

HEALTH BEHAVIOUR IN SCHOOL-AGED CHILDREN

RESULTS FROM THE IRISH HBSC SURVEY

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The WHO - Health Behaviour in School aged children study is a collaborative crossnational study supported by the World Health Organisation (European Office). It was initiated in 1982 by researchers from Finland, England and Norway and since then data have been collected in an increasing number of countries in four yearly cycles. In 1998, the study comprised 27 European countries including Ireland as well as the USA and Canada. Data were collected from more than 120, 000 school children aged between 11 and 15 years. The objectives are fourfold:

- To increase understanding of and monitor over time young peoples health and related behaviours
- To influence policy development and the design of effective interventions for young people
- To learn more about the social and familial contexts of these behaviours
- To promote multi-disciplinary and cross national research on young peoples health issues

The HBSC is rooted in the social and behavioural sciences rather than in classical medical epidemiology. It is not restricted to anyone theoretical framework or model, rather it is designed to facilitate multiple approaches to the investigation of health. Nevertheless, a common conceptual framework for the development of the HBSC, the socialisation perspective, has been adopted. This enables some of the social and psychological determinants of health and health behaviours such as the family, school and peer settings and personal capacity and coping skills, to be systematically

explored across various countries. For each cycle of data collection an international protocol is developed and students in each country are asked questions on a variety of health related issues. These include positive and negative health behaviours, perceptions of health and well-being, family and peer relationships and perceptions of school. In 1998, questions were added on injury and violence, body image, social inequalities and self-esteem. While each country publishes its own data (e.g. Friel *et al.*, 1999a), the international comparative report is also available (Currie *et al.*, 2000).

The HBSC protocol was first used in Ireland during the evaluation of the post-primary component of the Kilkenny Health Project (O Reilly & Shelley, 1991) and has since been employed in the evaluation of the North-Western Health Boards Lifeskills Programme (Nic Gabhainn & Kelleher, 1995) and the Irish Network of Health Promoting Schools (Nic Gabhainn & Kelleher, 1998). In 1994 the Department of Health Promotion, National University of Ireland, Galway joined the International Study team as the Irish Principal Investigators and the first set of Nationally representative and Internationally comparative data was collected in 1998. This involved the collaboration of the Departments of Health and Children and Education and Science as well as the regional Health Boards and the management, staff, parents and pupils in 187 primary and post-primary schools. The response rate from primary schools was 70% and from post-primary schools 77%. In total, data were collected from 8,497 pupils aged 9-17 with a self-completion questionnaire which was completed

by students in their classrooms. The sampling procedure was designed to ensure that individual pupils be sampled from Health Board regions in proportion to the populations of young people in those counties. In addition, the social class and gender distribution of pupils approximated the national data reported from the 1996 census (Friel *et al.*, 1999a).

The data collected from students in the Republic of Ireland can be employed in a number of ways; for providing a moving snapshot of health related behaviours and associated issues, for providing evidence on health and social inequalities between different groups of young people and for the investigation of the factors associated with health and health behaviour among Irish young people. Within any of these areas, the similarities and differences between Irish young people and those in North America and Europe can be investigated.

Friel *et al.* (1999a) discuss the first set of findings from the Irish HBSC study.

These relate to the National Targets set by the Department of Health and Children and, where appropriate, compare the data collected from children to those collected from adults in the SLAN survey which was conducted at the same time employing a similar methodology. In addition Friel *et al.* (1999b) report the similarities identified across health board regions in relation to these factors. The data contained in Currie *et al.* (2000) includes the comparisons of Irish children with those in the other 28 WHO HBSC countries in the areas of: The general health and well-being of adolescents; Family and peer relationships; The school environment and the health of adolescents; Socio-economic inequalities in

adolescent health; Exercise and leisure activities; Dietary habits, body image and dental care; Substance use.

Most Irish children in the study reported that they were both happy and healthy. While they reported considerable experimentation with both alcohol and tobacco, the proportions who reported on-going and current substance use were lower but still of concern and among the older age groups were either at or above national targets. A substantial number reported that they took regular vigorous exercise and ate fruit and vegetables at least daily. Nevertheless, most also ate sweets and other high fat and sugar foods at least daily. However, these generalities mask considerable differences across age groups and genders and in some cases across social classes. Health promoting behaviours are less likely to be reported amongst older pupils and health damaging behaviours become proportionately more common. Cigarette smoking and drinking alcohol increase with age as do eating high fat and sugar foods and dieting. On the other hand, regular exercise and eating fruit and vegetables decrease with age (although fruits remain more popular than vegetables). Accordingly the percentages reporting that they feel healthy and happy also decrease with age.

Substantial gender differences also emerge, which in some cases interact with age or social class. Overall, boys report being more satisfied with their lives and greater psychosocial health than girls. They also report more frequent exercise but lower consumption of healthy foods and greater alcohol intake. Although girls report higher levels of fruit consumption, they also report more cigarette smoking and most noticeably, lower levels of exercise participation. All of these gender differences increase with age and some (cigarette smoking and exercise) are most noticeable among girls from social classes 5 and 6. Indeed social class differences emerge more frequently among the girls than the boys and are noteworthy particularly for alcohol consumption (where girls from higher social classes are less likely to imbibe, frequently or otherwise).

Very few regional differences emerged on these health behaviour related variables. In general the gender and age patterns mentioned above held within most

of the health board regions and certainly the overall patterns stand. Only in relation to some risk behaviours do inter-board differences emerge. Children, and boys in particular from the Eastern Health Board area, which includes Dublin City, are more likely to have experimented with both tobacco and alcohol and are also more likely to report having sustained an injury (intentional or otherwise) during the previous year. It is however worth noting that although more boys in the Eastern Health Board area report smoking cigarettes, they do not smoke more cigarettes than boys in other parts of the country.

Of particular importance is the reported use of seat-belts and cycle-helmets, which is low for all age groups, genders and social classes within all regions. While very few reported that there was no seat-belt where they usually sat in the car, only a minority reported that they always wore a seatbelt and this masks some substantial inter-group differences. Boys were less likely to always wear a seat-belt and both boys and girls from lower social class groups were least likely to do so. Cycle-helmets were also only used by a minority of the younger students and this proportion reduced with age.

Students were also asked questions relating to their perceptions of their role in the school structure, and their relationships with teachers, fellow pupils and parents. Although only about one third of pupils reported that they took part in making school rules, (and this decreases across age and is particularly low among older girls), well over half agree that they are encouraged to express their views at school and a minority report that they are treated too severely or strictly at school. In general, students report having positive relationships with teachers. However this also decreases by age and is lower among the boys. Respondents are particularly happy about their relationships with other pupils, they report that they feel accepted, that pupils enjoy spending time together and that most of their classmates are kind and helpful. The role of parents in their education is also widely acknowledged and very high proportions of pupils report feeling supported and encouraged by both parents and teachers. Although there is little evidence of a social class gradient

in responses, there are clear gender and age patterns. Girls and younger students (up to age 15) tend to be more positive about all aspects of their school life and associated relationships.

A number of factors hypothesised to influence the health and health behaviours of young people have also been explored within the Irish data. Specifically the associations between self-esteem and behaviour, and between relationships with others and behaviours, have been investigated. While Irish students report relatively high levels of self-esteem on the Rosenberg Self-esteem Scale (Rosenberg, 1965), the linear relationships between self-esteem and health behaviours are weak. However the differences in behaviour reported between those high and low in self-esteem are more substantial and in many cases statistically significant. In general, the same patterns emerge for perceived relationship quality. While relationships with friends and parents are more predictive than those with teachers and class-mates, there are substantial and significant differences between those who perceive their relationships with others as negative or positive. Those who report higher levels of self-esteem and more positive relationships with others tend to report more positive and fewer negative health behaviours. The only exception to this is that experimentation with substances is more common among those who report more positive relationships with friends and more time spent with friends.

The international comparisons suggest that Irish children are mid-range on most factors. The major exceptions to this concern dietary behaviour and oral hygiene. In general, Irish children report more frequent consumption of vegetables (raw and cooked) than many other countries. However, they also report very high relative levels of sweet, crisps and chocolate consumption and relatively infrequent tooth-brushing. Although they are not at the bottom of the hierarchy, Irish children also report less ease talking to their parents, and fathers in particular, than children in many other participating countries.

*References available on request from
The Office For Health Gain*