

Self-reported weight and height: response rates from Irish schoolchildren. By C.N.M. KELLY, M. MOLCHO, C. KELLEHER and S. NIC GABHAINN, *Health Promotion Research Centre, 12 Distillery Road, National University of Ireland, Galway, Republic of Ireland*

Self-reports of weight and height are an important health surveillance tool, although it is recognised that a bias of under-reporting of weight and over-reporting of height is likely, and thus these data alone cannot be relied on to detect weight problems (Elgar *et al.* 2005). However, the association between overweight and obesity with lifestyle habits in youth is not different when based on measured or self-reported heights and weights (Strauss, 1999). The Health Behaviour in School-aged Children (HBSC) survey uses self-reports of weight and height to examine such associations.

As part of the 2002 HBSC survey, self-reports of weight and height were collected from 8424 Irish schoolchildren aged 10–17 years. Of the Irish children surveyed 43% did not report their weight or height. Conversely, in some countries BMI could be calculated for 98% of those surveyed. Children may be more aware of their height and weight in some countries than in others due to cultural differences. Moreover, in some countries children have preventive medical examinations completed in school in which their heights and weights are measured. Both factors may help account for the differences in response rates.

In an attempt to understand the high rate of missing data in Ireland, a study was undertaken involving a total of 143 pupils, from seven classrooms across three schools (aged 12–14 years). Both parental and pupil consent were received for all participants. In each classroom pupils completed a short self-report questionnaire and participated in facilitated classroom discussion on the items included in the questionnaire. These items included questions on height and weight, but also questions on whether pupils had weighing scales in their home and when they had last checked their height and weight. In addition, those who did not answer the questions on height and weight were presented with an open question asking them why not. Data collection took place in September 2005.

Only 39% of students recorded their weight and/or height. The reasons the students did not respond are provided in the table. In the subsequent classroom discussions, few questioned the relevance of these questions to the study of youth health, but pupils did point out that the questions were potentially sensitive, personal and possibly embarrassing, especially for those who are overweight. This was particularly the case for the question on weight rather than height. Nevertheless, the classroom discussion confirmed that the most frequent explanation for these missing data were that children simply did not know the answers.

Reasons for missing data on weight and height	Non-responders (%)
Do not know weight/height	56
Question too personal	16
Had not checked recently	11
Forgotten	9
Did not know without clothes	3
Too embarrassed	2
Did not think about it	2

The extent of missing data in this and similar self-report studies has obvious implications for the usefulness of these datasets. There would be substantial practical and ethical difficulties in attempting to reduce the missing data through pre-warming children or parents of the questions or conducting direct measurement in schools. It is therefore crucial that we investigate and report on the likely extent of error in population estimates based on such limited datasets.

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