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There have been considerable debates about physical education (PE)’s role in public health. Researchers, PE teacher educators and PE teachers have not only critically interrogated whether it is valuable, attainable and feasible to try to promote young people’s health through PE (e.g. Bailey et al., 2009), but proponents of health-based PE also hold distinctive visions about how teachers can realize it in practice. In other words, even among those in favour of health-based PE, there is currently no consensus on the most relevant goals and learning outcomes. These differences are contingent not only on the definition of health as including physical, social, intellectual and psychological aspects, but also on the specific perspectives and emphases taken within each of these definitions (e.g. is enhancing physical health about improving fitness or increasing activity levels?). In this chapter we will discuss the role of physical activity (PA) in PE from several different goal perspectives.

The PA consequences of different PE goal priorities

Physical fitness development as a goal of health-based PE

Numerous research and policy studies support the role of physical fitness in PE. With large-scale, cross-sectional, longitudinal and even prospective population studies among adults providing evidence for a relationship between physical fitness, cardiorespiratory health and risks for mortality (Boreham & Riddoch, 2001), PE teachers have long been expected to improve and monitor students’ physical fitness. Indeed, a common memory many adults hold of their PE experiences during childhood and adolescence is likely to be participation in physical fitness testing (Hopple & Graham, 1995).

In the 1990s in the US, The National Standards for PE (National Association for Sport and Physical Education, 1995) stated that students should achieve and maintain a health-enhancing level of physical fitness. At the same time, books (e.g. Pate & Hohn, 1994) were published on how the PE curriculum could be redesigned and restructured to teach lifetime fitness skills and attitudes. In Scotland and Australia, a number of innovative (yet ultimately unsustainable) daily health-related PE programmes emerged during this period (Kirk, 1991). In Europe, The Committee for Development of Sport developed the European Tests of Physical Fitness (Eurofit; Adam, Klissouras, Ravazolla, Renson & Tuzworth, 1988) recommended that Eurofit tests should...
be adopted for the purpose of measuring and assessing the physical fitness of school-aged children through PE. As a consequence, many PE teachers around the world started to incorporate and measure balance, coordination, flexibility, speed and reaction time, muscular strength as well as cardiorespiratory fitness and endurance testing in their lessons. Moreover, practices involving weighing children and taking skinfold measures were increasingly implemented (e.g. Wright & Dean, 2007) because overweight and increased body fat were found to be inversely related to physical fitness and were suggested as major risk factors for cardiovascular ill-health and mortality among adults (Boreham & Riddoch, 2001).

During the past two decades, however, the effectiveness of such fitness-oriented testing practices has been the subject of some debate given that there is no evidence to suggest they are effective in stimulating young people to become more active (Cale & Harris, 2002; Trost, 2004). Moreover, fitness testing often is perceived as unpleasant, uncomfortable and embarrassing. The information children generate from scores is largely redundant and even negative in that it can stimulate social comparison of test scores (Cale & Harris, 2009; Hopple & Graham, 1995).

Acknowledging that fitness testing may be problematic on a number of grounds, authors have published guidelines on how fitness testing and monitoring can be implemented in more positive ways (Cale & Harris, 2002; Keating & Silverman, 2004). Hopple and Graham (1995) suggest a need for students to better understand the purpose of the fitness testing. Others point out that students can be stimulated to self-assess their fitness levels (e.g. Castelli & Williams, 2007; Keating, 2003; Welk, 2008). These strategies can act as a basis upon which to design health pedagogies if the aim was simply to monitor and improve students’ fitness, however, there are important critiques of fitness-based approaches to health-based PE. Specifically, Trost (2004) suggests that physical fitness is strongly affected by heredity and sports participation outside PE, emphasizing the limited role PE can play in improving physical fitness. A second critique relates to the broad educational remit of PE beyond merely promoting physical fitness. Although the purely fitness-oriented view of health-based PE currently receives rather little support in the research literature, studies in the USA (e.g. Ferguson, Keating, Bridges, Guan & Chen, 2007) and the UK (Alfrey, Cale & Webb, 2012) show that many PE teachers continue to include fitness testing and monitoring in their practice and many US school districts and states collect and monitor fitness test scores.

Increasing PA as the major goal of health-based PE

The first national physical activity guidelines were based on the amount of physical activity required for the development of cardiovascular physical fitness (Boreham & Riddoch, 2001; Fulton, Garg, Galuska, Rattay & Caspersen, 2004). From the 1990s onwards, however, researchers argued that simply transposing adult fitness guidelines onto school-aged children had a negative impact on young people’s experiences in physical activity and sport (e.g. Trost, 2004). Several organizations then developed recommendations for appropriate amounts of physical activity (PA) rather than focusing on physical fitness (Fulton et al., 2004).

In line with these shifts in focus from physical fitness to PA, a well-established and widely recognized group of researchers in the USA began advocating for increased PA levels in PE classes (McKenzie & Lounsbery, 2014; Sallis et al., 2012; Trost & van der Mars, 2009). This was based on growing evidence that health benefits can be accrued very quickly (e.g. decreases in overweight and obesity). In recent publications, Sallis et al. (2012) use the term ‘health optimising PE’ (HOPE) to refer to PE lessons that keep students active at moderate to vigorous (MVPA) intensity levels for more than 50% of the lesson time, engage all students regardless of physical ability and significantly contribute to students’ overall PA
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levels. Another important HOPE goal is to teach students self-management skills, such as self-monitoring, self-evaluation and self-reinforcements, to further increase overall activity levels (McKenzie et al., 1996).

In accordance with the PA during PE focus, researchers have developed numerous interventions to train teachers to promote the highest possible activity levels in PE lessons. The Sports, Play and Active Recreation for Kids (SPARK) programme is one of the most thoroughly investigated and widely used PE programmes in existence (McKenzie, Sallis & Rosengard, 2009). The SPARK programme consists of lessons with a health-fitness and a motor-sport focus. SPARK trainers coach teachers to implement sample units and lessons plans, simultaneously mentoring them to improve class management and instructional skills, increasing children’s activity levels. Following SPARK, the Middle School Physical Activity and Nutrition (M-SPAN) intervention similarly focuses on increasing teachers’ awareness of the need for active PE, assisting teachers in designing and implementing active PE curricula, and developing teachers’ class management and instructional skills (McKenzie et al., 1996; McKenzie et al., 2009). Elementary PE teachers adopting the Child and Adolescent Trial for Cardiovascular Health (CATCH, McKenzie et al., 1996), receive a written PE curriculum (guidebook) and supporting materials (Activity Box), participate in a 6–9 hour training, and on-site consultation at school in alternate weeks at the completion of the training.

When the instructional focus is on increasing activity levels during PE, much can be learned from the way teachers were trained in intervention studies such as SPARK, M-Span and CATCH. Specifically, the results revealed sustainable impacts of the training with many teachers still using the materials provided after the studies ended (e.g. Dowda, Sallis, McKenzie, Rosengard, & Kohl, 2005). One key factor in intervention success was the sustained, on-site support. This addressed the tendency for children’s PA levels to return to baseline levels if teachers were not provided with long-term guidance (Dowda et al., 2005; McKenzie et al., 2003). This finding mirrors the wider literature on effective and ineffective teachers’ professional development (Clarke & Hollingsworth, 2002).

Despite reported beneficial effects on students’ PA levels, scholars also have critiqued these programmes. One source of criticism states that increasing PA during PE will never suffice to improve health. During the past 20 years, numerous studies have assessed PE lessons for their potential to increase PA. For example, PA has been measured using heart rate monitors, pedometers, accelerometers, and through numerous observational systems (e.g. System for Observing Fitness Instruction Time, (SOFIT); McKenzie, Sallis & Nader, 1992). Findings indicated tremendous variability in the number of minutes of PA students accrue as well as in the intensity of in-class PA, depending on a range of factors, including goals and lesson content (Pate, O’Neill & McIver, 2011). Most studies record rather low levels of MVPA in traditional elementary (Cardon, Verstraete, De Clercq & De Bourdeaudhuij, 2004) and secondary lessons with an average MVPA engagement of approximately 10–25 minutes per 30 minute lesson (Aelterman et al., 2012; Fairclough & Stratton, 2005; Slingerland, Ooman & Borghouts, 2011). Although Bassett et al. (2013) suggested that mandatory PE can contribute 23 minutes of MVPA per day, few lessons reach these averages unless the lesson is planned specifically to increase PA. Current evidence suggests that without additional PE instructional time (Haerens, De Bourdeaudhuij, Maes, Cardon & Deforche, 2007; Van Acker et al., 2011), promoting MVPA only during PE will remain an inadequate strategy for enhancing children’s health. Thus, PA promotion should be combined with many other strategies throughout the school day to promote adequate PA during school hours.

Other critics express concern about limiting the PE focus to merely promoting active lifestyles. Advocates of highly active PE lessons come mainly from the public health field, suggesting
that maximizing PA during PE is needed to combat obesity and chronic diseases. These researchers argue that PE teachers need to prioritize public health goals over all other PE goals (e.g. McKenzie & Lounsbery, 2014; Trost, 2004). They argue the current focus on a wide range of diverse learning outcomes is a reason PE has not made positive impact on public health. In this ongoing debate, advocates for a balanced PE approach (e.g. Ennis, 2011) argue that school-based PE is more than PA and should have a comprehensive educational focus on motor skill, sport, personal and social development as well as PA. Advocates of this perspective point out that some lessons that rank low in PA intensity, may have been of poor quality or simply focused on cognitive and affective goals, long considered central to educational approaches to PE.

Aelterman et al. (2012) and Chow, McKenzie and Louie (2009) showed that different activities and sports produce different activity intensity levels, suggesting that lessons with a predominant focus on increasing intensity levels should prioritize higher MVPA intensity sport activities over those with lower intensities. Thus, one critical question to be addressed when emphasizing MVPA is activity type – should teachers choose a series of Zumba lessons, for example, because students will probably be very active; or lessons in which students work together on dance choreography, provoking thoughtful conversation and reflective decision making, but at a much lower physical activity intensity. Lindsay (2014) points out that other lessons in which students work in stations, read instructions from task cards and keep track of their scores while learning a sport shooting technique might result in submaximal activity levels, but valuable linkages with maths (adding the scores) and reading (instructions for each station) can be made.

Enhancing motor skill development as the major goal for health-based PE

The dominant curriculum model used in PE worldwide is the multi-activity model (Siedentop, Mand & Taggert, 1986). In this model, teachers typically develop direct styles of instruction to teach the techniques of a wide range of sports such as soccer, basketball, gymnastics or athletics in blocks of 4–6 weeks (Curtner-Smith & Sofo, 2004). This sports-based approach to PE, which emphasizes mastery in a certain sport (Jewett, Bain & Ennis, 1995), is not considered optimal in facilitating the realization of health-related goals. Trost (2004), for example, argues that a sports-based approach tends to serve athletically gifted children’s needs and interests at the expense of less gifted children who have greater need for regular PA.

Despite the critiques of the multi-activity model, however, researchers are increasingly arguing that the development of motor skills in and through PE should not be overlooked in a health promoting perspective. Children between the ages of 3 and 5 years quickly expand their array of motor skills, and studies have indicated that motor competence is critically sensitive to change until about the age of 12 (Fransen et al., 2014; Gallahue & Donnelly, 2003). In particular, Gallahue, Ozmum and Goodway (2012) point out the development and mastery of fundamental motor skills, including locomotor (e.g. skipping, running, galloping) and object control skills (e.g. throwing, catching, kicking), are essential building blocks for more complex movement and sport skills (e.g. Seefeldt, 1980). Several studies have demonstrated that motor skill development is reciprocally associated with PA (e.g. Stodden et al., 2008). Moreover, although the evidence from experimental, longitudinal or prospective studies is still limited, more authors are suggesting that well-developed fundamental motor skills are a prerequisite to engagement in – and enjoyment of – regular PA for health (Logan, Robinson, Wilson & Lucas, 2012).

Since studies have revealed that fundamental motor skills do not develop naturally through maturational processes or when children engage in free play (Gallahue et al., 2012; Van Beurden et al., 2003), researchers continue to investigate how motor competence is developed through PE programmes, especially for younger aged children (Lubans, Morgan, Cliff, Barnett & Okely,
2010). If the focus is on stimulating motor development, much can be learned from prior structured motor skill intervention studies (e.g. Ericsson & Karlsson, 2014; Goodway, Crowe & Ward, 2003), which have shown that motor delayed children can significantly improve their fundamental motor skills through relatively short structured and organized interventions. Specifically, interventions consisted of relatively short (9 weeks with two 35 minute sessions per week) periods during which children participated in planned movement activities that were developmentally and instructionally appropriate (Gagen & Getchell, 2006). In these studies, fundamental motor skills were learned, practised and reinforced (Goodway & Branta, 2003; Robinson & Goodway, 2009; Valentini & Rudisill, 2004).

In terms of developing health pedagogies, however, there are some important lessons in the current motor development literature. First, the majority of interventions were implemented by researchers themselves (Apache, 2005; Goodway & Branta, 2003; Goodway et al., 2003; Robinson & Goodway, 2009; Valentini & Rudisill, 2004). There is less information supporting motor skill development where limited instructional time and/or novice teachers are included purposefully in the research design. More information also is needed examining the effects of teacher training and teachers’ fidelity to the target programme during implementation (Apache, 2005; Logan et al., 2012). In addition, there is some evidence to suggest that PE teachers have limited ability to improve students’ motor performance due to limited instructional time (Ennis, 2011; Lounsbery & Coker, 2008). Future researchers should focus on understanding more about the feasibility of asking teachers and educators to influence motor skill development in PE.

Another lesson relates to the dominant focus in existing research in the area of motor development of younger children with delayed motor development patterns. More studies are needed to assess the effectiveness of such approaches for all children, including older and normally motor developed children, who are all participating in PE. Finally, it is currently unclear whether and how existing test batteries (Cools, De Martelaer, Vandaele, Samaey & Andries, 2010) devised to accurately measure motor competence might serve the realization of PE goals. Many issues and concerns that were discussed in regard to fitness testing would also apply to motor skill development (e.g. risks for increased social comparison).

**Stimulating autonomous motivation as the major goal of health-based PE**

During the past few years, researchers have increasingly argued that PE can promote active and healthy lifestyles when the curriculum consists of personally relevant, interesting and enjoyable activities encouraging young people to develop strong personal interests in sport and PA (Haerens, Kirk, Cardon, De Bourdeaudhuij & Vansteenkiste, 2010; Lindsay, 2014). This perspective is supported by motivation theories such as Self-Determination Theory (Deci & Ryan, 2000; see Chapters 39–44, this volume), suggesting that when students find activities inherently interesting, meaningful and enjoyable, or when these activities hold personal relevance or value, students are more likely to engage in these activities outside PE (Haerens et al., 2010; Haerens, Kirk, Cardon & De Bourdeaudhuij, 2011; Van de Bergh, Vansteenkiste, Cardon, Kirk & Haerens, 2012). This health-based PE approach prompts physical educators to acquire knowledge and understanding of behavioural (e.g. social cognitive theory) and motivational theories (e.g. Self-Determination Theory), to become the “motivating coach” who promotes young people’s lifelong PA engagement (Trost, 2004). In addition to motivational insights and skills, this view also requires teachers to have a sound technical understanding of PA teaching methods and strategies to support different aged students’ safe and effective health-related PA participation.
There is an extensive body of research showing that secondary school students learn more and are more active when they enjoy and value the activities offered (e.g. Aelterman et al., 2012; Jaakkola, Liukkonen, Laakso & Ommundsen, 2008; Lonsdale, Sabiston, Raedeke, Ha & Sum, 2009; Xiang's Chapter 40, this volume). The focus on valuing and enjoying PA requires a pedagogical shift, however, from physical, behavioural and motor learning outcomes towards affective and motivational learning outcomes. Thus, fostering students’ enjoyment and value of PE requires an alternative approach to be adopted by the teacher when interacting with students. Specifically, whereas an exclusively directive teaching style might be effective for increasing PA or stimulating motor development, it might not be appropriate for achieving affective and cognitive learning outcomes. This is because the latter may require students to accept, endorse and internalize information in the process of coming to know and value the benefits of a physically active life, and to become relatively independent decision-makers (Haerens et al., 2011). Within this philosophy on health-based PE, teachers provide opportunities for students to act and think for themselves in terms of how to choose and organize physical activities that are easily transferable into leisure time (Harris, 2000; Whitehead & Fox, 1983). In addition, teachers clarify expectations and facilitate student learning by prompting students with information on activity-related guidelines and the benefits of an active lifestyle, and providing them with strategies for becoming more active. This approach is not explicitly aimed at eliciting high MVPA levels or maximizing opportunities to develop physical fitness or motor skills. Yet, recent intervention studies in which teachers are trained to incorporate such a motivating approach have documented beneficial effects on students’ engagement and skill development during the lesson, and their future PA intentions (e.g. Kirk & Tinning, 1994). Haerens et al. (2011) developed a pedagogical model for health-based PE (HBPE) with the theme of ‘valuing and enjoying a physically active lifestyle’ as its conceptual foundation, although the model’s effectiveness has not yet been tested in traditional multi-activity sports-based settings (Armour & Makopoulou, 2012).

Training teachers in health pedagogies

In the USA, where alarm over increases in the incidence of obesity and diabetes have led to the formulation of new standards by the Society of Health and Physical Education (SHAPE), pre-service and in-service continuing professional development (CPD) programmes for teachers are shifting quickly towards a more health-based approach (Cothran, McCaughtry, Kulinna & Martin, 2006). Yet, in many other countries there is evidence that professional development tends to focus on sport-specific update courses such as games, dance and gymnastics (Armour & Makopoulou, 2012; Armour & Yelling, 2004), with rather less content available on health-based PE. So, as Armour and Harris (2013) and Cothran et al. (2006) suggest, as long as PE teachers lack the content knowledge and pedagogies to deliver health-based PE effectively, it seems unlikely that health aspirations will be realized. This issue becomes even more problematic when PE teachers themselves are not aware of the existing knowledge gaps (e.g. Castelli & Williams, 2007) and therefore see little need to modify their current practices (e.g. Clarke & Hollingsworth, 2002).

To add a further complication, there is evidence that given the diverse ideologies on HBPE and related learning outcomes, many researchers, PE teacher educators and PE teachers are uncertain about the precise nature of HBPE, making it difficult to develop training in health pedagogies (Armour & Makopoulou, 2012; Puhse et al., 2011). There is a wealth of studies proposing designs of effective CPD programmes (for overviews see Kahn et al., 2002; Kriemler et al., 2011; Lonsdale et al., 2013; Parker & Patton’s Chapter 30, this volume). Although these studies offer valuable information describing curricula content leading to significant change
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(e.g. effectively increasing PA during PE, improving fundamental motor skills), there are fewer studies addressing the underlying mechanisms that determine whether teachers adopt effective health pedagogies after engaging in a CPD programme. Studies conducted in the USA have demonstrated that ‘top down’ implementation of predefined health-related curricula tends to fail when long-term guidance is lacking. This may be due to the fact that teachers are overwhelmed by the amount of information and the imposed changes conflict with the teachers’ school context and their current beliefs about effective PE (Cothran et al., 2006). These findings correspond to findings in the wider CPD literature shifting a focus on change as something that is done to teachers who are relatively passive participants to change as a complex process that involves teachers’ active learning through reflective participation in training and practice (e.g. Clarke & Hollingsworth, 2002).

For CPD training to be effective, teachers must be offered time and support to analyse different forms of health-related PE, taking into account their beliefs and context needs (Deglau & O’Sullivan, 2006). They also need practice-relevant ideas with clear benefits for their personal practice (Armour & Yelling, 2004, 2007; Guskey, 2002; O’Sullivan & Deglau, 2006). Specifically, when CPD guides in-service teachers in developing and health-based PE, teachers can experience what works in their specific context, and develop confidence to implement different forms of health-based PE (see Deglau & O’Sullivan, 2006 for an example). Teachers then also need continuous follow-up support and guidance on strategies to integrate new information with their existing knowledge and current curriculum (Cothran et al., 2006; Dowda et al., 2005; McKenzie et al., 2003). By stimulating (self-)reflection (e.g. Reason & Bradbury, 2008) throughout this process, teachers can gradually discover which perspectives and approaches align with their personal convictions and current practice, and can iteratively refine their approaches through a process of enacting and reflecting (Clarke & Hollingsworth, 2002). For example, Deglau and O’Sullivan (2006) showed how an approach involving a 15 month programme including eight workshops, several debriefing sessions and more than 126 contact hours resulted in effective changes to practice. Teachers in this study demonstrated a willingness to implement new curricula, share new innovations and ideas with others, and contribute to the implementation of innovations in their broader professional community.

**Future directions**

Current validations of different approaches to health-based PE through research are predominantly situated at the pupil level (e.g. improved motor competencies, increased activity levels). More research is needed regarding possible mechanisms that determine the effectiveness of health-based PE training at the teacher level (e.g. teaching practices, beliefs). This corresponds to the suggestions made by Kriemler et al. (2011) and Lonsdale and colleagues (2013), who argue that in future research there is a need for more transparent reporting of intervention strategies and CPD organization. To illustrate with just one of many examples, Van Beurden et al. (2003) conducted an intervention that aimed at enhancing motor skill development while at the same time obtaining high activity levels during PE. In their study, they mention that their intervention incorporated professional development for teachers by means of four workshops, but apart from a general description of what these workshops were about, it remains unclear how the intervention was delivered to the teachers, and which strategies could explain the changes teachers made to their way of teaching. To address this omission, it would be preferable for future studies to be embedded in the wider professional development literature (e.g. Clarke & Hollingsworth, 2002), so that teacher change and an understanding of the likely mechanisms that brought about the change are studied more systematically.
There also is a strong need to involve teachers themselves in the development and optimization of teacher training, not only in terms of content (e.g. developing realistic and sound practical examples), but also delivery methods (Aelterman et al., 2013). Through involving teachers in health-based PE CPD development, teachers themselves can become the social agents who help train other professionals in the field (Clarke & Hollingsworth, 2002; Deglau & O'Sullivan, 2006).

Summary of key findings: overarching and shared views

Debates are ongoing about which types of programmes are effective in promoting health, and which should be disseminated on a larger scale (e.g. Canadas, Veiga & Martinez-Gomez, 2014). Interestingly, many public health advocates share a view of what HBPE is not about. One message that comes across very clearly is that the mixing of health goals with the dominant goals of sport-based, multi-activity PE programmes risks undermining sustained implementation of any health-based initiative. There is little evidence to suggest that PE students can learn health-related goals in a sport-specific skills and mastery-oriented activity-based approach (Jewett et al., 1995).

There are also several shared ideas across each of the presented views on HBPE.

• The ultimate goals of and rationale for HBPE in each of the described approaches all relate to increasing young people's engagement in sport and physical activity for enhanced health outside PE.
• Health pedagogies require an interdisciplinary and developmental approach, which, in turn, requires the provision of new training for both pre-service and in-service teachers. Such training would need to develop broader perspectives on the relationships between physical fitness, PA, motor development and health, along with insights into social, psychological and behavioural theories that are prominent in health promotion.
• Moreover, a change in teachers' philosophies about teaching and learning in PE would be required, from a disciplinary mastery orientation towards an integration of self-actualization and social reconstruction orientations (Harris, 2000; Jewett et al., 1995).
• Indeed, shared pedagogical approaches across the four health-based PE perspectives involves students' self-assessing and monitoring their progress in situations where positive experiences are reinforced and the use of social comparisons is avoided.
• Literature revealed that effective change requires considerable additional PE teacher training that is sustained. Further, in-service training needs to encourage teachers' participation, input, testing and implementation of different forms of health-based PE.

Reflective questions for discussion

(Imagine) You are a physical education teacher in secondary school …

• In what sense do you think you have a role to play in stimulating and motivating your pupils to remain or become active beyond the context of the PE lesson?
• Think about a typical lesson you delivered during the past month.
  • Think about the goals and the concrete learning activities. Do they align with one or more of the four perspectives on health-based PE? Can you think of two strengths and two criticisms of the approach you have taken?
  • Could you redesign the activity in light of a different health-based approach?
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- In what sense would you change your goals?
- How would you then change your activities? Can you think of two concrete adaptations you would make (e.g., how could you include self-assessment, facilitate positive experiences, avoid social comparison)?
- How would you change your instructions and feedback? On what would you focus?
- What do you think the community of PE teachers needs to implement health-related PE effectively? As a professional, what role could you play to support the profession in meeting these needs?
- What are the barriers to implementing health-based PE in schools in your area?
- What opportunities do PE teachers have to expand their role to provide health-based leadership to all members of their school community?
- What learning theories have been prevalent in health-based PE programmes? As you anticipate the future, in what ways can new approaches to HBPE expand students’ understanding of PA and assist them to be more physically active outside of schools?

References


