical Thinking
b. Teacher will know the origins & Rationale of the IHC programme, including its Thematic Approach
c. Teacher will become aware of some of the potential benefits of the programme, including feedback from previous participants in Irish Schools
d. Teacher will understand why the programme has been contextualized to the Irish situation.
e. Teacher will know what resources are needed for the delivery of the IHC programme

Rationale for session 1
To introduce the programme, providing the background to its development, highlighting the gap identified by the IHC Team and how they propose this initiative addresses this gap, linking that to the requirements of the curriculum in Ireland. The facilitator will be introducing or re-introducing the resources available (this will vary across CPD programmes and be influenced by the level of prior engagement with IHC resources). The facilitator will reassure the teacher that they will have adequate training and resources to successfully deliver it. Reference to the curricular map will demonstrate its relevance to the Irish curriculum.

Resources Used
Laptop
IWB for PowerPoint presentation (laptop on its own if 1:1 or 1:2)
Curricular map
TG, CB, P, C

Outline
1. Welcome!
   - Timetable
   - Outline of content
2. Health Literacy
The western world has become saturated with information and misinformation. Information, opinions and offers are often inaccurate and/or unsolicited. Confirmation bias extends to medical information. Negotiating the new landscape and developing the skill of deciphering good from bad information has become a necessary skill of life. It is a form of targeted critical thinking.

“it gets the children to look outside the box and as you say critical thinking and think differently maybe” (teacher)

3. Informed Health Choices - rationale:
- We in the EU have some protection from the worst of the snake oil salesmen (although not entirely immune from it).
- Other countries may not be as lucky in this regard.
- This skills gap was spotted by researchers, with some in Uganda developing the Informed Health Choices program to address it (in partnership with the University of Oslo in Norway).
- An Informed Health Choice is…
- A skill that is universal and transferrable and lifelong.
- A lens through which one can engage with social media, advertising, misinformation - none of this is going away and our children are exposed to all this at a very young age.
- This is an early intervention programme.

4. IHC programme - overview:
- An evidence based programme for kids
- Designed to develop critical thinking skills through engagement with processing health related information.
- Uses a thematic approach that, although most closely aligned to Social Personal and Health Education (SPHE), overlaps with many areas of the curriculum (particularly English Language and Science).

“There’s huge scope for it there across a wide curriculum” (teacher)

5. IHC programme: Benefits and why has it been adapted for Irish Schools:
- The skill of looking beyond the ‘fact’ being presented. Where the ‘fact’ comes from is now nearly as important as the ‘fact’ being presented.
- IHC gets children to question the source, spot a poor basis, and ask the questions necessary to make more informed choices.
- More informed choices lead to better health outcomes

“the motivating factors are what can the children get out of it and you know will it improve their health and wellbeing” (teacher)
The potential benefits of the IHC programme, and lack of an equivalent in Ireland, was realised by a group of health researchers in NUIG in 2017.

It was also clear that some changes may be needed to align some of its content and delivery with Irish norms.

The resources and delivery, including this CPD, was modified and the programme has been run in a small number of schools:

"I actually was surprised at the amount that I learnt from them from the programme" (teacher) *11

6. Facilitator outlines the resources used and ensures all have a copy of each.

Slide 1
Welcome!

• 1 day of CPD

• 3 Sessions
  – Why the programme was developed and why it’s useful
  – Methodologies used
  – Run through of the programme

Session 1 - Introduction

• The world has become saturated with information and misinformation.
• We are all bombarded by health claims about treatments.
• It can be difficult to know which claims are backed by good science and which are not.
• Wouldn’t it be great if we could spot erroneous claims?
• Wouldn’t it be great if kids could learn to do this? A skill they could use in other areas of life and take with them into adulthood.
• That’s where the Informed Health Choices Programme (IHC) comes in
Health Literacy and Critical Thinking

• Health Literacy
  – A person’s ability to understand and make use of health information
  – Something we use every day (e.g., brushing teeth, eating healthy, buying medicines)
  – We are often asked to make choices about our health and about treatments
  – Health literacy involves being able to ask the right questions before making a choice

• Critical Thinking
  - The process of being able to objectively analyse and assess an issue information in order to form a judgement
  - Improving critical thinking skills is desirable outcome in Education
  - IHC attempts to teach critical thinking skills within the construct of Health Literacy

“JHC gets children to look outside the box”

Origins of IHC

• Snake oil
• 2014 to 2016
• Researchers from Norway and Uganda
• Human-centred design approach
• Tested in African and European Schools
• Evidence based
Slide 6

An Informed Health Choice is...

• A transferrable and lifelong skill

• A lens

Slide 7

IHC Overview

• An early intervention programme

• An evidence based programme for kids

• Critical thinking skills developed in a Health Literacy sandbox

• A multi-curricular, thematic approach programme with roots in SPHE

“There is huge scope for it across a wide curriculum”
IHC Benefits

- Looking beyond the fact/claim being presented
- Recognising the importance of the source or the basis of a claim
- Questioning a claim
- Learning to make more informed choices
- Better health outcomes

“Motivating factors are what can the children get out of it and will it improve their health and well-being”

IHC in Ireland

- 2017 – NUIG researchers recognised the potential benefits
- Some adaptation required
- Resources and delivery were modified and tested in a number of schools

“I was actually surprised at the amount that I learned from the programme”
Session 2 – Useful Teaching Points and Information on Methodology

Learning Outcomes
a. Teacher will know the structure of the CB
b. Teacher will become familiar with some of the features of the resources and how they may use them
c. Teacher will become aware of the method underpinning the concept development in this programme
d. Teacher will know the rationale behind the use of this particular form of narrative and how it may be used to develop understanding through the teaching strategies of pre-teaching vocabulary, simplified language for complex concepts, broadened definitions for common words and the use of narrative examples as starting points for discussion.

Rationale for session 2
The Irish trained teacher will be familiar with the teaching approaches used in this programme (See Teacher Guideline documents for the SPHE and English Language curricula → Methodology sections, available on Curriculumonline). It is important that they understand why the teaching strategies in this programme are used and how they have the potential to facilitate an understanding of the concepts. It is important to note that some of the definitions used in this programme require individuals to expand their definitions of some words. For example, many teachers would think of a claim in terms of insurance and suing people (PLACE QUOTE HERE). Teachers will need to resist the temptation to dismiss or speed over the definitions as the nature of these definitions become very important later in the book. Therefore, the focus of this CPD session will be on how there are certain nuanced deviations from traditional narrative based reading lessons.

Resources Used
CB, TG, P, C

Outline
*The macro-structure of this book (CB)*
1. Facilitator asks teachers to open their CB to discuss the structure of the book.
   - 1 Introductory Chapter
   - 7 chapters of comic strip narrative
   - 1 Review chapter
   - Vocab → Reading → Discussion → Reading → Discussion → Activity → Exercise (Chapter 1)

“I was surprised at the thinking that was involved in it for them and the opportunity it gave them to debate and to challenge their own thoughts” (teacher) *12; 13; 18*
- Introduces some vocabulary and broadens understanding of other vocabulary used (e.g. developing a wider definition of what constitutes a treatment). *1; 6;

“most of us when we heard treatment we thought like a, like a surgery or like, like just exercise, but like really we found out that like brushing your teeth, so it’s new to us” (student)

“what surprised me were the amount of new words that they had you know, came across from the entire program, its quite a new expansive vocabulary for them to have” (teacher) *12

- Learning objectives listed at the start of every chapter (pg 28)
- Discussions, when facilitating the programme, will involve relating the topics to the children’s lives (pg 106). *5
- Activities are ‘response to scenario based on the learning’ activities and can be subsumed into the final discussion process of each chapter for efficiency (pg 42, 93) *5; 13
- Additional scenarios are listed in the TG where needed (Cards, Poster), including Irish examples to enrich and relate. All scenarios are there to supplement the more important, overriding objective of skills development. Narratives are not an end in themselves. *4; 5; 15; 18

“It’s a good thing for them to be able to challenge the world around them, because I suppose sometimes, they will need that skill in life you know” (teacher) *12; 14

“they have become more articulate” (teacher) *12

- Exercises can be carried out in class (SPHE or Science copies) or could be done for homework and as part of a home-school link.
- There are also Home-School link exercises in most chapters providing parallel learning opportunities at home.

“the kids absolutely love to go home and challenge their parents, it would lead to maybe you know in the most cases lead to great positive debates at home” (teacher)*12; 18

2. Teachers asked to open their TG to discuss:
- Teachers can write in their books
- Teacher’s Manual contains several key pages of the student book embedded
- Variations and differentiation in lesson implementation to suit your class are welcome and encouraged. *10; 15; 16
- Early finishers – use pre-existing differentiation modes (golden time, Drop Everything And Read, etc) *17; 18

“there’s great scope there to put in your own stamp on it and I suppose that makes it individual for each classroom” *12; 15; 17; 18
**Vocabulary and Concept Development**

**The requirement for pre-teaching of the vocabulary in each chapter**

1. Facilitator refers back to CB and states:
   - Each chapter/segment within a chapter may have specific vocabulary in green boxes (pg 4, 28)
   - Many of the words are known or may seem simple to the students (pg 4, 90)
   - Pre-teaching required to broaden the definition (e.g. claim) or because the simple words will be used later to describe a more complex concept (e.g. good/bad effects) *7
   - Open the glossary section to review the vocabulary used in this programme. *1; 8

**The need for using over-simplified language to counter-balance the increasingly difficult concepts**

Facilitator points out that, following on from the second point of the last section, the teacher may have noticed that some of the vocabulary may even seem a little too easy for a 5th class child (pg 5, 9). Facilitator then states that:
   - This is purposeful in the book design.
   - Being clear about the vocabulary allows them to explore the implications of the concepts more fully (pg 191).

**The need to broaden the definitions of certain common words for understanding**

1. Facilitator explains:
   - The meanings are correct in terms of health/medical vocabulary and allow the children to better access the core concepts (pg 191)
     *1
   - Later word combinations of simpler words allow the children to express concepts more easily than through direct teaching (e.g. claim + reliable + basis $\rightarrow$ “this is an unreliable basis for a claim”) (pg 28, 40) *7

**The use of narrative examples as a starting point for discussion**

1. Facilitator highlights the importance of this method in making the content relatable to the children’s own lives and offers the following guidance using the CB:
   - Make use of any example as a starting point for discussing equivalent examples in the children’s lives (e.g. cow dung for burns $\rightarrow$ water, cream, oil) (pg 32, 67)
   - Teacher should consider stopping for discussion either at the outset (when an anecdote occurs) or at the next planned break for discussion in the text *15
Session 2
Teaching points and Methodology

IHC – What does it look like

• A look at the Children’s Book
  – 9 Lessons
  – 1,7,1

• Teacher’s Guide containing some Supplementary Materials

“I was surprised at the thinking that was involved in it for them and the opportunity it gave them to debate and challenge their own thoughts”
IHC – What does it look like – Children’s Book

• A typical chapter
  - Vocab → Reading → Discussion → Reading → Discussion → Activity → Exercise
  - Introduces some vocab and broadens understanding of already known vocab

“what surprised me were the amount of new words that they had you know, came across from the entire program, it’s quite a new expansive vocabulary for them to have”

“most of us when we heard treatment we thought like a, like a surgery or like, like just exercise, but like really we found out that like brushing your teeth, so it’s new to us” (student)

Slide 13

IHC – What does it look like – Children’s Book

• A typical chapter
  - Learning objectives listed at the start
  - Discussions involve relating the topics to the children’s lives
  - Activities are generally ‘response to scenario’
  - Additional scenarios, including Irish ones, are in the TG

“It’s a good thing for them to be able to challenge the world around them, because I suppose sometimes they will need that skill in life”

“they have become more articulate”
IHC – What does it look like – Children’s Book

• A typical chapter
  – Exercises in class or at home (SPHE or Science copy)
  – Home-School Link activity

“the kids absolutely love to go home and challenge their parents, it would lead to maybe you know in the most cases lead to great positive debates at home”

IHC – What does it look like – Teacher’s Guide

• Teachers can write in their books

• Key pages from the CB included

• Variations and differentiation are welcome and encouraged

• Early finishers

“there’s great scope there to put in your own stamp on it and I suppose that makes it individual for each classroom”
IHC – Teaching Points and Methodologies

• Vocabulary and Concept Development (open CB)
  – Green boxes
  – Many words may seem too simple or familiar at first
  – Pre-teaching advised
  – Check out the Glossary

IHC – Teaching Points and Methodologies

• Is the language too simple?
  – 5th class vocabulary developed beyond this… at first glance
  – The simplicity is purposeful
  – Definition clarity early in the book allows a greater depth of concept study later

• Do we really need to broaden the meaning first?
  – Yes → health literacy building blocks
  – Children will be applying the meaning in more complicated phrasing later in the book
IHC – Teaching Points and Methodologies

- Response to narrative example
  - Used throughout the book
  - Makes the content relatable
  - Draw in Irish examples
  - Stop and talk any time
Session 3 – Chapter Highlights and Concepts Covered

Learning Outcomes
a. Teacher will be exposed to the contents of every chapter in the programme
b. Teacher will know the main learning outcomes for each Chapter
c. Teacher will have engaged in discussion with the facilitator on the above
d. Teacher will see some practical examples of the methodologies in action
e. Implementation methodologies, at classroom and school wide level, to be discussed.
f. Teacher will have any additional questions of theirs answered

Rationale
Given the prior experiences the teachers in Irish primary schools have with the teaching strategies and narrative style used within this initiative, the 1.5 hours allocated to this section is adequate (we will seek feedback from the teachers in relation to this).
It is accepted practice and teachers are generally encouraged to differentiate lessons to suit the needs of their children. Accordingly, the emphasis in this content section needs to be on the core teaching points and methodologies rather than a read and repeat approach with advice and guidance.

Resources
TG

Outline
*Develop the teacher’s understanding of the core concepts addressed in this book.*

1. Using the TG, facilitator explores the definitions and concepts with the teacher, pointing out where and how they are developed in the programme:
   Chapter 1
   - Treatment and effect, Health and Health Researcher
     o Pg 28 – definitions – review and discuss
     o Pg 30 – broadening the definition of ‘Treatment’ – point out the treatments that wouldn’t fall under the definition in our normal understanding.
     o Pg 32-37 – developing the understanding of ‘Effect’ – explain that a lot of understanding later in the book hinges on developing topic adequately now (don’t skip).
     o Remainder of Chapter describes what will be covered in the book
   Chapter 2
   - Claim, basis, unreliable
   - Personal experience is a bad basis for a claim
     o Pg 60 – definitions – review and discuss
     o Comic strip narrative – cow dung heals burns = personal experience is a bad basis for a claim
Chapter 3
- How long a treatment has been used or how many people have used it are both bad bases for a claim
- How much money it costs or how new it is are both bad bases for a claim
  o Pg 96 – In use for a long time = bad basis
  o Pg 96 – Lots of people use it = bad basis
  o Pg 98 – expense = bad basis
  o Pg 98 – New = bad basis

Chapter 4
- Endorsement by the person selling something is a bad basis for a claim
- Endorsement by an expert is a bad basis for a claim
  o Pg 122 - Claim by salesperson = bad basis
  o Pg 124 - Expert = bad basis

Chapter 5
- A reliable claim is one with a good basis
- What it means to compare treatments and why it is done
- Research question
  o Pg 148 - definitions – review and discuss
  o Pg 156 - Comparing treatments helps quantify their effectiveness (refer back to the need for broadening the understanding of what constitutes a treatment- e.g. ‘not doing something is a treatment’)
  o Pg 159 – see extra examples - A research question describes the comparison to be tested

Chapter 6
- Fair comparison
- The use of chance for fair comparison – OJ vs Water
  o Pg 178 - definitions – review and discuss
  o Pg 186 – demonstrating the need for chance
  o Pg 190 – avoiding making unfair comparisons

Chapter 7
- The need for high numbers of participants in fair comparison – OJ vs Water
  o Pg 212 - definitions – review and discuss
  o Increased volume reduces the effects of chance outcomes
  o Pg 236 – use of cards in this activity

Chapter 8
- Advantage/disadvantage
- Informed choice
- The need for informed choices
- How to make informed choices
  o Pg 250 - definitions – review and discuss
  o Pg 255, 258 – 2 questions to ask, allowing you to make an informed health choice

Chapter 9
- Review
- The use of the poster
  o Pg 299 – Summary poster

Toolboxes within the TG
- Alternative and contextualized narrative examples
- Home-school link exercises
- Alternative activities
- Flashcards
- Posters

How to get things started
1. Read the entire children’s book yourself first (it won’t take long)
2. Invite parents to an introductory talk, or schedule IHC for after the annual parent teacher meetings and mention it there, or send a note home with a programme outline and a link to the IHC website. *9
3. Pick and choose how you want to navigate the content of this programme. You know your class best. The toolboxes/resources are there to support your work, not to prescribe it. *10; 15

Q&A

Slide 19
IHC – A Run Through – Using the TG

- **Chapter 1**
  - Treatment and effect
  - Health and Health Researcher
- **Chapter 2**
  - Claim, Basis, unreliable
  - Personal Experience is a bad basis for a claim
- **Chapter 3**
  - How long a treatment has been used is a bad basis for a claim
  - How many people have used it is a bad basis for a claim
  - How much money it costs is a bad basis for a claim
  - How new it is – this is a bad basis for a claim

IHC – A Run Through – Using the TG

- **Chapter 4**
  - Endorsement by the salesperson is a bad basis for a claim
  - Endorsement by an expert is a bad basis for a claim
- **Chapter 5**
  - A reliable claim is one with a good basis
  - What it means to compare treatments and why it is done
  - Research question
- **Chapter 6**
  - Fair comparison
  - The use of chance for a fair comparison
IHC – A Run Through – Using the TG

• Chapter 7
  – The need for high numbers in a comparison

• Chapter 8
  – Advantage/disadvantage
  – Informed choice
  – The need for informed choices
  – How to make informed choices

• Chapter 9
  – Review
  – The use of the poster

IHC – How to Get Things Started

• Read the CB (it will take less time than you think!)

• Communicate your intentions to parents
  – At a talk
  – At the p-t meeting
  – With a note home

• Pick your own route and pace through this programme
Thank you!

Q&A
Recommendations that informed the contextualised teacher programme

The teacher preparation programme was based on the following recommendations. The session outline also includes the number of the recommendation(s) that apply:

1. The Teacher Training Programme to include additional discussion on the children’s book about the issue. Much of this focus should be on the contents of the Children’s Book on pages 6 and 7.

2. Teacher Training Programme of up to 1 school day (4-5 hours of contact time).

3. Facilitator must have Face to face contact with every participating teacher at the Teacher Training Programme (i.e. all participating teachers should attend for training and not just a representative sample)

4. Teacher Training Programme to highlight the importance of skills being taught over considerations of narrative relevance (i.e. the stories in the book are more important for what they teach rather than how believable or culturally relevant they are)

5. Teacher Training Programme must draw focus on the use of narrative examples as a starting point for Discussion

6. Significant focus needed in the Teacher Training Programme and a reminder in the Teacher Guide of the importance of broadening the definition of the word ‘Treatment’ (This can be done using the Children’s Book to discuss the topic and to show the broadened definition is needed for understanding more difficult concepts later in the book)

7. Teacher Training Programme to include a focus on the glossary and the importance of the concept building approach (i.e. how the programme uses simple words and definitions early in the book to create a solid foundation of understanding, which are later used as the building blocks for more complex concept building in the later chapters)

8. Suggest to schools that they invite parents in to hear a speaker on the programme (e.g. class teacher) or have video clips online to introduce the programme (site location included in the letter home)

9. Encourage the Teacher’s to be flexible and creative in their delivery of the programme at Teacher Training Programme session

10. A clear and convincing pitch of the programme is needed in the introductory Teacher Training Programme
11. Incorporate positive feedback quotes/data in the Teacher Training Programme presentation

12. During the Teacher Training Programme, emphasise the need for use of discussion as a learning tool for constructing meaning and for contextualising the learning in class

13. Teacher Training Programme should clarify that although the topics covered are narrow and focused, the skills learned are transferable and lifelong

14. Recognise and encourage Teacher autonomy in the Teacher Guide and the Teacher Training Programme (e.g. in choosing additional stopping points for discussion during a lesson).

15. Recognition of the need for differentiation in the Teacher Guidelines and Teacher Training Programme

16. Advice to use pre-existing methods for dealing with this issue of differentiation (e.g. Drop Everything And Read, or DEAR, where children who finish early are allowed to take out a book and silently read until the other students catch up)

17. Pedagogical focus, during the Teacher Training Programme, should be on enrichment and differentiation of the programme to meet the needs of each class (i.e. recognising and acting upon opportunities in class for the teacher to enrich the learning process through the use of more contextualised examples and activities). This reflects the nature of skills transfer.

18. The Teacher Training Programme should include a module on practical issues for school implementation (i.e. describe a subject and a programme coordinator driven implementation structure).
Feedback from Irish teacher CPD sessions

CPD School 1 (medium suburban):
Content – Relevant and useful. The teacher felt it was important to explain why the vocabulary was simple and the session gave him a better feel for the programme.

Duration (20min + 90 min) – Teacher felt the length of the session was appropriate.

Relevance - He felt the relevance of the content was that it rang true with current issues in society (including ones not mentioned in the book such as vaccinations).

Reflections on comments made by the teacher during observation visits so far – Teacher has been surprised by the complexity of concept developed from what he originally thought was simplistic language. He now feels that the programme is entirely age appropriate for 5th class and up. He remarked on the appeal it had to some children in the way that it allowed them to analyse and express themselves in a way that other subject areas would discourage (i.e. broader definition of what is a right and wrong answer). The teacher liked that he could “knock a bit of craic” out of it with them, especially when they occasionally indulged in a side-tracking issue (e.g. coming up with their own misleading or incorrect slogans for a medically orientated advertisement campaign). The teacher said he has enjoyed the programme more than hr thought he would (packaging?).

CPD School 2 (small rural)
Content – Teacher felt the session was excellent. It was very informative and relevant to the modern world we live in.

Duration (160min) – Teacher felt that 3 hours it was a little long (it wasn’t 3 hours). Teacher felt that some things didn’t need explaining as the Teacher’s guide was already very clear on it.

Relevance – Teacher seemed very happy with the programme and was looking forward to teaching it. He felt, in relation to relevance, that it was all excellent but reiterated that it was a little bit of overkill on some points.

Reflections on comments made by the teacher during observation visits so far – Teacher has been pleased with the programme and has seen many opportunities for using different approaches and methodologies from his own tool kit of learning. There has only been one visit so far in this class for an early lesson (concepts delivered become more advanced in the middle and late chapters) so it will be interesting to see his views on the age appropriateness of the content given that his class includes 3rd class and up.
Changes made to reflect the feedback

- Both slideshows have been amalgamated into one
- Slide, “We already know this one!”, deleted and some of its content redistributed
- Slide, “Planning and Implementation” – removed research related points, added a point on the best practice of using the teacher’s guide in class and another on the potential for interesting parallel learning opportunities that might arise (diversions).
Teacher’s lesson evaluation form

Informed Health Choices – Primary school learning resources
TEACHER’S LESSON EVALUATION FORM

This form is for you to:
1. Reflect on what you did well in preparing and teaching this lesson, and how you could improve
2. Provide feedback on the materials for this lesson and how we could improve them
3. Help us understand why the children did or did not achieve the lesson objectives

School: ____________________________________________

Class: _____________________________________________

Lesson: ___________________________ Date: ______________

Self-evaluation

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What did you do well in preparing and teaching this lesson</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>2. How could you improve?</td>
<td></td>
</tr>
</tbody>
</table>
Evaluation of the materials for teaching and learning

1. Rate the suitability of the *children's book* for teaching and learning this lesson for your class

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very bad</td>
<td>Bad</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. Rate the suitability of the *teacher's guide* for teaching and learning this lesson to your class

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very bad</td>
<td>Bad</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3. Rate the suitability of the *activity* for teaching and learning this lesson for your class

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very bad</td>
<td>Bad</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4. Rate the suitability of the *exercises* for teaching and learning this lesson for your class

<table>
<thead>
<tr>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>Very bad</td>
<td>Bad</td>
<td>Good</td>
<td>Very good</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Evaluation of children’s success in achieving lesson objectives

1. How many children were in the class for this lesson? __________

2. How much time did you spend preparing for this lesson? __________

3. Was that too little or too much time?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Much</strong></td>
<td><strong>too little</strong></td>
<td><strong>Too little</strong></td>
<td><strong>About right</strong></td>
<td><strong>Too much</strong></td>
</tr>
</tbody>
</table>

4. How much class time did you use for this lesson? __________

5. Was that too little or too much time?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Much</strong></td>
<td><strong>too little</strong></td>
<td><strong>Too little</strong></td>
<td><strong>About right</strong></td>
<td><strong>Too much</strong></td>
</tr>
</tbody>
</table>
6. Were the objectives of this lesson appropriate for your class?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Inappropriate</td>
<td>Somewhat inappropriate</td>
<td>Somewhat appropriate</td>
<td>Appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

7. How difficult was this lesson for the children?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very difficult</td>
<td>Difficult</td>
<td>Easy</td>
<td>Very easy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8. How difficult was this lesson for you?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very difficult</td>
<td>Difficult</td>
<td>Easy</td>
<td>Very easy</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

9. How comfortable were you teaching this lesson?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very uncomfortable</td>
<td>Uncomfortable</td>
<td>Comfortable</td>
<td>Very comfortable</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

10. How interesting was this lesson for the children?

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very uninteresting</td>
<td>Uninteresting</td>
<td>Interesting</td>
<td>Very interesting</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
11. What made it *easy* for the children to achieve the lesson objectives?

12. What made it *hard* for the children to achieve the lesson objectives?
Lesson observation form

IHC Translation

Observation of Classroom Lesson for Contextualising the Informed Health Choices (IHC) programme and resources for delivery in the Irish Primary School System

For classroom lesson observation:

Lesson observation form

The objectives of observing the lessons in the classroom within this contextualisation is to to 1) look for ways to improve the initiative within the context of Irish primary schools / 2) to explore whether teachers and children in Ireland experience the resources as useful, easy to use, understandable, credible, desirable and well-suited to the Irish context.

Primary focus should be on aspects of the initiative that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders understanding or use in your setting is helpful to record as it will help us improve future resources.

These forms/guides are based on those used in Rwanda pilot, fall 2017. They can be translated and adapted for your setting. Particularly the interview guides are a starting point, and can be adapted.

IHC SCHOOL RESOURCES – CLASSROOM PILOT

LESSON OBSERVATION FORM

[Date____________]

CHAPTER ...............
SECTION A: Pre-lesson
Observer:
Date:
School:
Scheduled start time of lesson:
Scheduled end time of lesson:
Number of children:
Age range of children:
(From youngest to oldest child)
Number of benches:
(This is so we know about how much space each child had)
Number of teachers in the room:

SECTION B: Start of lesson
Actual start time of lesson:
(Do not let teacher or children know you are timing lesson)
What did the teacher do before the class started reading the chapter? For how long?
(E.g. make jokes, ask questions or answer question)
........................................................................................................................................................................................
........................................................................................................................................................................................
........................................................................................................................................................................................

SECTION C: Reading
Follow along in the guide, so you can note how the teacher uses and understands instructions, e.g. whether the teacher misunderstands or skips any.
Note things like:
- What the children and teacher misunderstand, e.g. a picture, an example or an exercise
- What words the teacher and children struggle with
- What that the children and teacher seem to like especially
- Anything else that you think is important for the book's effect

Remember to note things like:
- How the teacher uses and understands instructions
- What the children and teacher misunderstand, e.g. a picture, a word, an example or an exercise
- What examples the children and teacher use, other than those in the book
........................................................................................................................................................................................
........................................................................................................................................................................................
........................................................................................................................................................................................
........................................................................................................................................................................................
SECTION D: Activity

Note things like:
- What the children and teacher misunderstand, e.g. picture, example or exercise
- What words the teacher and children struggle with
- What that the children and teacher seem to like especially
- Anything else that you think is important for the book’s effect

Remember to note things like:
- How the teacher uses and understands instructions
- What the children and teacher misunderstand, e.g. picture, example or exercise
- What examples the children and teacher use, other than those in the book

SECTION E: Exercises

If they do not spend time on exercises during the lesson, skip this section.

Note things like:
- What the children and teacher misunderstand, e.g. picture, example or exercise
- What words the teacher and children struggle with
- What that the children and teacher seem to like especially
- Anything else that you think is important for the book’s effect

Remember to note things like:
- How the teacher uses and understands instructions
- What the children and teacher misunderstand, e.g. picture, example or exercise
- What examples the children and teacher use, other than those in the book

SECTION F: Post-lesson
Actual end time of class: ......................
When did the teacher leave the children to work on their own or do other things? ............
About how long did the class spend reading the story?
.................................................................................................................................
About how long did the class spend doing the activity?
.................................................................................................................................
About how long did the class spend doing exercises with the teacher in the room? ............
About how long did the children break for? ..............

Who read aloud?
Was it all the children together, one child at a time, the teacher or some combination?
.................................................................................................................................

Did the children seem interested or disinterested in the lesson? How so?
.................................................................................................................................

How did the teacher engage the children?
.................................................................................................................................

How did the teacher use the blackboard (or other equipment)?
.................................................................................................................................

What did the children do with the books at the end of class?
Did they take them home or hand them in?
.................................................................................................................................
Appendix 6 – Interview guides

IHC Original Template

IHC School Pilot user-test interview guides (English)

Children interview guide
Teacher interview guide

The objectives of classroom pilot and user-test interviews is to 1) look for ways to improve the translation and 2) to explore whether teacher and children in [your country or setting] experience the resources translated to [your language] as useful, easy to use, understandable, credible, desirable, and well-suited to the [your country or setting] context.

Primary focus should be on aspects of the translation that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders understanding or use in your setting is helpful to record as it will help us improve future resources.

These forms/guides are based on those used in Rwanda pilot, fall 2017. They are meant to be a starting point and can be translated and adapted for your setting.

IHC SCHOOL RESOURCES – USER TEST

CHILDREN INTERVIEW GUIDE
(Children’s Book)
[Date]

CHAPTER ............

The objectives of conducting user test interviews with the children is to 1) look for ways to improve the translation and 2) to explore whether the children in [your country or setting] experience the resources translated to [your language] as useful, easy to use, understandable, credible, desirable, and well-suited to the [your country or setting] context.

Primary focus should be on aspects of the translation that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders the children’s understanding or use is helpful to record as it will help us improve future resources.
SECTION A: Pre-interview
Interviewer: .................
Observer: ..................
Date: .................
School: .................
Interview subject(s): .................
Write their code, e.g. child001, not their name.
If they have been interviewed before, use the same code as last time.
Gender: .................
Was interview after a pilot lesson? .................

SECTION B: Introduction
Start time: .................
Briefly introduce yourself.
Tell them that we want to help people making choices that matter to their health.

Tell them that:
- They are testing what we have made.
- We are not testing them.
- We think the resources are better based on previous pilots conducted.
- The resources are for someone like them.
- Their thoughts can help us make the resources translated better.
- There are no wrong answers to our questions.

Tell them that the interview will last less than an hour.

Remind them that they are free to leave at any time.

Tell them that:
- We want to record the interview so we can be sure of what they said.
- We will not attach their names to the notes or recording.

Ask if they have any questions.

Make sure they have understood and signed all necessary consent forms

Start recording if they approve.

SECTION C: Profile
If you have interviewed the same person before, skip this section.
How old are you? .................
What year of school are you in? .................

SECTION D: Think-aloud
They should only read aloud if they want.
Go through the chapter, page by page. Ask them to think out loud, what they like and don’t like, what they understand, and don’t understand, any comment that comes to mind, or things they remember from their experience in the classroom. You can demonstrate the technique for them.
For each part of the book, ask if it is easy to use and understand.
Use questions like:
- What do you think this part is about?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X--[Specific page or section of book]
- What do you think this part is about?
- Was it is easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?

How can we improve the text in [your language]?
..................................................................................................................................................
..................................................................................................................................................

Page X--Activity
- Can you describe what you think about this activity?
- Was the description/instruction was easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X--Exercise X
Is it a familiar type of exercise?
- Can you describe what you think about these/this exercise? (Type of exercise, number of exercises)?
- Was the description/instruction was easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

SECTION E: General

What questions do you have about what John and Julie learn in this chapter?

Do you trust what is in this chapter? Why?

After reading this chapter, do you think the book is for a class like yours? Why?
How would you explain to a friend what John and Julie learn in this chapter?

Do you think what John and Julie learn fits in your life? If so, how?

Do you think the chapter is interesting or important? Why?

Do you think the people at your home would be interested in the book? Why?

Do you have anything more you want to say to us about the book or project?

SECTION F: CLAIM questionnaire
Hand them the separate page(s) with the CLAIM question(s).

Remind them:
- They are testing what we have made, so we can make it better.
- We are not testing them.
- We will not attach their names to their answers.

Tell them they can keep the page(s) when they have answered the question(s), if they want.

Ask them to:
- Think aloud as they read and answer.
- Circle any words that are unfamiliar.

Note their answer and what they say:

SECTION G: User test observer’s questions
The observer asks whatever questions they have.

SECTION H: Participant’s interview experience
Is there anything we could have done to make the interview a better experience for you?

Stop recording and thank them.
SECTION I: Post-interview discussion

What were the most important findings?

What do the findings suggest we should do for the resources to be more useful, easy to use, understandable, credible, desirable, or well-suited to the [your country or setting] context?

Enter findings and transcribe the interview recording as soon as possible.
CHAPTER ..............

The objectives of conducting user-test interviews with the teachers is to 1) look for ways to improve the translation and 2) to explore whether the teachers in [your country or setting] experience the resources translated to [your language] as useful, easy to use, understandable, credible, desirable, and well-suited to the [your country or setting] context.

Primary focus should be on aspects of the translation that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders the teachers’ understanding or use is helpful to record as it will help us improve future resources.

SECTION A: Pre-interview

Interviewer: .................
Observer: .................
Date: .................
School: .................
Interview subject(s): .................

Write their code, e.g. teacher001, not their name.
If they have been interviewed before, use the same code as last time.
Gender: .................
Was interview after a pilot lesson? .................

SECTION B: Introduction

Start time: .................

Briefly introduce yourself.
Tell them that we want to help people making choices that matter to their health.
- They are testing what we have made.
- We are not testing them.
- We think the resources are better based on previous pilots conducted.
- The resources are for someone like them.
- Their thoughts can help us make the resources translated better.
- There are no wrong answers to our questions.

Tell them that the interview will last less than an hour.

Remind them that they are free to leave at any time.

Tell them that:
- We want to record the interview so we can be sure of what they said.
- We will not attach their names to the notes or recording.

Ask if they have any questions.

Make sure they have understood and signed all necessary consent forms.
Start recording if they approve.

**SECTION C: Profile**
If you have interviewed the same person before, skip this section.
Tell them:
- We want the resources to be used and understood by people with different backgrounds.
- For example, we want them to be easy to use for people of different ages.
Remind them that their names will not be attached to anything they say.

How old are you?

What is your level of education?

How long have you taught?

What subjects have you taught?
*E.g. science.*

What years have you taught?
*E.g. year five, primary school.*

**SECTION D: Think-aloud**
Ask the teacher to:
- Put the guide on the table.
- Think aloud as he/she reads it page by page.
- Circle any unfamiliar words or words that they think would be unfamiliar to the children.
They should only read aloud if they want.
Go through the chapter, page by page. Ask them to think out loud, what they felt worked well and less well, what they understand, and don’t understand, any comment that comes to mind, or things they remember from their experience in the classroom. You can demonstrate the technique for them.

For each part of the resources, ask if it is easy to use and understand.
Use questions like:
- What do you think this part is about?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X—[Part of guide]
- What do you think this part is about?
- Was it easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How
- Is there anything that there should there be more or less of? Why?

How can we improve the text in [your language]?

Page X--Activity
- Can you describe what you think about this activity?
- Was the description/instruction was easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X--Exercise X
Is it a familiar type of exercise?
- Can you describe what you think about these/this exercise? (Type of exercise, number of exercises)?
- Was the description/instruction was easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

SECTION E: General
What is missing to help you answer any questions from the children? E.g. details or examples.

Do you trust what is in this chapter? Why?

After reading this chapter, do you think book is for a class like yours? Why?

How would you explain the lesson goals to a colleague in your own words? What examples of your own would you use?

How do you think the lesson goals apply to your own life and the children’s lives?

Do you think the chapter is interesting and important? Why?

Do you have anything more you want to say to us about the book, guide or project?
SECTION F: CLAIM questionnaire

Hand them the separate page(s) with the CLAIM questionnaire.

Remind them:
- They are testing what we have made, so we can make it better.
- We are not testing them.
- We will not attach their names to their answers.

Tell them they can keep the page(s) when they have answered the question(s), if they want.

Ask them to:
- Think aloud as they read and answer.
- Circle any words that are unfamiliar.

Note their answer and what they say:

SECTION G: User test observer’s questions

The observer asks whatever questions they have.

SECTION H: Interview experience

Is there anything we could have done to make the interview a better experience for you?

Stop recording and thank them.

SECTION I: Post-interview discussion

What were the most important findings?

What do the findings suggest we should do for the resources to be more useful, easy to use, understandable, credible, desirable, or well-suited to the [your country or setting] context?

Enter findings and transcribe the interview recording as soon as possible.
Post-programme Teacher Interview Guide

Exploring other factors that could affect impact – Teachers interview guide

Informed Healthcare Choices – extra factors – Head Teachers’ Interview Guide

<table>
<thead>
<tr>
<th>Interviewed person no.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>School:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Interviewer’s Name:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Audio or video recording?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Section D. (School System and Environment)

Have you changed any of your initial thoughts on the IHC programme having delivered it in your class?

What factors in the Primary School system would help or hinder future uptake of the IHC lessons at your school?

In your experience, what should be in place to enable more schools to take up this programme?

Is there a need for a Home-School link element in this programme? Why?
Section B. (Feedback on materials)

Having implemented the programme, do you feel that IHC is age appropriate for 5th class?

To what extent do cultural barriers remain a problem in this programme and how would you address them?

In your own opinion, to what extent is the IHC program compatible with the current primary school curriculum?

Are there any structural recommendations you would make about either book?

Section A. (About the teachers)

What factors do you think motivate or demotivate teachers to take on the IHC programme in its current format?

What level of teacher CPD is needed and what should it target?

Section E. Potential Adverse or beneficial effects

Having delivered the programme, what do you see as potential positive or negative effects, if any, for the pupils?

Do you have any comments on the vocabulary used in this programme? For example, the broadening of the definition of the word ‘treatment’?

Are the skills you have taught in this programme useful or transferrable?

Here is a list of possible good or bad impacts people have suggested we should think about. Are there any of these items that you have seen examples or signs of, or that you have been aware of or concerned with yourself? (List on two separate sheets)

<table>
<thead>
<tr>
<th>Potential bad impacts</th>
<th>Corresponding good impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict between children and Children challenging their teachers.</td>
<td>More open and engaging discussion of the basis of diverse claims or beliefs</td>
</tr>
<tr>
<td>Conflict between children and Children challenging their parents</td>
<td>Better understanding between children and parents due to children conversing with their parents about what they are learning and parents feeling more engaged with what their children are learning + engagement of parents in discussions of health issues</td>
</tr>
</tbody>
</table>

253
### Potential bad impacts

<table>
<thead>
<tr>
<th>Potential bad impacts</th>
<th>Corresponding potential good impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distrust of health professionals or conflict between children and health professionals.</td>
<td>Appropriate questioning of health professionals, better understanding and better healthcare</td>
</tr>
<tr>
<td>Conflict due to undermining of religious beliefs</td>
<td>Engagement of children and others in discussion about religious beliefs and science</td>
</tr>
<tr>
<td>Shortened enjoyment of the innocence of childhood</td>
<td>Increased enjoyment of school and childhood</td>
</tr>
<tr>
<td>Nihilism or cynicism</td>
<td>Healthy scepticism and appreciation of science</td>
</tr>
</tbody>
</table>

### Other potential good impacts

<table>
<thead>
<tr>
<th>Impacts on teachers</th>
<th>The learning resources might improve the teachers’ understanding and ability to apply the concepts being taught to the children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impacts on parents</td>
<td>The learning resources might indirectly improve parents’ understanding and ability to apply the concepts being taught to the children</td>
</tr>
</tbody>
</table>

- **Assertiveness**: Children asking more questions and not taking things for granted
- **Improved decision-making**: Children making more thoughtful and informed decisions
- **Nonviolent conflict resolution**: Claims being presented and addressed in a friendly manner even when there is a disagreement about the claim, as illustrated in the resources
- **Friendship formation**: Friendly interactions between adults and children and among children, as illustrated in the resources
- **Collaboration for problem solving**: Collaboration for problem solving among the children, as illustrated in the resources
**Creativity**  
Thinking outside the box

**Numeracy**  
Improvements in numeracy, reflecting what is learned in lessons 6 and 7 (on fair comparisons and the play of chance)

---

**Section F. Other**

Do you have any other feedback you’d like to share with us, either positive or negative about these resources or your involvement in this project?

---

**Section G. Feedback on our session.**

How has this interview been conducted?
Interview Prompt Sheet

SECTION A: Pre-interview - Talk-through
- Initial focus on Chn’s Guide. Generally, on T. Guide later. Will be recording/check consent.
- Explain Read through process
- Fill out page 1 of the interview guide

SECTION B: Introduction (Start Recording)
- Myself, the programme what it’s for. What the research is for (see objectives above). Expected duration.
- Free to leave. Any Q’s? Informed consent/ Check consent forms signed/Explain not named in any report
- Age, education, career summary/experience

SECTION D: Think-aloud as he/she reads 2 chapters of Children’s Guide Page by Page.
  - As you go through the read aloud please circle any words that they think will be unfamiliar to children.

Read Through – Probe
Page 4 — Text - meaning/understandability/improvement/volume
Page 22 — Activity — opinion/understandability/improvement/volume
Page 45 — Exercise 2 — familiarity/opinion/understandability/improvement/volume

SECTION E: General – Go to T. Manual
- From your engagement with the resources tell me about their placement within the current primary school curriculum? — (improve the fit, other curricular areas)

- How relevant is the education of teachers in Ireland in relation to this programme? (CPD duration, resources for reduction)

- What did you think of the Teacher’s Manual? (Pitch, length, changes for the Irish system)- PROBE

- Can you please talk me through the implementation of this programme? (room on the timetable, additional resources needed, who is drawn in) – PROBE

- Do you envisage any cultural barriers during the delivery of this programme? (How might these be addressed, learning opportunities?)

SECTION F-H: User test observer’s questions
- Any Q’s?
- Is there anything we could have done to make the experience for you?

That is interesting. Can you tell me more about that?
Can you give me an example?
  - What would that look like?

How? In what way?
Why? ‘What kinds of?’
And Then? What else?
IHC user-test interview guides

Children interview guide
The objectives of classroom pilot and user-test interviews is to 1) look for ways to improve the contextualisation and 2) to explore whether children in Ireland experience the as useful, easy to use, understandable, credible, desirable, and well-suited to their context.

Primary focus should be on aspects that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders understanding or use in your setting is helpful to record as it will help us improve future resources.

IHC SCHOOL RESOURCES – USER TEST
CHILDREN INTERVIEW GUIDE
(Children’s Book)
[Date]

CHAPTER ............... 
The objectives of conducting user test interviews with the children is to 1) look for ways to improve the contextualisation and 2) to explore whether the children in Ireland experience the resources as useful, easy to use, understandable, credible, desirable, and well-suited to their context.

Primary focus should be on aspects of the translation that could be improved for better understanding. However, any aspect of the resources (content, design, structure, etc) that hinders the children’s understanding or use is helpful to record as it will help us improve future resources.

SECTION A: Pre-interview
Interviewer: ............... 
Observer: ............... 
Date: ............... 
School: ............... 
Interview subject(s): ............... 
Write their code, e.g. child001, not their name.
If they have been interviewed before, use the same code as last time.
Gender: ............... 
Was interview after a pilot lesson? ...............
SECTION B: Introduction

Start time: ................

Briefly introduce yourself.
Tell them that we want to help people making choices that matter to their health.

Tell them that:
- They are testing what we have made.
- We are not testing them.
- We think the resources are better based on previous pilots conducted.
- The resources are for someone like them.
- Their thoughts can help us make the resources translated better.
- There are no wrong answers to our questions.

Tell them that the interview will last less than an hour.

Remind them that they are free to leave at any time.

Tell them that:
- We want to record the interview so we can be sure of what they said.
- We will not attach their names to the notes or recording.

Ask if they have any questions.

Make sure they have understood and signed all necessary consent forms.

Start recording if they approve.

SECTION C: Profile
If you have interviewed the same person before, skip this section.

How old are you? ............... 

What year of school are you in? ............... 

SECTION D: Think-aloud
They should only read aloud if they want.

Go through the chapter, page by page. Ask them to think out loud, what they like and don’t like, what they understand, and don’t understand, any comment that comes to mind, or things they remember from their experience in the classroom. You can demonstrate the technique for them.

For each part of the book, ask if it is easy to use and understand.

Use questions like:
- What do you think this part is about?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X--[Specific page or section of book]
- What do you think this part is about?
- Was it easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?

How can we improve the text in [your language]?

Page X--Activity
- Can you describe what you think about this activity?
- Was the description/instruction easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

Page X--Exercise X
Is it a familiar type of exercise?
- Can you describe what you think about these/this exercise? (Type of exercise, number of exercises)?
- Was the description/instruction easy to use and understand?
- What is difficult to understand? Why?
- What should be improved? How?
- Is there anything that there should there be more or less of? Why?
- Are there any words that should be changed?

SECTION E: General

What questions do you have about what John and Julie learn in this chapter?

Do you trust what is in this chapter? Why?

After reading this chapter, do you think the book is for a class like yours? Why?

How would you explain to a friend what John and Julie learn in this chapter?

Do you think what John and Julie learn fits in your life? If so, how?

Do you think the chapter is interesting or important? Why?
Do you think the people at your home would be interested in the book? Why?

Do you have anything more you want to say to us about the book or project?

SECTION F: User test observer’s questions
*The observer asks whatever questions they have.*

SECTION G: Participant’s interview experience
Is there anything we could have done to make the interview a better experience for you?

*Stop recording and thank them.*

SECTION H: Post-interview discussion
What were the most important findings?

What do the findings suggest we should do for the resources to be more useful, easy to use, understandable, credible, desirable, or well-suited to the [your country or setting] context?
Prompt sheet for focus groups

SECTION A: Pre-interview - Talk-through
- Follow the guide

SECTION B/C: Introduction/Profile (Start Recording)
- Myself, Tell them that we want to help people making choices that matter to their health.
- They are testing what we have made, we are not testing them.
- We think the resources are better based on previous pilots conducted.
- The resources are for someone like them.
- Their thoughts can help us make the resources suit Irish schools better.
- There are no wrong answers to our questions.
- Free to leave. We want to record. Any Q’s? Informed consent/forms? Anonymity
- **START Recording** – Age and Class

SECTION D: Think-aloud
Read Through – Probe using criteria below (stop the as they read)
Page 4—Text - meaning/understandability/improvement/volume
Page 166—Activity – opinion/understandability/improvement/volume
Page 169/170—Exercise 1+2
familiarity/opinion/understandability/improvement/volume

SECTION E: General – Go to T. Manual
Refer directly to Interview guide for Q’s

SECTION F + G: User test observer’s questions
- Any Q’s?
- Is there anything we could have done to make the interview a better experience for you?
- **STOP Recording** – Thank them

SECTION F: Post Interview Discussion
- Findings and implications of same

Chapter 8
Demonstrate using pg 124
Do any words need changing?
Post-programme Teacher Interview Guide

Exploring other factors that could affect impact – Teachers interview guide

<table>
<thead>
<tr>
<th>Interviewed person no.:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>School:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Date:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Interviewer’s Name:</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Audio or video recording?</td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

**Section D. (School System and Environment)**

Have you changed any of your initial thoughts on the IHC programme having delivered it in your class?

What factors in the Primary School system would help or hinder future uptake of the IHC lessons at your school?

In your experience, what should be in place to enable more schools to take up this programme?

Is there a need for a Home-School link element in this programme? Why?
Section B. (Feedback on materials)

Having implemented the programme, do you feel that IHC is age appropriate for 5th class?

To what extent do cultural barriers remain a problem in this programme and how would you address them?

In your own opinion, to what extent is the IHC program compatible with the current primary school curriculum?

Are there any structural recommendations you would make about either book?

Section A. (About the teachers)

What factors do you think motivate or demotivate teachers to take on the IHC programme in its current format?

What level of teacher CPD is needed and what should it target?

Section E. Potential Adverse or beneficial effects

Having delivered the programme, what do you see as potential positive or negative effects, if any, for the pupils?

How did the students receive the programme?

Do you have any comments on the vocabulary used in this programme? For example, the broadening of the definition of the word ‘treatment’?

Are the skills you have taught in this programme useful or transferrable?

Here is a list of possible good or bad impacts people have suggested we should think about. Are there any of these items that you have seen examples or signs of, or that you have been aware of or concerned with yourself? (List on two separate sheets)

<table>
<thead>
<tr>
<th>Potential bad impacts</th>
<th>Corresponding potential good impacts</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict between children and teachers due to children challenging their teachers.</td>
<td>More open and engaging discussion of the basis of diverse claims or beliefs</td>
</tr>
<tr>
<td>Conflict between children and parents due to children challenging their parents</td>
<td>Better understanding between children and parents due to children conversing with their parents about what they are learning and parents feeling more engaged with what their children are learning + engagement of parents in discussions of health issues</td>
</tr>
<tr>
<td>Distrust of health professionals or conflict between children and health professionals.</td>
<td>Appropriate questioning of health professionals, better understanding and better healthcare</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Conflict due to undermining of religious beliefs</td>
<td>Engagement of children and others in discussion about religious beliefs and science</td>
</tr>
<tr>
<td>Shortened enjoyment of the innocence of childhood</td>
<td>Increased enjoyment of school and childhood</td>
</tr>
<tr>
<td>Nihilism or cynicism</td>
<td>Healthy scepticism and appreciation of science</td>
</tr>
</tbody>
</table>
### Other potential good impacts

<table>
<thead>
<tr>
<th>Impacts on teachers</th>
<th>The learning resources might improve the teachers’ understanding and ability to apply the concepts being taught to the children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Impacts on parents</td>
<td>The learning resources might indirectly improve parents’ understanding and ability to apply the concepts being taught to the children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Assertiveness</th>
<th>Children asking more questions and not taking things for granted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved decision-making</td>
<td>Children making more thoughtful and informed decisions</td>
</tr>
<tr>
<td>Nonviolent conflict resolution</td>
<td>Claims being presented and addressed in a friendly manner even when there is a disagreement about the claim, as illustrated in the resources</td>
</tr>
<tr>
<td>Friendship formation</td>
<td>Friendly interactions between adults and children and among children, as illustrated in the resources</td>
</tr>
<tr>
<td>Collaboration for problem solving</td>
<td>Collaboration for problem solving among the children, as illustrated in the resources</td>
</tr>
<tr>
<td>Creativity</td>
<td>Thinking outside the box</td>
</tr>
<tr>
<td>Numeracy</td>
<td>Improvements in numeracy, reflecting what is learned in lessons 6 and 7 (on fair comparisons and the play of chance)</td>
</tr>
</tbody>
</table>

### Section F. Other

Do you have any other feedback you’d like to share with us, either positive or negative about these resources or your involvement in this project?

### Section G. Feedback on our session.

How has this interview been conducted?
Appendix 7 – Data and coding samples

Braun and Clarke (2013) provided the step by step guide of coding and analysis used in this study. Included in this appendix are examples of the work associated with each step:

1. Transcription (excerpt from an interview transcript)

Dara - T009
Duration: 65.54 Minutes

Q Thank you very much for joining me today. My name is Dara Glynn and we are here to discuss the health choices book from the informed health choices program. And in particular the research that will contextualise the program to the Irish context. Now it’s a program that is designed to teach children critical and constructive thinking skills and when they grow up then to be able to make informed health choices in their lives. Accordingly we are now going to try and contextualise the content to the Irish curricular situation. The expected duration of the interview is one hour and you are free to leave at any stage. Do you have any questions on that?

A No that’s fine, thank you.

Q You have signed the informed consent form.

A Yes.

Q Great and just to reassure you that your name will not appear on any of the reports but I may, with your permission contact you again at some later date to validate some of the themes that come up.

A No problem.

Q So I have some profile questions to begin with. And the first one of those is your age.

A 59.

Q And what is your level of education.

A PhD.
Q And how long have you taught.
A 38 years.
Q And what class areas.
A Every class in primary school.
Q So what I’d like you to do, to begin with is if you wouldn't mind we’ll have a read through of the children’s guide, then we’ll have a little bit of a focus later on, on the teachers manual but to begin with if you wouldn't mind reading through chapter one and feel free at any stage during the process to stop and to say anything that comes into your head, if there are any comments or any phrases or pictures that you want to make a comment on please feel free to do so. And just to reiterate, I’m not sure if I said it already you are free to leave at any stage during this interview.
A Great, thank you. So do I read silently or.
Q Out loud if you wouldn't mind.
A Ok and going through each paragraph?
Q Absolutely and you don’t have to stop if you don’t want to but if anything does occur to you to say then please do.
A *Ok health treatments and effects of treatments, what do we learn from this lesson, what health is, what a treatment is, what an effect of a treatment is, what a health researcher is, what this book is about.* Then the key words. *Your health is how well your body and mind are. A treatment is something you do for your health. An effect of a treatment is something that a treatment makes happen. A health researcher is someone who carefully studies health to find out more about health.*
Q Now if you wouldn't mind actually, I just want to ask you 1 or 2 questions about this page. There will be 2 other pages that I’ll just ask a few extra questions about. So just in relation to that first introductory page, do you feel the meaning was clear, was it understand
A Yeah it was interesting when I even read it before, very good as an adult, its lovely to know that and to understand it. Yeah I think they’re really good.

Q **Ok and in terms of the volume of text, do you feel.**

A Yeah there’s quite a lot of text there but I know they’re the key words and they’re explained later. So that’s fine. You’re probably hitting the children with a lot, probably if I was starting a lesson I might start, maybe a gentler start. But then you know looking at, we’re looking at upper primary aren’t we here.

Q **Yeah.**

A So then I know children would be used to being told well this is what your going to learn about. But I think if I was starting I might start with a story or just a gentler approach and then mention these but not to dwell on them. Because they’re explained very well. So yeah that would be the way I would go. So we move on to health, your health is important and I like the way, you know the bold print is there. *Is how well your body and mind are if you are free from sicknesses and injuries, your health is good, if you’re sick or injured your health is bad.* That’s very clear. *When your health is good there’s much more that you can do, for example you can play, learn and sleep well.* And there’s a picture of good health and bad health and then the discussion. *What are some sicknesses and injuries that you have had.* Well I hope you have plenty of time for that now because you’ll have a great time and there will be telling you about every pain and ache for months afterwards I think. They’ll be coming in looking for plasters and all of that. And I think, I suppose you know even thinking of that and how you might consider maybe you know the children’s grandparents, would they have any association there or, and I know it’s to do with your sickness and injury but maybe someone in your family or community might just be a way around it. Because sometimes you can be feeding the children and they’ll think they have to find a pain or an ache. So that just might add to it. So the treatment then. *Treatment is something you do for your health, when people say treatment most times they’re talking about taking*
medicine, however in this book treatment is anything you do so your health says good or gets better. There are many different types of treatments. Using medicine is a type of treatment, for example taking a tablet, getting an injection and using a cream are treatments. And I know there’s discussion at the end but I think I would be having a discussion after each one of those, using medicine. Then getting an operation is a type of treatment, for example removing a rotten tooth is a treatment. Then using equipment is a type of treatment, for example using crutches, a bandage and toothbrush are treatments. I suppose if you’re doing it with, you know say the middle years more discussion, seniors you could probably move on.

Q And can I ask you why would you do that after each section.
A I just think there’s a lot in there so there’s using medicine, there’s getting operations, there’s using equipment, this was kind of news for me even when I was reading it. So like you want the children to internalise it, you want them to understand and that will happen through engagement where they can talk about it and take ownership and they can identify with it. So using the medicine, the tablet, you know what is it, what did you get an injection for and the cream, which ones and I mean even there now the last few days the story about Difene being linked to, I think heart illness or whatever. And even with children who would be exercising, a sport, you know they take Difene or Diclac gel or that and they would be familiar with it. So I think a discussion to ensure the children understand it. You don’t, I suppose I think of, you know when students teach lessons and teaching practice, they float in, teach the lesson and float off. But the teacher needs to do the consolidation and the revision and making sure the children understand. So you’re upskilling them and you’re giving them the vocabulary. So exercising then is a type of treatment, for example running, playing
2. Reading/familiarisation - taking note of items of potential interest.

Dara - T009
Duration: 65.54 Minutes

Q Thank you very much for joining me today. My name is Dara Glynn and we are here to discuss the health choices book from the informed health choices program. And in particular the research that will contextualise the program to the Irish context. Now it’s a program that is designed to teach children critical and constructive thinking skills and when they grow up then to be able to make informed health choices in their lives. Accordingly we are now going to try and contextualise the content to the Irish curricular situation. The expected duration of the interview is one hour and you are free to leave at any stage. Do you have any questions on that?
A No that’s fine, thank you.
Q You have signed the informed consent form.
A Yes.
Q Great and just to reassure you that your name will not appear on any of the reports but I may, with your permission contact you again at some later date to validate some of the themes that come up.
A No problem.
Q So I have some profile questions to begin with. And the first one of those is your age.
A 59.
Q And what is your level of education.
A PhD.
Q And how long have you taught.
A 38 years.
Q And what class areas.
A Every class in primary school.
Q So what I’d like you to do, to begin with is if you wouldn’t mind we’ll have a read through of the children’s guide, then we’ll have a
little bit of a focus later on, on the teachers manual but to begin with
if you wouldn't mind reading through chapter one and feel free at
any stage during the process to stop and to say anything that comes
into your head, if there are any comments or any phrases or
pictures that you want to make a comment on please feel free to do
so. And just to reiterate, I’m not sure if I said it already you are free
to leave at any stage during this interview.
A Great, thank you. So do I read silently or.
Q Out loud if you wouldn't mind.
A Ok and going through each paragraph?
Q Absolutely and you don’t have to stop if you don’t want to but if
anything does occur to you to say then please do.
A Ok health treatments and effects of treatments, what do we learn
from this lesson, what health is, what a treatment is, what an effect of a
treatment is, what a health researcher is, what this book is about. Then
the key words. Your health is how well your body and mind are. A
treatment is something you do for your health. An effect of a treatment is
something that a treatment makes happen. A health researcher is
someone who carefully studies health to find out more about health.
Q Now if you wouldn't mind actually, I just want to ask you 1 or 2
questions about this page. There will be 2 other pages that I'll just
ask a few extra questions about. So just in relation to that first
introductory page, do you feel the meaning was clear, was it
understand
A Yeah it was interesting when I even read it before, very good as an
adult, its lovely to know that and to understand it. Yeah I think they’re
really good.
Q Ok and in terms of the volume of text, do you feel.
A Yeah there’s quite a lot of text there but I know they’re the
key words and they’re explained later. So that’s fine. You’re
probably hitting the children with a lot, probably if I was starting a
lesson I might start, maybe a gentler start. But then you know
looking at, we’re looking at upper primary aren’t we here.
Q Yeah.
So then I know children would be used to being told well this is what you're going to learn about. But I think if I was starting I might start with a story or just a gentler approach and then mention these but not to dwell on them. Because they're explained very well. So yeah that would be the way I would go. So we move on to health, your health is important and I like the way, you know the bold print is there. Is how well your body and mind are if you are free from sicknesses and injuries, your health is good, if you’re sick or injured your health is bad. That’s very clear. When your health is good there’s much more that you can do, for example you can play, learn and sleep well. And there’s a picture of good health and bad health and then the discussion. What are some sicknesses and injuries that you have had. Well I hope you have plenty of time for that now because you'll have a great time and there will be telling you about every pain and ache for months afterwards I think. They’ll be coming in looking for plasters and all of that. And I think, I suppose you know even thinking of that and how you might consider maybe you know the children’s grandparents, would they have any association there or, and I know it’s to do with your sickness and injury but maybe someone in your family or community might just be a way around it. Because sometimes you can be feeding the children and they’ll think they have to find a pain or an ache. So that just might add to it. So the treatment then. Treatment is something you do for your health, when people say treatment most times they're talking about taking medicine, however in this book treatment is anything you do so your health says good or gets better. There are many different types of treatments. Using medicine is a type of treatment, for example taking a tablet, getting an injection and using a cream are treatments. And I know there’s discussion at the end but I think I would be having a discussion after each one of those, using medicine. Then getting an operation is a type of treatment, for example removing a rotten tooth is a treatment. Then using equipment is a type of treatment, for example using crutches, a bandage and toothbrush are treatments. And I suppose if you’re doing it with, you know say the middle years more discussion, seniors you could probably move on.
Q  And can I ask you why would you do that after each section.
A  I just think there’s a lot in there so there’s using medicine, there’s getting operations, there’s using equipment, this was kind of news for me even when I was reading it. So like you want the children to internalise it, you want them to understand and that will happen through engagement where they can talk about it and take ownership and they can identify with it. So using the medicine, the tablet, you know what is it, what did you get an injection for and the cream, which ones and I mean even there now the last few days the story about Difene being linked to, I think heart illness or whatever. And even with children who would be exercising, a sport, you know they take Difene or Diclac gel or that and they would be familiar with it. So I think a discussion to ensure the children understand it. You don’t, I suppose I think of, you know when students teach lessons and teaching practice, they float in, teach the lesson and float off. But the teacher needs to do the consolidation and the revision and making sure the children understand. So you’re upskilling them and you’re giving them the vocabulary. So exercising then is a type of treatment, for example running, playing.
3. Coding – complete; across the entire dataset.

(Initial codes in Brackets) = raw data

<table>
<thead>
<tr>
<th>T009</th>
<th>1</th>
<th>(Volume of Text) - You’re probably hitting the children with a lot</th>
<th>T009.2</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>(Learning Outcomes list) - So then I know children would be used to being told well this is what your going to learn about</td>
<td>T009.2</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>starting I might start with a story or just a gentler approach and then mention these but not to dwell on them</td>
<td>T009.2</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>(Discussion Box) - I hope you have plenty of time for that now: they’ll be telling you about every pain/ache for months afterwards</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>(Home School Link) - you might consider maybe you know the children’s grandparents</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>(Vocab difficulty) - If you’re doing it with, you know say the middle years more discussion, seniors you could probably move on</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>I just think there’s a lot in there, this was kind of news for me even when I was reading it</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>you want the children to internalise/understand it through engagement where they can talk about, take ownership and identify with it</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>So I think a discussion to ensure the children understand it</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>the teacher needs to do the consolidation and the revision and making sure the children understand</td>
<td>T009.3</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>example running, playing basketball and dancing are treatments. And that’s something that adults mightn’t even think of.</td>
<td>T009.4</td>
</tr>
<tr>
<td></td>
<td>12</td>
<td>(IHC) - many are now are health promoting schools encouraging healthy eating and healthy lifestyle. So this ties in very well there</td>
<td>T009.4</td>
</tr>
<tr>
<td></td>
<td>13</td>
<td>(Discussion Boxes) - So I know there is discussion at the end but I would be discussing going through it</td>
<td>T009.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Perception of the Children’s Book generally is that it is too big.</th>
<th>Stakeholder Interviews</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Volume of text) - reducing it would be good</td>
<td>T003.7</td>
</tr>
<tr>
<td>just points would be sufficient rather than sentences</td>
<td>T003.7</td>
</tr>
<tr>
<td>teacher will elaborate</td>
<td>T003.7</td>
</tr>
<tr>
<td>too much explanation</td>
<td>T003.7</td>
</tr>
<tr>
<td>pictures and points would be sufficient.</td>
<td>T003.7</td>
</tr>
<tr>
<td>The children’s book could be reduced considerably in size and still get across the key messages</td>
<td>T003.13</td>
</tr>
<tr>
<td>the children’s book could be a smaller pamphlet</td>
<td>T003.15</td>
</tr>
<tr>
<td>Cut down on the size of the book</td>
<td>T004.10</td>
</tr>
<tr>
<td>Even that first chapter an awful lot of it could be condensed into two pages</td>
<td>T004.10</td>
</tr>
<tr>
<td>just feel the book itself is quite a weighty text</td>
<td>T007.8.7</td>
</tr>
<tr>
<td>it be converted to possibly an A4 size</td>
<td>T007.8.7</td>
</tr>
<tr>
<td>I wouldn’t sacrifice the use of space the way it is in the book but potentially it could be narrowed and stretched</td>
<td>T007.8.8</td>
</tr>
<tr>
<td>it might have been better presented in an A4 format because there’s a lot of page turning</td>
<td>T007.8.12</td>
</tr>
<tr>
<td>it’s so at odds with the shape of every other school book I’ve seen, it reads like a little dictionary</td>
<td>T007.8.19</td>
</tr>
<tr>
<td>If it was A4 workbook size it’s more convenient for bags, or for folders and stuff, actually the larger size if it’s thin-</td>
<td>T007.8.19</td>
</tr>
<tr>
<td>You’re probably hitting the children with a lot</td>
<td>T009.2</td>
</tr>
<tr>
<td>There’s definitely not too much anyway. I think its clear and its simple and I think that’s what kids need</td>
<td>T010.2</td>
</tr>
<tr>
<td>Volume seems to be perfectly fine</td>
<td>T010.17</td>
</tr>
<tr>
<td>maybe the book publishers would come on board</td>
<td>T002.20</td>
</tr>
<tr>
<td>someone would write a text book maybe for schools appropriate for Irish children based on what the curriculum</td>
<td>T002.20</td>
</tr>
<tr>
<td>the volume of text is fine, actually you know it’s not cluttered</td>
<td>T011.3</td>
</tr>
<tr>
<td>FG and Tpp</td>
<td></td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>there's a little bit of repetition in it and maybe it could be condensed a little bit</td>
<td>T010pp.1</td>
</tr>
<tr>
<td>the children themselves you know they kind of, you know the lessons were a little bit too long some of them to sustain their</td>
<td>T010pp.1</td>
</tr>
<tr>
<td>A lot of the pages seem to be very similar to each other</td>
<td>T010pp.6</td>
</tr>
<tr>
<td>most books now we don't write into anyway. You write into the copies</td>
<td>T010pp.8</td>
</tr>
<tr>
<td>(activities): They explain the same thing over and over again</td>
<td>FG001.6</td>
</tr>
<tr>
<td>I think they often waste paper in some - Especially in the start, like there was, there's like just, just</td>
<td>FG001.9</td>
</tr>
<tr>
<td>there's a lot of empty space and are you also</td>
<td>FG001.9</td>
</tr>
<tr>
<td>Vocabulary I suppose that could be left out really, maybe the Ugandan words and things like that</td>
<td>T004pp.10</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Obs</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Children began to work on the written exercise but were already beginning to watch the clock towards the end of the activity section of the lesson. It would probably have been better to give the written exercises for homework</td>
<td>T.010.obs.L2.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>T. Reflection</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>too much class time spent on the lesson</td>
<td>T.010.EV.1</td>
</tr>
<tr>
<td>I should keep an eye on time management</td>
<td>T.010.EV.5</td>
</tr>
<tr>
<td>The volume of content made it harder for children to achieve the lesson objectives</td>
<td>T.010.EV.9</td>
</tr>
<tr>
<td>The lesson was long winded and repetitive</td>
<td>T.004.EV.7</td>
</tr>
</tbody>
</table>
5. Reviewing themes (producing a thematic map – i.e. themes and subthemes and the relationships between them).

<table>
<thead>
<tr>
<th>Theme</th>
<th>Where the programme fits in</th>
<th>Interviews</th>
<th>FG &amp; Tpp</th>
<th>Obs</th>
<th>T. Reflection</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sub-theme</strong></td>
<td>This programme covers a lot more than SPHE</td>
<td>Its SPHE, it fits in with many of the SPHE programs. I think there’s a gap in the market for it. Scientific method, a science, a SESE curriculum, SPHE, language development oral development within it so you know they are potentially could be an integrated piece.</td>
<td>Looking at my 5th class children, I definitely think they were the ones who benefited the most from it and were engaged in it and really liked the program. There’s huge scope for it there across a wide curriculum.</td>
<td>Drew in language and examples from other areas of the curriculum (probability – ‘likely/unlikely’ ‘possible’; Oral Language – exploration of alternative meanings for ‘Claim’)</td>
<td>Opportunities to integrate the lesson with other curricular areas such as Drama, OL and probability in Maths.</td>
</tr>
<tr>
<td><strong>Sub-theme</strong></td>
<td>The importance of middle management support</td>
<td>Normally there has to be some kind of a driver for this. Something would have to drive this. Management structure: teacher: responsibility for the area of health and fitness, that person.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sub-theme</td>
<td>Involving the Department of Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Launched at national level with backing from the inspectorate and the department.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Our curriculum is being revised so maybe when it comes to the SPHE or the SESE and with PDST that this would be a slot.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>They are talking about more integrated approaches and more flexi-time and there might be schools in the country where this work would be more relevant than others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Definitely the government will need to help out and bring it into the education centres, train the teachers how to use it and how to implement it in the classrooms.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cultural shift – absolutely.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>The cost would certainly be one.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Summary Statement</th>
</tr>
</thead>
<tbody>
<tr>
<td>This theme relates to the teachers and other key stakeholders’ views of programme implementation and sustainability. Their views relate to issues at classroom, school management and Department of Education levels and the contribution required at each level to support the embedding of the programme.</td>
</tr>
</tbody>
</table>
### 6. Defining and naming themes.

<table>
<thead>
<tr>
<th>Factors and Sources (IHC Domain)</th>
<th>Title of Finding</th>
<th>Brief Explanation</th>
<th>Supporting Quotes</th>
<th>Origin Code</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Curricular Placement</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The perception is that this Programme covers a lot more than SPHE</td>
<td>Interviewees seemed to recognise that IHC, although most closely aligning with SPHE, is an integrated learning theme programme and spills over into many areas of the curriculum.</td>
<td></td>
<td>Re-brand as an integrated learning theme programme (Social Personal and Health Education/Language/Social Environmental and Scientific Education) + other subjects/skills where the mapping is less pronounced (e.g. Maths, Drama, PE, critical thinking, entrepreneurialism)</td>
</tr>
<tr>
<td></td>
<td>SPHE, part of P E, problem solving</td>
<td></td>
<td>SPHE, part of P E, problem solving</td>
<td>T003.12</td>
<td>A curricular map to justify time taken from SPHE and other subject areas</td>
</tr>
<tr>
<td></td>
<td>the basis for critical thinking right across all subjects as a whole methodology I think.</td>
<td></td>
<td>the basis for critical thinking right across all subjects as a whole methodology I think.</td>
<td>T003.12</td>
<td>Include linkage opportunities to other areas of the curriculum for each lesson in the T Guide. For example, the link between the experiment using 100 runners in a</td>
</tr>
<tr>
<td></td>
<td>Debating - something that probably we don’t do enough of.</td>
<td></td>
<td>Debating - something that probably we don’t do enough of.</td>
<td>T003.13</td>
<td></td>
</tr>
<tr>
<td>University to the study of percentages in Maths</td>
<td>Adjust written exercises to reflect the thematic approach of the programme, without diminishing core concept of repetition (e.g. using Drama to write your own scene/narrative of someone citing personal experience as the basis for a claim)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>you could link it into report writing in English, explaining and procedures</td>
<td>T007.8.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The comic book style is a nice example too of comic writing or story writing</td>
<td>T007.8.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SPHE, science, a little bit of geography - 4th, 5th and 6th class</td>
<td>T009.17</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>curriculum placement - Well they are kind of a hybrid I think</td>
<td>T011.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>scientific method, a science, a SESE curriculum, SPHE, language development oral development within it so you know they are potentially could be an integrated piece</td>
<td>T011.18</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>what I liked about the program was it was opportunities for pair working and group work</td>
<td>T010pp.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>the good thing about the program is that it can be done in a thematic approach or an integrated approach</td>
<td>T010pp.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
They took a look at the opening picture on pg 64 and spent some time predicting what they thought would happen in the story the (Building Bridges School)

Opportunities to integrate the lesson with other curricular areas such as Drama, OL and probability in Maths

Positive Learning Environment

Teachers see the lesson timetables in IHC as too prescriptive

There was a sense that there were too many steps and too much unnecessary detail.

(Timetabling) - There’s a lot of other SPHE type things coming in like mediation and mental health

So to give it the time that is listed on the booklet here there isn’t a chance id be able to do that.

I find it hard enough to get science stuff done or history and geography

I would use it as an SPHE lesson, SPHE is half an hour per week so I would make it fit into that

If it was a case that I would be able to use the lesson as is, I would gladly go ahead with it

the time constraints would be another huge issue there
I think the timing, the length of the program would be quite a lot really. 10 hours I think

The lesson was long winded and repetitive

Timing and pacing - it was a long lesson

| Prescriptive timetabling was seen as incompatible with many Irish classrooms. |

| The standardised approach, it was felt, could not take account of the varied classroom contexts in the Irish system. |

| (Implementation) - take a flexible attitude to how you would implement the curriculum in the class |
| to make it relevant to the children that would be in front of me there would be some adaptation |
| something that teachers in Ireland in general would do |
| I feel all teachers all over Ireland would have the same opinion that there would be a lot of changes. |
| if it’s not officially with SPHE I would find it in science or use it as a discretionary time activity |
I think it would be difficult to implement it having 2nd and 3rd class in the room as well as the 4th, 5th and 6th class. A straight 4th, 5th or 6th class I could see this program being easily implemented. A single stream school would be easiest.

Breaking it up into a 2 year cycle - that would be very good alright.

What I found and I think would be very difficult to get into the schools would be just to find the time for it in the current climate where we’ve got lots of things going on.

Spent a significant amount of time pre-teaching vocabulary in this way (15 mins).

Multi class and EAL scenarios would make accessing this material more difficult for children.

There was a sense that more scope for differentiation was needed in the programme.

I know the children in front of me.

(idea) - have an extra section for the children who are finished early, high achievers.

Recognition of the need for differentiation in the Teacher Guidelines and Teacher Training Programme.

Advice to use pre-existing methods for dealing with this issue of differentiation (e.g. Drop Everything And Read, or DEAR, where children who finish early are allowed to take out a book and silently read until the other students catch up).
<table>
<thead>
<tr>
<th>maybe on the other side of that maybe a differentiated kind of a work sheet for a child who maybe would find it difficult</th>
<th>T010.21</th>
</tr>
</thead>
<tbody>
<tr>
<td>in line with how you run your English or your maths, that you try and get some elements of differentiation at either end</td>
<td>T010.21</td>
</tr>
<tr>
<td>Differentiating the lessons</td>
<td>T.010.EV.9</td>
</tr>
</tbody>
</table>
7. Writing – final analysis.

Braun and Clarke say that this involves writing up an analysis that achieves balance between data sets and analytical narrative. The researcher must speak for the accompanying data, not just restate it. The findings, discussion and recommendations of this thesis have aimed to achieve that.
Appendix 8 – Adjusted children’s book – Sample chapter

John and Julie learn about
BAD BASES for CLAIMS about treatments

4

Other bad bases for claims about treatments (Part 2)

What you will learn in this lesson:
Why these are bad bases for claims about the effects of a treatment:
1. That someone selling the treatment said something about it
2. That an expert said something about the treatment

Keyword for this lesson:
An EXPERT is someone who knows a lot about something.

People in this lesson

Professor Compare
Professor Fair

Julie
John

Mr. Jones
Ms. Obafemi
Ms. Smith

These are some friendly people that John and Julie met at the market. They have all bought different treatments.
Mr. Jones and Ms. Smith's Claims

Mr. Jones, if people believe that bananas are better for your health, do you think that woman will sell more bananas?

Yes...

Are Mr. Jones and Ms. Smith here?

Good!

Mr. Jones: Bananas are better for your health than mangoes. The woman who sold me these bananas said so!

Ms. Smith: Mangoes are better for your health than bananas! The man who sold me these mangoes said so!

Let's take a look...

I am Mr. Jones. Bananas are better for your health than mangoes. The woman who sold me these bananas said so!

No! Professor! I am Ms. Smith. Mangoes are better for your health than bananas! The man who sold me these mangoes said so!

So, what someone selling a treatment says is a good basis for a claim about the treatment...

The person could be making the claim so that they make more money!

If more people believe the woman selling bananas, he will make more money.

If more people believe the man selling mangoes, she will make more money.

Which could be why they are making those claims!

Extra example:

Ms. Ryan's claim: "This snake oil will cure any sickness because somebody who sells the oil said so on the radio!"

Treatment: Using the snake oil.

Effect: Curing sicknesses

Facts: What the person selling the snake oil said on the radio

Explanation: Ms. Ryan's basis for her claim is bad, so her claim is unreliable. It is possible the person who is selling the snake oil says it cures any sickness because that person will make more money if people believe the claim.
Good morning, Professors! This small electric machine makes a sound tomosquitoes go away. It stops you from getting malaria. I am sure because an expert told me. This expert knows a lot about mosquitoes.

Ms. Obafemi, experts can be wrong about treatments.

Mr. Obafemi, you are experts, too! You know a lot about health!

Ms. Obafemi, experts can be wrong about treatments.

Yes, they can.

Can your claims be unreliable?

For example, an expert's claim is unreliable if the basis for the claim is only:
- how long the treatment has been used
- how many people have used it...
- how much money it costs

Mr. Obafemi, I have used such a machine, and I still got malaria.
But Professors, what is a good basis for a claim about a treatment? When are claims reliable?

We'll start to teach you about this next week.

Come visit our office at the university!

And remember, when you hear a claim about a treatment, always ask what is the basis for the claim?

And, is it a good or a bad basis?

Instructions

Objective: Explain the basis of different claims

Children sitting at the same bench are a team. The teacher has a list of claims about the effects of treatments.

Step 1: The teacher reads one of the claims about the effects of a treatment.

Step 2: Teams discuss what they think was the basis for the claim.

Step 3: The teacher asks the teams what they think was the basis for the claim.

Step 4: Teams stand up to give their answers; then sit back down, as in the activity in Lesson 3.

Step 5: Children raise their hands to explain their answers.

EXAMPLE: Teacher: "Margaret's football coach leaves a list about football and exercising. Margaret says stretching for half an hour after playing sports will stop you from getting injured. She says it is so because her coach said so." Teams discuss.

Teacher: "Who thinks someone's personal experience was the basis for Margaret's claim?

Teacher: "Who thinks how long the treatment was used or how many people used it was the basis for Margaret's claim?" Teams that think so stand up.

Teacher: "Who thinks how much money the treatment costs or how easy the treatment is was the basis for Margaret's claim?" Teams that think so stand up.

Teacher: "Who thinks that someone selling the treatment saying something about it was the basis for Margaret's claim?" Teams that think so stand up.

Teacher: "Who thinks that an expert saying something about the treatment was the basis for Margaret's claim?" Teams that think so stand up.

Teacher: "Please explain your answers.

Child: The basis was an expert saying something about the treatment! Margaret said her claim was right because of what her coach said and her coach is an expert!" Teacher: "Right! This means Margaret's claim is unreliable! It is possible that her coach was wrong!"
EXERCISE 1

Write each sentence in your copy and whether you think it’s true or false.

Example:
The newer a treatment is, the better it is. **FALSE**

1. New treatments are sometimes worse than old treatments.
2. Not all experts make reliable claims.
3. If an expert makes a claim based on a personal experience, the claim is unreliable.
4. The basis for the claim is more important than who is making the claim.

Ask at home: Who are the experts?

Can you think of people who are seen as experts?

Ask your parent or guardian to help you come up with a list of 10 experts (for example, a teacher is an expert in education).

Write out the list in your copy and bring to the next lesson.

EXERCISE 2

In your copy, write why the claims are unreliable.

Example: Alice eats potatoes everyday. She says it makes her stronger because many people have told her so.

The claim is unreliable because: The basis is how many people have said that eating potatoes everyday makes you stronger. This is a bad basis for the claim.

1. Christopher has bought some candles. He says that if you use the candles, you will not get malaria. He says it is right because people who sell the candles say so.

The claim is unreliable because:

2. Josephine says that eating soup will make the flu go away. She says it is true because a cook told her so. The cook knows a lot about foods.

The claim is unreliable because:

3. Rehema heard a fisherman say that eating boiled fish is better for your health than eating grilled fish. Rehema says the fisherman is right because he knows so much about fish.

The claim is unreliable because:
List of changes made to IHC programme text

Lesson 1:
No Change

Lesson 2 onwards:

1. Change ‘Kasuku’ to ‘Charlie’
2. Drop all translations into Luganda and Kishwali (in green boxes)
3. Pg 41 – Change spelling of ‘Moreen’ to ‘Maureen’

Lesson 4 onwards:

1. Name changes: Mr. Mwaka → Mr. Jones
   Ms. Nantaba → Ms. Smith
   Ms. Namuli → Ms. Obafemi (a better known Nigerian surname in Ireland)
2. Pg 67 – Change ‘Mr. Acheng’ to ‘Mr. Ryan’
3. Pg 69 – Change ‘Mr. Opio’ to ‘Mr. O’Shea’

Note:
- Skin colour variance is not financially feasible in this project but advisable for some characters in a future iteration in response to stakeholder feedback.
- There are no geographical names to be changed.
- Location settings are similar to Ireland (village, clinic, school, etc) but they would be visually exotic to Irish children. Again, visual changes are not financially feasible during this project.
Appendix 9 – Teacher’s Guide – Samples illustrating changes

Reduce Prescription for teachers – Lesson 4 before and after modification

Before
Objectives

What the children should learn in this lesson:

• Why these are bad bases for claims about the effects of a treatment
  1. That someone selling the treatment said something about it
  2. That an expert said something about the treatment

Preparation (20 minutes)

This is what you should do before the lesson.

Read ahead

♦ Read pages for this lesson in the children's book
♦ Read pages for this lesson in the guide

Gather materials

Make sure you have:

♦ This guide
♦ The lesson evaluation form
♦ Some rubbers

Make sure each child has:
A copy of the children’s book
Their exercise book
A pencil or pen

**Summary of story:** John and Julie meet Professor Compare and Professor Fair at the market. John and Julie have collected claims from people there. The Professors choose three of the claims to use as examples to explain two more bad bases for claims about the effects of treatments. First, the Professors use Mr. Jones and Ms. Smith’s claims as examples. Mr. Jones’s claim is about bananas and Ms. Smith’s claim is about mangoes. Second, the Professors use Ms. Obafemi’s claim as an example. Ms. Obafemi’s claim is about a small electric machine.
Lesson (80 minutes)

<table>
<thead>
<tr>
<th>TEACHERS</th>
<th>CHILDREN</th>
<th>TIME</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STEP 1</strong> Review last lesson</td>
<td>Review the last lesson by asking the questions on page 117 in this guide.</td>
<td><strong>10 min</strong></td>
</tr>
<tr>
<td><strong>STEP 2</strong> Read aloud</td>
<td>Answer the questions as instructed.</td>
<td><strong>25 min</strong></td>
</tr>
<tr>
<td></td>
<td>Lead reading aloud starting on page 118 in this guide. <em>For different ways of reading see page 19 in this guide.</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Open to page 62 in their books and read aloud as instructed.</td>
<td></td>
</tr>
<tr>
<td><strong>BREAK</strong></td>
<td></td>
<td><strong>5 min</strong></td>
</tr>
<tr>
<td><strong>STEP 3</strong> Discuss</td>
<td>Discuss the story by asking the questions on page 129 in this guide.</td>
<td><strong>10 min</strong></td>
</tr>
<tr>
<td></td>
<td>If necessary, give extra examples on page 130 in this guide.</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 4</strong> Lead activity</td>
<td>Answer the questions as instructed.</td>
<td><strong>15 min</strong></td>
</tr>
<tr>
<td></td>
<td>Lead the activity starting on page 131 in this guide.</td>
<td></td>
</tr>
<tr>
<td><strong>STEP 5</strong> Manage exercises</td>
<td>Open to page 73 in their books and do activity as instructed.</td>
<td><strong>10 min</strong></td>
</tr>
<tr>
<td></td>
<td>Manage the exercises starting on page 136 in this guide. Help children as they complete exercises and lead marking of exercises. <em>For different ways of marking see page 20 in this guide.</em></td>
<td></td>
</tr>
<tr>
<td><strong>STEP 6</strong> Fill in evaluation form</td>
<td>Open to page 76 in their exercise books and complete exercises.</td>
<td><strong>5 min</strong></td>
</tr>
<tr>
<td></td>
<td>Fill in the lesson evaluation form.</td>
<td></td>
</tr>
</tbody>
</table>
These are questions and answers for reviewing the previous lesson, with the children.

1. What was Ruth’s claim?
Ruth’s claim was that her herb cures sicknesses.

2. Why was Ruth’s claim unreliable?
The basis for Ruth’s claim was that many people had used the herb for a long time. How many people have used a treatment or how long they have used it are bad bases for claims about the effects of the treatment. There are many treatments that many people have used for a long time that have other effects than what people thought – for example, putting cow dung on a burn.

3. What was Ahmed’s claim?
Ahmed’s claim was that his glasses were better than other glasses.

4. Why was Ahmed’s claim unreliable?
The basis for Ahmed’s claim was that his glasses were newer and cost more money than other glasses. How new a treatment is or how much it costs are bad bases for claims about the effects of the treatment. Old treatments that cost little money can be as good or even better than new treatments. Ahmed saw as well with his old glasses as with his new ones.
Objectives

What the children should learn in this lesson:

• Why these are bad bases for claims about the effects of a treatment
  1. That someone selling the treatment said something about it
  2. That an expert said something about the treatment

Preparation (20 minutes)

This is what you should do before the lesson.

Read ahead

♦ Read pages for this lesson in the children's book
♦ Read pages for this lesson in the guide

Gather materials - Make sure you have:

♦ This guide
♦ The lesson evaluation form
♦ Some rubbers

Make sure each child has:

♦ A copy of the children’s book
♦ Their exercise book
♦ A pencil or pen

Summary of story: John and Julie meet Professor Compare and Professor Fair at the market. John and Julie have collected claims from people there. The Professors choose three of the claims to use as examples to explain two more bad bases for claims about the effects of treatments. First, the Professors use Mr. Jones and Ms. Smith’s claims as examples. Mr. Jones’s claim is about bananas and Ms. Smith’s claim is about mangoes. Second, the Professors use Ms. Obafemi’s claim as an example. Ms. Obafemi’s claim is about a small electric machine.
Appendix 10 – Other contextualised resources developed for Ireland

Flashcards - sample

Health

Treatment

Effect

Health Researcher
1. Faith healers


Like virtually all healers, Johnny won’t say. “I make the sign of the cross, and say a few prayers after it.” Although modern tradition is divided over whether people seeking the cure must believe, healers generally agree that the person with the cure must have faith that, whether through religious, spiritual, or psychological means, it can and will work.

Shingles: The ritual itself is equally important, Francis says. It involves touching the rash with a holly bush – which is believed to be sacred – while reciting a particular prayer.

“She told me to take off my top,” Keith recalls. “She took out a holy medal from a cloth pouch and rubbed on it the affected area. It was metal, and it burned like a hot knife. I closed my eyes and winced as she whispered a prayer – I couldn’t hear what she was saying – and when she stopped, the burning sensation left. She said it would be gone within three days. On the fourth, it was gone.”

Epilepsy: Crucially, Amanda insists that anybody who comes to her must also go to a conventional medical doctor, and that they must follow that doctor’s advice. Her cure involves reciting a Christian-based charm or prayer – unsurprisingly, she won’t reveal it – while patients must also drink a specially prepared herbal remedy, which she says can only work if it is made fresh.
2. Herbal medicine

Psoriasis: a tincture that includes turmeric, burdock and milk thistle among others. Tinctures are liquid extracts of herbs distilled in alcohol. It makes me feel a bit tipsy the first few times. Turmeric is reputedly anti-inflammatory; burdock has long been used for skin ailments though there is insufficient evidence; milk thistle’s active ingredient, silymarin, has antioxidant and anti-inflammatory properties.

Stress/Sleep deprivation: She gives me a tea to help with stress and sleep problems. It contains lemon balm, nettle, linden, cleavers and liquorice. Nettle: so damn healthy for many reasons. Lemon balm: calming and digestive. Linden: anti-spasmodic and sedative. Liquorice: dangerous if consumed in high volumes, not good for people with high blood pressure and heart problems, but University of Maryland studies show it can help healthy people with a variety of ailments

Common Cold: In Irish folk medicine, honey has long been put forward as a cure for the common cold.

Hot whiskey with honey.

Onions or garlic in your socks.

Mouth Ulcers: Another Irish remedy involving honey is used to treat aphthous ulcers, which occur on the mucous membrane inside the mouth. In Leitrim, they are treated with a swab of honey and borax (a salt of boric acid).

Hiccups: The Irish swear that the best cure for hiccups is to the afflicted person a terrific shock. Jumping out from behind a doorway or stealing up behind them and shouting loudly in their ear.

Holding your breath

Breathing into a brown paper bag

Drinking water upside down
Upset Stomach/Sickness: Lucozade or flat 7up

A sprig of mint or lavender tied around the wrist or worn around the neck will quell an upset tummy.

Nightmares: Bluebells, that most common and magical of Irish flowers, are believed to call the fairies when they’re rung. That meant they were sometimes regarded as an unlucky thing to bring into the house. But others turn to them as a first line defense against nightmares – place them in a vase in your bedroom.

Hay Fever: A daily spoonful of locally produced honey

Arthritis: The Irish believe that nettle juice – yes, from the stinging plant – that’s harvested on May Day will keep arthritis away.

Iron deficiency: Nettle soup

Cuts/bleeding: The use of cobwebs to stem bleeding isn’t just an Irish cure; it has been used all over the world since the beginning of time

Nettle sting: Rub with Dock Leaf

Maintain/Improve Eyesight: Eat carrots

Check this website: http://www.firodaschool.ie/index.php/old-cures/

3. Superstitions

Bad luck:

A single magpie (you must wave at it)

Disturbing a Fairy Fort

Failing to have a candle on your window during Christmas

Breaking a mirror (7 years)
A black cat crossing your path

Knocking over your chair when you stand up (bless yourself as you put it back)

Putting new shoes on the table

**Good luck:**

A bird poos on you.

Seeing a pair of Magpies

Hanging a horseshoe above your doorway

**Premonitions:**

Itchy nose = A fight is about to happen

Burning sensation on your ears = someone is gossiping about you

Hearing the Banshee = someone you know will die

Seeing the Banshee = you will die
A **Claim** is something that someone says can be right or wrong.

The **Basis** for a claim is the support, foundation or reason for the claim.

**Claim**

**Bad Basis?**

**Personal Experience**

- **But she said she put cow dung on her burn and her burn healed!**

**Experts can be wrong**

- **This electric machine stops you from getting malaria. I am sure because an expert told me.**

**How much money it costs or how new it is**

- **These new glasses are better than other glasses because they are new and cost a lot of money.**

**Additional poster – sample – Lesson 1-5 review**
### Appendix 11 – Audit trail data checklist

<table>
<thead>
<tr>
<th>Item</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Examples of raw data, extracts from interviews and field notes across chapters of this thesis and in this Appendix.</td>
<td>Yes – Samples found in Findings chapter and Appendix 3</td>
</tr>
<tr>
<td>Data reduction and reconstruction samples</td>
<td>Yes – Samples found in Appendix 7, Findings and Recommendations Chapters</td>
</tr>
<tr>
<td>Process notes</td>
<td>Yes – Methodology Chapter</td>
</tr>
<tr>
<td>Materials relating to intentions and dispositions</td>
<td>Yes – Appendix 3 and section 3.9.1</td>
</tr>
<tr>
<td>Instrument development</td>
<td>Yes – Appendix 5 and 6</td>
</tr>
</tbody>
</table>