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Education and Health

Editor

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Welcome to the second issue for 2012. We continue with the proud tradition of independent publishing and offer an eclectic mix of articles: Conception rates; New Zealand HPS; Healthy eating intervention; Food practices in Norway, Scotland and England.

The journal, published since 1983, is aimed at those involved with education and health who are concerned with the health and wellbeing of young people. Readers come from a broad background and include: primary, secondary and further education teachers, university staff, and health-care professionals working in education and health settings. The journal is also read by those who commission and carry out health education programmes in school and college.

Articles focus on recent health education initiatives, relevant research findings, materials and strategies for education and health-related behaviour data.

Contributors

Do you have up to 3000 words about a relevant issue that you would like to see published? Please contact david.mcgeorge@sheu.org.uk

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[Ed: This article is a commentary on figures supplied by the ONS¹.]

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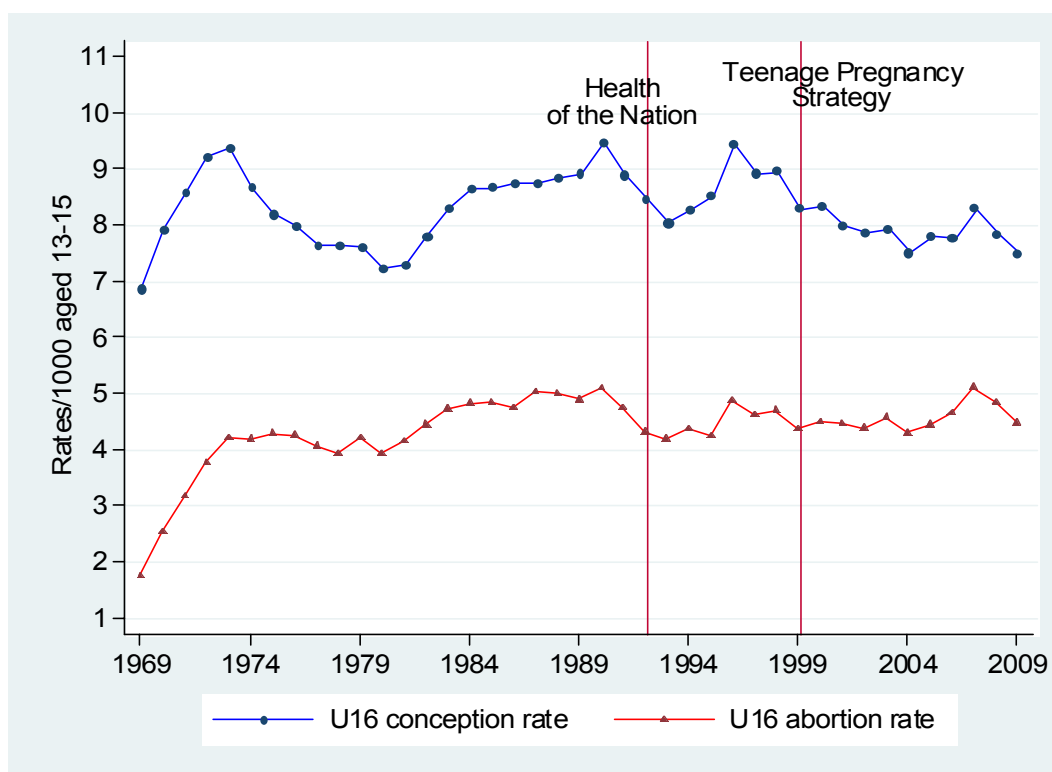
Underage conceptions and abortions in England and Wales 1969-2009: the role of public policy

Over the past 40 years, millions of pounds have been spent by policy makers on numerous initiatives aimed at cutting teenage pregnancy rates in the U.K. However, identifying the impact of policy interventions on trends in underage conceptions since 1969 (shown in Figure 1) presents something of a challenge. Indeed, it is striking that the rate of conceptions to under-16s in England and Wales was almost exactly the same in 2009 as 40 years previously. Over this period, there have been a number of temporary movements in the series both up and down, but it is very difficult to establish a strong case that standard policy interventions have been at the root of such changes.

For example, the underage conception rate reached an historic peak in 1996, just four years after the launch of a major initiative ("The Health of the Nation") aimed at cutting teenage conceptions by 50%. From 1996, the series began an 8-year decline. The next significant initiative, the 1999 Teenage Pregnancy Strategy, started several years after this decline had started. Further, as expenditure on this latest strategy was rolled out in the early 2000s, the downward trend in underage conception rates levelled off, whilst the most recent decrease (from 2008 to the present) has come at a time when policies promoted by the Strategy were under significant pressure due to spending cuts.

Notably, the decrease in underage pregnancy

Figure 1: Under 16 conception and abortion rates, England & Wales, 1969-2009



Note: Rates are per 1000 females aged 13-15 at time of conception.

Source is the Office for National Statistics.

1. The conception rates for under 16s in England and Wales every ten years: 1969 [6.9] 1979 [7.5] 1989 [8.9] 1999 [8.3] 2009 [7.5]. Rates are per 1000 females aged 13-15 at time of conception. Source is the Office for National Statistics.

that has occurred since the late 1990s stems largely from a decrease in underage births. In contrast, the rate of underage conceptions ending in abortion (probably the best measure of unwanted pregnancy) appears to have been particularly resistant to policy interventions, with the rate in 2009 being higher than at the start of the 1999 Strategy.

Impact of policies

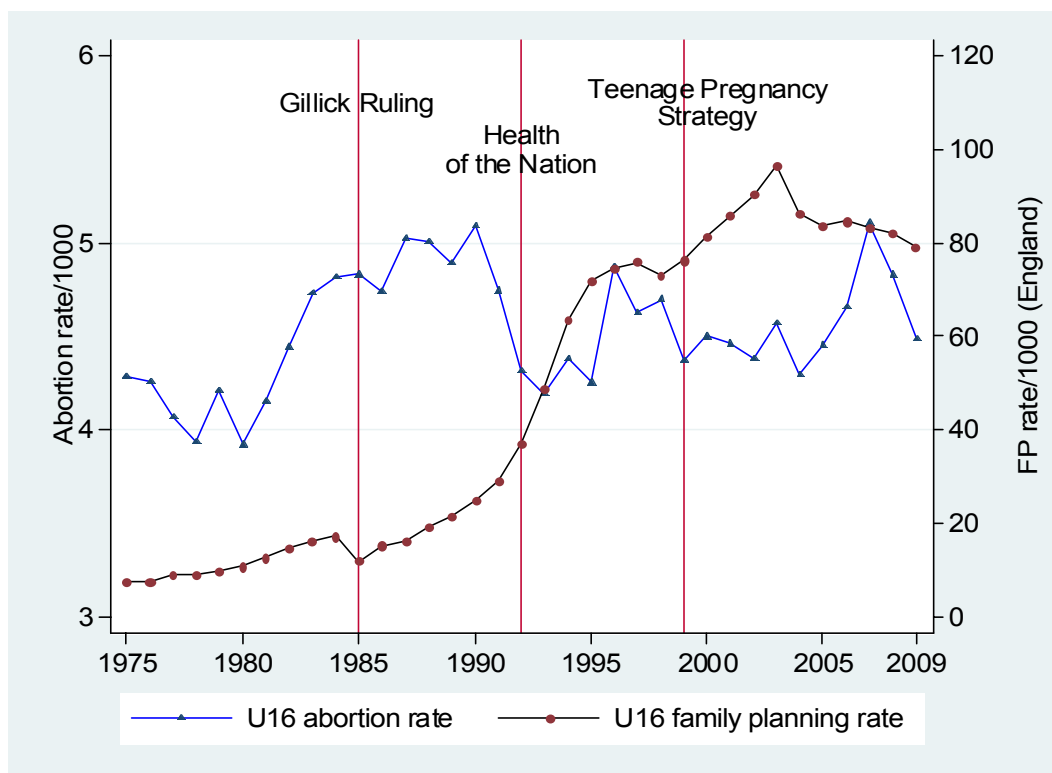
There is considerable agreement that underlying socio-economic factors such as poverty, educational achievement and family stability have significant impacts on teenage birth rates and an improvement in some of these measures appears likely to be at the root of reductions in underage births since 1996. More controversial, however, is the impact of policies aimed directly at reducing unwanted pregnancy or abortion rates. The conventional wisdom is that school-based sex education (SRE) and access to family planning for young people are essential to such efforts many of the policy initiatives over the past 40 years have centred around these measures.

Implicit (and sometimes explicit) in these approaches has been an assumption that access to family planning will reduce pregnancy rates

amongst those teenagers who were already having sex but will not cause an increase in the proportion of all teenagers who engage in sexual activity. Standard economic models, however, suggest that the two factors are irretrievably interlinked. Easier access to family planning reduces the effective cost of sexual activity and will make it more likely (at least for some teenagers) that they will engage in underage sexual activity. Given high failure rates of contraception amongst this group, the overall impact of access to family planning on underage pregnancy rates is impossible to predict *a priori*. Trends in family planning take-up and abortion over the past 40 years (reported in Figure 2) illustrate the complex nature of their relationship.

Clearly take-up of family planning by under-16s is partly determined by changes in attitudes to early sexual activity. However, there have been a series of "exogenous" shocks to the provision of family planning which can help in identifying causal effects of policy. For example, the Gillick Ruling prevented the provision of family planning to under-16s without parental consent for most of 1985. Family planning take-up amongst this group went down by over 30%, but there was no

Figure 2: Under 16 abortion rates and family planning take-up, England & Wales, 1975-2009



Note: Rates are per 1000 females aged 13-15. Family planning data are the annual rates of first contacts by females at family planning clinics in England. Sources are Department of Health for family planning & Office for National Statistics.

discernible impact on the under-16 abortion rate in that year. The 1992 Health of the Nation report and the 1999 Teenage Pregnancy Strategy both led to major initiatives to improve access to family planning for young people. In each case, we can see a significant increase in the take-up of family planning amongst under-16s, but no discernible reduction in underage abortion rates.

The ambiguous relationship between access to family planning and unwanted pregnancy rates is corroborated by formal statistical studies. For example, research published last year in the *Journal of Health Economics* found that those areas promoting emergency birth control (EBC) did not experience bigger reductions in underage conceptions than other, similar areas. More worryingly, these areas did experience relative increases in underage diagnoses of sexually transmitted infections (STIs). Indeed, not a single peer-reviewed study to date has found that access to EBC has led to a statistically significant reduction in unwanted pregnancy or abortion rates (see, for example, Girma and Paton, 2011, Raymond et al, 2007).

Earlier SRE

In a similar vein, although it is difficult to read a commentary on teenage pregnancy rates in the media without some reference to the need for statutory or earlier SRE in schools, the peer-reviewed evidence on the impact of SRE on pregnancy rates is, at best, weak. For example, Wilkinson's (1996) evaluation of the Teenage Pregnancy Strategy was unable to find a correlation between those local authorities judged to have the best SRE provision and those with the biggest decreases in teenage pregnancy rates. Cross-county comparisons, similarly provide a mixed picture. Contrary to common perception, school SRE in the Netherlands (where underage abortion rates are indeed significantly lower than in the U.K.) is compulsory at a later stage than in the U.K. and, as in the U.K., there is no uniform or statutory SRE content (Van Loon, 2003; Eurydice/NFER, 2009).

Involvement of parents

Intriguingly, the policy area on which the evidence is most promising is one that has been neglected in the U.K., namely involvement of parents in sexual health decisions of minors,

especially abortion. U.S. states that have introduced mandatory parental involvement laws have not only seen relative decreases in abortions to minors (New, 2011), but also a reduction in teenage STIs (Klick & Stratmann 2008) and improvements in teenage mental health (Sabia & Rees, 2012). These studies provide an obvious source of intelligence for policy makers who want to improve sexual health amongst underage children in England and Wales.

Conclusion

In conclusion, despite recent decreases in the overall underage conception rate, unwanted pregnancy amongst minors in England and Wales has proved remarkably resilient to policy initiatives implemented by different Governments over the past 40 years. Looking forward, the time appears ripe for a shift in focus from policies aimed at reducing the risks associated with underage sexual activity to those which are aimed more directly at reducing the level of underage sexual activity.

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[Ed: This article is a commentary on figures supplied by the ONS¹.]

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Natalie Collyer and Richard Essery

Commentary on the conception rates for under 16 year olds from 1969 - 2009

We know that most young people under the age of 16 don't have sex. We've all seen the headlines, the teenagers using abortion as "*a form of contraception*" and how "*giving girls the Pill raises teen pregnancy*", but the Office for National Statistics (ONS) figures¹ on the conception rates for under 16s confirm what those of us who work with young people or in sexual health already know - that teenagers are far less likely to get pregnant now and in 2010 the rates (7.0 per 1000) are the lowest they have been for 40 years.

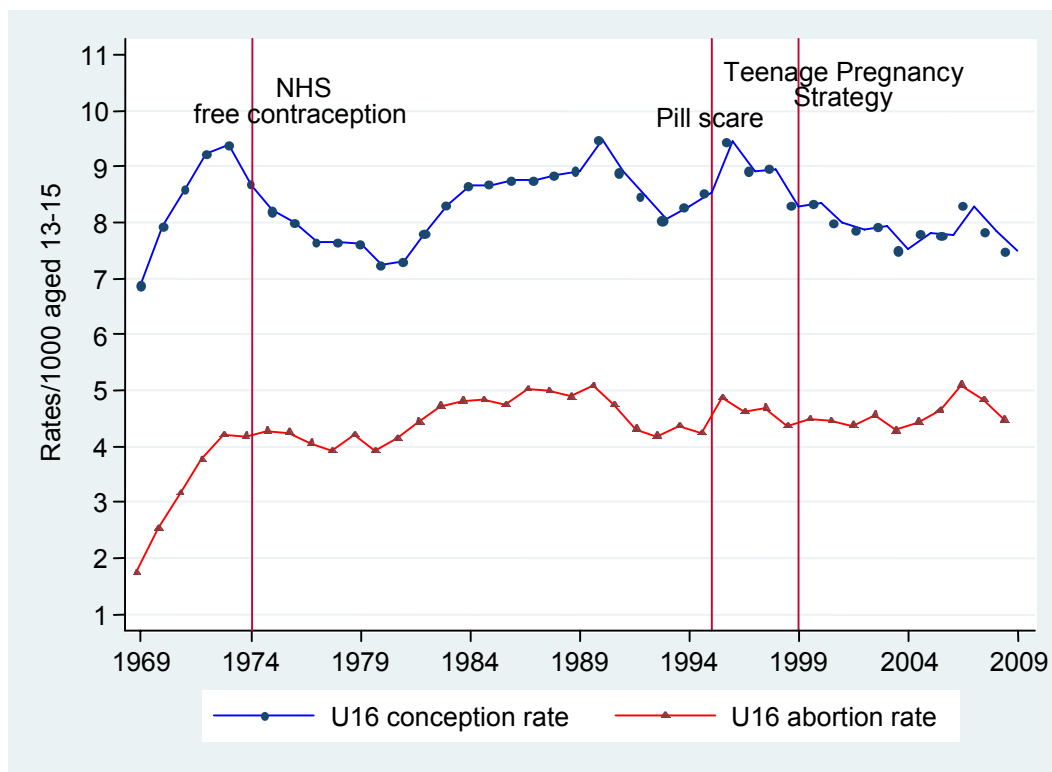
We also know that the myths young people hear about sex, and that they talk to us about on the Ask Brook helpline, such as you can't get pregnant the first time, or that the "*withdrawal technique*" is a reliable way to avoid pregnancy,

only add to the confusion and lead to further teenage pregnancies.

Such is the prevalence of myth and misunderstanding surrounding young people in the press that, in 2008, Brook resolved to commission a MORI public opinion poll - and it threw up some very interesting results: some 95 per cent of respondents overestimated the number of teenage pregnancies, and four in five also believed that teenage pregnancy rates had increased, when in fact they have declined since 1998.

The ONS figures are shown since records began in 1969 (Figure 1). Looking at the conception rates per thousand for every tenth year¹ it appears, at first glance, they are almost static, so should it come as a surprise to us that

Figure 1: Under 16 conception and abortion rates, England & Wales, 1969-2009



Note: Rates are per 1000 females aged 13-15 at time of conception.

Source is the Office for National Statistics.

1. The conception rates for under 16s in England and Wales every ten years: 1969 [6.9] 1979 [7.5] 1989 [8.9] 1999 [8.3] 2009 [7.5]. Rates are per 1000 females aged 13-15 at time of conception. Source is the Office for National Statistics.

so many people believe little progress has been made?

The thing is, to get a clearer picture, you have to *read between the lines*, and look at the many fluctuations that have occurred in the preceding years, because a huge amount of good work has taken place, and real progress has been made. There has been a big decrease in the conception rate for under 18s, and conception rates for under 16s have followed a similar downward trend - but, because their numbers are smaller, they are subject to greater change and may not look as impressive to the casual observer (or tabloid reader).

Free contraception

Since the introduction of free contraception on the NHS in 1974 (see Figure 1), the overall trend has actually been one of decline, and, where spikes have occurred the reasons have usually been pretty clear cut, such as fears over patient confidentiality. Research has consistently shown that young people won't use services unless they can be sure they are confidential, and our experience at Brook confirms this: in the early 1980s many under 16s were confused about their right to confidential contraception advice and were concerned that their confidence would be broken, so it followed that attendance figures for this age group at both Brook and family planning clinics in England showed a significant drop during this period.

It was a combination of this, along with cuts in funding to community health services (similar to those we are experiencing now) that lead to the closure of many family planning clinics and young person's services, further restricting people's access to contraception.

Although the legal issues surrounding contraception and confidentiality were resolved in the House of Lords, in 1985, it took at least a further five years to rebuild confidence in the system, and for attendance figures to recover.

The early to mid-nineties saw an expansion of both young person's services and specialist health services, bringing with it a 16 per cent reduction in the teenage pregnancy rates for under 16s over the same period; sadly, much of this good work was undermined by the 1995 pill scare, which saw the percentage of Brook's clients choosing the contraceptive pill drop by 32 per cent among under 16 year olds.

Teenage Pregnancy Strategy

The Teenage Pregnancy Strategy was developed in 1998; it both focused on and highlighted the good work being done, and, critically, it provided an excellent analysis of how to work effectively with boys, black and minority ethnic groups and looked after children. This, together with the historical ups and downs in the stats, means that we are clear about what works to improve young people's sexual health and wellbeing, we know how to reduce rates of unplanned pregnancy and sexually transmitted infections, and we need to get on with making that happen consistently across the UK.

The system in the Netherlands is often highlighted as the best model to follow, and it's not difficult to see why: Holland has the lowest teenage pregnancy rate in Europe, one sixth of that in the UK, and also one of the lowest abortion rates for teenagers too - but they also have an open and accepting attitude toward teenage sexuality, widely available information and sex education, and easy access to confidential contraceptive services. Evidence from the last ten years shows that when we put those things in place in the UK we see our rates going down too, for example: in Oldham, where Brook has one of its busiest services, the under 18s pregnancy rate fell by just over 36 per cent between 1998 and 2010.

Conclusion

Looking at the statistics over time, it's clear to see that when access to services and information is restricted, the rates go up, so it's incredibly important that, in these times of austerity, these figures are there to serve as a warning of what can happen as we head down this route again.

But, while we must continue to keep an eye on these figures, of ultimate importance is the young people behind the statistics. Yes, recent tabloid headlines might scream that "*three girls have had EIGHT abortions*" but there will always be extreme cases - and, like most extreme cases, the young people involved are often some of the most vulnerable members of society.

If we really want to make big changes in the numbers of teenage girls getting pregnant, to bring us in line with our Northern European neighbours, we need to grow up and start dealing with the issues responsibly - then we

have to make big changes in the way we think about sex: we need to ensure a culture that is open and positive about sex and relationships; we need to stop ignoring young people and start engaging with them, and we need to have high expectations for them so they have high expectations for themselves. All of us involved with young people and sexual health talk about informed choices, but a choice is only a choice if you know you have it, and have the skills, confidence and opportunity to make it.

Brook is the country's largest young people's sexual health charity. We have been providing sexual health services, support and advice to young people, under the age of 25, for over 45 years.

Our mission is to ensure that all children and young people have access to high quality, free and confidential sexual health services, as well as education and support. To enable them to make informed, active choices about their personal and sexual relationships so they can enjoy their sexuality without harm.

You can read our Position Statement on [Teenage Pregnancy @ www.brook.org.uk](http://www.brook.org.uk)

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Johannes Keogh, Louise Rummel, Grace Benson, Evelyn Hikuroa and Elizabeth Farrell

Health-promoting schools in New Zealand: Belonging and empowerment in two primary schools

The concept of Health-Promoting Schools (HPS) was first proposed by the World Health Organisation (WHO) in the early 1980s (Deschenes et al, 2003). "A *health-promoting school is one that constantly strengthens its capacity as a healthy setting for living, learning and working*" (WHO, 2010).

Much has been written on the outcomes of the HPS approach but very little on the actual structures required for developing and sustaining the concept of a health-promoting school.

This paper describes the evolution of two primary schools, in the South Auckland Region of New Zealand, toward becoming health promoting schools.

Health-Promoting Schools in New Zealand

The HPS concept was developed and introduced by the New Zealand Ministry of Health in 1995.

Grant (2004) indicated that the philosophy of HPS in New Zealand is embedded in the Treaty of Waitangi. It is based on a holistic approach, to include all four aspects of health, namely the physical, social, emotional and spiritual aspects.

Different countries introduced different approaches to HPS as well as different educational theories to underpin the concept thus providing no definitive model to follow (Grant, 2005; Cushman, 2008).

Cushman (2008) described the New Zealand Government's approach to implementing the concept of HPS using a framework containing 3 distinct but interwoven processes. These were:

1. The curriculum
2. The school organisation and ethos
3. The links with parents and health providers.

Counties Manukau is a district in South Auckland providing school services for 130 primary and intermediate schools and 23 secondary schools. South Auckland is an ethnically diverse, primarily low socio-economic status area (Grant, 2005). Getting schools interested in the concept of HPS presented health promoters with problems. The Kidz First Public Health Nursing of Counties Manukau District Health Board (CMDHB) eventually provided a framework on which to base a HPS model.

In some countries, school health nurses and public health nurses established HPS (Grant, 2005; Manchester, 2004; Swart & Reddy, 1999). This was also the approach in the Counties Manukau Region, as nurses had a strong association with the community in general. Public health nurses helped schools gain an understanding of the concept of HPS, and identify factors which promote and support the health and well-being of all members of the school community. They did this by working with schools to identify students, staff and parents who could serve as resource people for health education programmes¹.

Methodology

Research design

A qualitative descriptive case study design described the process of two schools which had attained the Kauri level of the CMDHB Tipu Ka Rea model of a health promoting school. The

1. http://www.cmdhb.org.nz/funded-services/hospital-specialist/Services/KidzFirst/public_health_nurses.htm

two schools were selected from a list of schools in the CMDHB region that had attained the Kauri level. From this list, schools were divided into groups by decile rating¹. The decile 1-4 rated schools formed one group (School X) and the decile 5-10 schools formed the second group (School Y). Both schools are primary schools. School X (Decile 1-4) draws from a lower socio-economic population whereas School Y draws from a higher socio-economic population (Decile 5-10).

Aims of the study

The study sought to gain insight into the developmental stages of the Tipu Ka Rea model, the required infrastructure, and potential sustainability of two schools which have used the HPS model. For each school, the case study describes the process of implementing the Tipu Ka Rea model; the perceptions of key stakeholders at this school (in terms of their understanding of the HPS approach); and explores the sustainability of the health-promoting schools concept at the Kauri level.

The "Tipu Ka Rea" model

An operational model for HPS was developed for schools within Counties Manukau - the "Tipu Ka Rea" model, which in Maori means "To grow, expand and multiply". Sustainability is inherent in the metaphor that refers to levels of a regenerating forest. The model enabled the schools to progress through three developmental phases. Each level of the development of a HPS are represented by three indigenous New Zealand trees, namely the Manuka (for the initial pioneering or establishment level), the Kowhai (for further growth to a more structured or more developed level), and the Kauri (for a fully developed, independent and self-sustaining level) (Grant, 2005).

Data collection

Semi-structured interviews were undertaken with: the Principal of School X; the Acting Principal from School Y; Three senior teachers at School X; two facilitators, who were involved

in establishing the original concept of the Health Promoting School in the CMDHB region; One community representative from School Y; One Board of Trustee (BOT) from School Y; One adult student liaison, and two former pupils from School Y who were original Health Promoting School representatives when the concept was first established in the school. Student participation was twelve students from School X and four students from School Y who were House leaders and mediators.

The final authored article was developed by Johann Keogh and Louise Rummel and was circulated to all researchers prior to submission for publication.

Sampling and consent

Ethical approval for the study was obtained from the MIT Ethics Committee.

Participating schools were chosen to represent both ends of the decile spectrum and were selected by the Public Health Nurse who was familiar with the region. She initiated contact with the relevant schools. Once the initial contact with the schools was established, the Principal (School X) and Acting Principal (School Y) selected the rest of the participants. In School X, the Principal contacted the staff and students and obtained ethical consent at the time of the arranged interviews. In School Y, the Acting Principal obtained consent from the students who participated in the interviews. Participants were given the questions prior to interview, thus enabling them to pre-consider responses. One Board of Trustee member in School X was invited to be interviewed but declined. Parents were invited to be interviewed, but none participated. The facilitators, BOT, and community workers identified by the Principal and Acting Principal were contacted by a member of the research team gaining their consent to be involved.

Analysis of the data

The recorded interview material was transcribed. All transcripts were returned to participants for verification and correction. The data were analysed using content analysis,

1. The Decile classification is a summarising indicator derived from Census data. Each decile comprises approximately 10% grouping of the number of children within a specific geographical area and the decile assigned to a school is allocated by considering a range of socio-economic variables (New Zealand Ministry of Education 2010). Factors used to calculate this summarising classification include household income, occupation, household crowding, educational qualifications and the extent, if any, to which income is supported.

<http://www.minedu.govt.nz/NZEducation/EducationPolicies/Schools/SchoolOperations/Resourcing/OperationalFunding/Deciles/FrequentlyAskedQuestionsAboutDeciles.aspx>

although no definite categories were built.

Presentation of the findings

The facilitators

The Health Promoting facilitators were involved in establishing the Health Promoting School Concept in both schools. Theirs was an overarching role spanning a number of schools in the CMDHB region. The facilitators were thus involved in establishing the partnership between the school, community students and staff so they could collectively determine how to address health issues. As health issues arose, the facilitators would liaise with other health services, such as public health nurses and link together with relevant community services. Each emphasised the integration of the HPS in the total school community (students, school, parents, staff) and were clear that implementing principles of a HPS had to be a deliberate process that involved children.

Both facilitators identified a holistic approach as crucial; it is not only about physical health, but also about social, emotional and environmental aspects each of which impact on the overall health of the child.

The facilitators clearly identified the benefits of the programme and saw programme sustainability as advantageous. The involvement of parents and children, as driving forces in the programme, was also recognised. Hindering factors were that the implementation involved staff who had to be prepared for new roles.

The Principals

Principals were viewed as pivotal to HPS implementation as health promotion has to be at the centre of the school activities if it is to succeed. In school X the programme was originally implemented because of problems around sexual behaviour. This was not the case in school Y. As noted earlier, School X and School Y are primary schools. Students commence primary schooling at age 5 years and conclude aged between eleven and thirteen years.

The Principal, Acting Principal and teachers described the selection process for recruiting health promoting representatives in their schools in great detail. They noted that the high staff-turnover in the schools presented continuity problems and no formal educational

programme for preparing teachers for HPS was available.

One of the greatest achievements of the HPS programme was participation in Whanau nights (PTA-meetings). Before the HPS concept was implemented in School X, only four parents attended. After implementation, the attendance increased to up to 200 parents per night. Because of this greater involvement, teachers engaged directly with parents and were able to discuss important issues (for example teenage pregnancy) with parents and involve them in problem-solving strategies.

The Teachers

The interviews were conducted with teachers from School X only. In school Y the Acting Principal was the only staff member interviewed because a new principal was being appointed and all teachers at the school were new. The teachers all indicated that the support of the principal was crucial to the success of the programme.

The teachers believed that the HPS concept was introduced because of the large numbers of girls leaving School X at the age of 13 and having babies when they were 14 years old. A new approach to sex education was necessary in order to change this outcome; one that involved parents in the process of preventing pregnancies at a young age. It seemed that the parents themselves were not well informed, thus being unable to give appropriate information to their children. However, teachers were unable to indicate if the sessions resulted in any changes in children's sexual behaviour.

Teachers identified specific problems in implementing health promoting activities at school. They had little time for new activities but acknowledged an increase in workload only at the beginning of the HPS programme. Once all structures were in place their workload diminished.

The Children

The children were excited and proud to be part of the structure of the HPS. They were able to define health according to their own standards, although this was often limited to an activity, such as eating fruit, cleaning teeth or doing sport. At the time of the interviews, most children were engaged in some form of "physical activity" even if they only walked with

their parents after school. There were some specific questions as to the activities that kept people healthy, which were by and large answered correctly, for example doing sport, hours of sleep, eating the right food (5+ a day was often mentioned) and the effect of sugar on the body. One child indicated that he went "hyper" if he ate a lot of sugar.

To be a HPS representative, children from year 6 (the most senior level at the school) were eligible to be elected as a House Leader or a Mediator and candidates had to promote themselves to be elected. There was also an interview process by teachers to gauge the House Leader's values and how candidates saw themselves fitting into the Health Promoting School concept. The children were very proud of their new school roles (House Leaders or Mediators), and could provide a list of their "tasks" within these roles. They also knew how they were selected for these roles, and could describe the voting procedure thus affirming transparency at all levels within the hierarchy.

For the House Leaders in School Y this involved setting up the hall and being on duty during assemblies. The Mediators, on the other hand, felt themselves responsible for solving other peoples' problems. Mediators would identify problems amongst their peers and empower those peers to solve their own problems. They emphasised to the students that they must treat people respectfully. For instance, if a child was lonely, the student could go and sit on a special chair in the playground and their peers knew that they needed to befriend that student. From the lonely child syndrome grew a PALS (Physical Education Activity Leaders) movement.

Year six students developed and led lunch time physical activities for students in year four and below. The children proudly reported some of the changes that happened at school such as introducing the breakfast club which improved their concentration in class, healthier food for lunch, changing the school bells in favour of music, and lowering instances of bullying.

The children at Primary school Y were also involved in projects at school, which they too found satisfying. Examples given were compilation of a recipe book, involvement in the 'worm farm' and compost production, as well as a flower project at school.

The Acting Principal of School Y stated:

"I think that is what separates us from schools who are not HPS. Our students feel empowered to act and come up with ideas. For example, a group of year five girls went to our Principal and said "we have done a lot of fund raising for ourselves and our school. This year we would like to fund raise for Star Ship Children's Hospital (a large children's hospital in Auckland NZ) by doing a fun run". Those girls went ahead and organised the fun run, the sponsorship forms, and the date and liaised with the appropriate people. They then ran the day (the teachers helped to ensure that all students could be involved), they organised the parents to come and help and take the monies raised and... present it to Starship from the school."

The Community Worker

The community worker was active in School Y, and specified that the whole school had to be involved before the HPS concept could be implemented. There were other projects running before it became a HPS, but she felt that HPS could bring the whole community together.

Successes could be shown in the bullying project, but the biggest influence was probably the WHO conference in Wellington. The community worker accompanied representative children to the WHO conference, where they had the opportunity to talk to the health ministers of different countries, asking how the HPS concept was implemented in their own countries.

In School X, a big problem was bullying. To create a strategy to deal with bullying, teachers surveyed parents and students from Years One to Eight using smiley faces to ask how they felt about their school.

From the data, the teachers were able to work out when the bullying was occurring and put strategies in place to address it. For example,

Teacher S: stated:

"We asked for, if there is a bully, who would those people be, and your opinion, and it was all no names, and then we as a staff would monitor those children then we could use mediators and staff that we have to work alongside them ... rather than just having them wander around in the playground, we would take them and re-channel them and put them out into a sporting programme where they could get rid of that

energy and work as a team."

Teacher C stated:

"Junior bullies ... for some it was pure boredom ... so we got out the sports trolleys so the junior children could access equipment and also opened up the library at lunchtimes so that we're dispersing the children as well. We had organised sport on the field and teachers were expected to say, "there is soft-ball happening on the field". We put music on so that the children could dance and bob around if they wished."

Teacher K stated:

"We also provided a teacher to be on between 0800 and 0830 a.m. for the children who came early to school for this too was identified as a problem time."

The Board of Trustees (BOT)

The BOT member at school Y was convinced that the principal and her husband were the main drivers behind the whole project. He felt that the children should be happy to come to school, and the school environment was, therefore, important. Bullying should not be tolerated, and parents should have a good feeling about leaving their children at school. It was important that children knew about local cultural needs of fellow students, and the BOT member was happy that a teacher of Maori origin taught Maori culture to all children at the school. He felt that HPS was in the interest of the children, and supported the process whole heartedly.

Discussion

In an interview, with the two facilitators, they clearly stated that HPS could only be introduced as a deliberate process covering all areas of health - not only the physical aspects. The HPS must be seen as a partnership between the school, staff, students and the community. These prerequisites were mentioned in a paper *About health promoting schools*, published in 2003 by the New Zealand Ministry of Health¹. It would seem that both schools managed to involve parents, staff and children in the process of developing their own HPS model.

Interestingly, all those involved in implementing the model saw the Principal as being the "kingpin" of the whole process. The Principal and Acting Principal were very enthusiastic about implementing the HPS

model and actually voiced the need to implement HPS as a national 'standard' in education. Each school had some health promotion activities operating by the time the HPS model was introduced which probably aided the overall process. Teachers were already used to some activities, but more importantly, they were used to working with public health nurses thereby introducing multi-disciplinary approaches to health promotion.

The *Support Manual for Health Promoting Schools* mentioned a lack of social support and relationship difficulties, including sexual relations, as one of the factors causing distress in New Zealand children aged 13 - 18. Introducing the HPS model in the decile 1-4 school (School X) was, therefore, of the utmost importance given the background described by the Principal and teachers. The fact that early teenage girls left school X and had babies at the age of 14 was a clear cause for concern; clearly if the HPS approach could prevent or minimise early pregnancies and births, the aims of the model would have been achieved.

Further justifications mentioned by the Principal, teachers, and facilitators for introducing the model included alcohol and drug abuse. These factors were also mentioned in the support manual for HPS as factors leading to distress in as young as 13 years. Introducing the HPS model and mentioning their success in limiting these problems could, therefore, be seen as one of the many and varied programme successes. It was clear that the children were very proud to be part of the programme. Their involvement and the fact that they had the opportunity to voice their needs and demands gave them the opportunity for personal development, which in itself, met the goals of HPS. The advantages of using the 'bottom-up' approach could be clearly seen in the children's responses.

The WHO identified mental health as one of the important health indices and the *Support Manual for HPS* reinforced this by specifying that individuals have a need to develop a feeling of belonging, being valued, and being respected by family members.

Another source of distress to teachers in School X was the expectation that they could be asked to inform parents about unwanted pregnancies. This seemed to be an important

1. <https://www.healthed.govt.nz/health-topic/health-promoting-schools>

privacy issue for young people, but at the same time, it is a social problem that clearly impacts upon the child's development. Not finishing schooling impacts upon future employment due to the lack of skills. These risk factors are highlighted in the *Support Manual for HPS*. In School X, teacher C identified that young boys would come to her and state "Oh my girlfriend is pregnant. Can you tell my mum?"

The USA has one of the highest rates of teenage pregnancy in the industrialised world. At the same time, teachers are viewed as having significant influence in the lives of students from the age of 6-18 yrs. Teachers, though willing to provide advice on general matters of health feel ill equipped to offer advice in mental health, behavioural and reproductive areas (Cohall et al., 2007). Bennett and Nassim (2005) reported that the consequences of introducing educational programmes was inconclusive insofar as reducing the teenage pregnancy rate. As in New Zealand, concerns were raised about the preparation of teachers, professional support and the importance of broadcasting a consistent message. Moreover, funding for adequate services impacted on programme effectiveness.

The Health and Physical Education National School curriculum prepares students at primary school level to develop competencies for mental wellness, reproductive health, positive sexuality and safety management. A review of the School Based Health Services in secondary schools in the Counties Manukau region (Counties Manukau, 2011), reveals many difficulties related to reproductive health education. Difficulties range from the way the subject is taught, to the provision of services for young people. Funding for sustaining programmes is also problematic. A co-ordinated school-based health service with special attention to sexual health needs and professional health support is clearly needed by schools so they can provide information and services to students and families. There was no corresponding review of primary school services and yet it would appear from this case study that young people are sexually active prior to entering secondary school. Given this, it is clear that senior primary school students need health education about specific sexual and reproductive health behaviours prior to leaving primary school.

Conclusion

The introduction of the HPS model in New Zealand was a step in the right direction. Preventing the anguish of young girls faced with unwanted pregnancies serves as a justification for introducing HPS. This paper has described some obvious successes and some failures. The overall impressions from this case study were positive. It was clear that principals and teachers were convinced of their successes, although minor irritations were also mentioned.

The two primary schools demonstrated many and varied successes after implementing the programme and children developed a stronger feeling of 'belonging'. Students in representative roles developed leadership skills which they had not developed beforehand. Students gained a sense of achievement because they participated in simple decisions such as what lunch food would be presented and exchanging the school bells for music. Because of the voting process used to recruit leaders, children learned to make responsible decisions from the beginning. Parental involvement in school activities could also be deemed a success.

Programme sustainability was a major concern. The Government's financial support was finite and teachers queried what the future would hold for HPS once the money ran out. It is, therefore, of paramount importance that both the New Zealand Ministry of Health and the Ministry of Education critically review research conducted in this field so they can rethink their strategy about supporting the HPS concept.

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Exploring primary school teachers' experiences of implementing a healthy eating intervention.

In response to rising levels of childhood obesity, schools have become an influential environment in the promotion of health behaviours and in particular programmes aimed at increasing children's consumption of fruit and vegetables. A range of UK school-based interventions have been developed to target children's fruit and vegetable consumption (Ransley et al, 2007; Wardle, Herrera, Cooke & Gibson). One intervention that has been suggested to be particularly effective is the *Food Dudes* programme.

The programme is based upon psychological principles of behaviour change and aims to increase children's fruit and vegetable consumption through repeated tasting, peer modelling and rewards (Lowe, Dowey & Horne, 1995). The *Food Dudes* are four superheroes who gain special powers by eating their favourite fruit and vegetables that help them maintain the life force in their quest to defeat General Junk and the Junk Punks. The *Food Dudes* encourage children to 'keep the life force strong' through letters and DVD episodes of their adventures. Evidence suggests that the programme is effective in producing substantial increases in fruit and vegetable consumption (Lowe et al., 2004; Horne et al., 2004, 2009, 2011). However, the effectiveness of interventions such as the *Food Dudes* programme is arguably dependent upon a number of other factors including the perceptions of those responsible for implementing programmes (Baranowski & Stables, 2000). Indeed, health behaviour change programmes are embedded within a system of structures including participating agencies (e.g. schools) and programme implementers (e.g. teachers). Furthermore, following the introduction of the National Healthy Schools Programme and the Enhancement Model

(Department of Children, Schools and Families, 2009), all schools in England are required to adopt the ethos of a health promoting school. Teachers are therefore influential agents in the promotion of healthy eating within schools (Speller, et al, 2010) and perceptions of this group are likely to be integral to beliefs about programme effectiveness.

This study aimed to gain an understanding of the experiences of primary school teachers responsible for implementing the *Food Dudes* programme. More specifically, to explore what teachers perceived to be the successes of the programme, barriers to implementation and areas for further development.

Method

Semi structured interviews were conducted with six teachers of the *Food Dudes* programme from six primary schools in one West Midlands city.

Procedure

Following completion of the intervention, all teachers responsible for co-ordinating the programme within their school were contacted via telephone and asked to participate in an interview regarding their experiences of the programme. Interviews were arranged at a mutually convenient time for both the researcher and teachers. Two out of the eight teachers contacted by the researcher were unavailable for interview. An interview schedule was developed to guide the semi-structured interviews with teachers. A funnelling approach was adopted to elicit not only teachers' general views about the *Food Dudes* Programme but also to explore more specific issues. Four main areas were identified to be explored throughout the course of the

discussion:

- a) Their understanding of *Food Dudes* before the intervention took place
- b) Aspects of the intervention that worked well
- c) Any aspect(s) of the intervention that they felt to be challenging
- d) How the intervention affected the children in their school

Initial prompts were drafted and subsequently refined to ensure neutrality, avoid assumptions and increase an open discussion by the use of open rather than closed questions. Interviews were conducted, digitally recorded and transcribed in full.

Ethical approval was gained from the Institute of Health and Society's Ethics Committee and verbal consent given from teachers prior to interview.

Analytic framework

Transcripts from each focus group discussion were analysed using Ritchie and Spencer's (1994) Thematic Framework method. This enabled a detailed exploration of how teachers made sense of their experiences, their understandings, perceptions and views while providing a systematic and rigorous framework enabling the researcher to carefully rework ideas as the analysis developed. Initial themes were identified and an index was constructed by identifying links between categories, grouping them thematically and developing a hierarchy of main and subthemes.

Analytic procedure

The analysis was guided by Ritchie and Spencer's (1994) Framework which depicts five key stages of the analytic process: familiarisation, the identification of initial themes or concepts, indexing, charting and mapping and interpretation.

In order to become familiar with the teachers' accounts, each transcript was examined individually and read multiple times by the researcher. Digital recordings of each of the interviews were also revisited to facilitate this process. The next stage involved identifying initial themes present in the data and interesting and significant issues were noted in the margins. To ensure conceptual clarity, an index was constructed by identifying links between

categories, grouping them thematically and developing a hierarchy of main and subthemes. Following this, each main theme and associated subthemes were plotted on a separate thematic chart. Finally, the charted data were examined in order to identify patterns and develop explanations for the data and discuss their application to health promotion within schools.

Results

Analysis of the data revealed three main themes: successful aspects of the intervention, challenges to implementation and maintenance of healthy eating in the long term.

Successful aspects of the intervention

Teachers suggested that the intervention had raised children's awareness of healthy eating, increasing their exposure to fruit and vegetables and providing increased opportunities to try different fruits and vegetables.

"It has raised awareness of fruit and veg to children, a lot of children are having fruit as a snack." Teacher, School 3

"Where it's changed and where I think it's had the most impact is that those, the minority of pupils that don't like fruit and veg, it has changed them, opened their minds a little bit." Teacher, School 2

"I thought 'I'll just ask them (children) 'are there any fruits or vegetables that you would eat now that you wouldn't before?' and a number of children mentioned peppers which I think is a really good example, people have a perception around the word 'pepper' that it's not going to be edible. They were saying that they were genuinely eating peppers and they didn't before, they wouldn't have eaten them or wouldn't have tasted them." Teacher, School 4

However, there was also some recognition that increased exposure to fruit and vegetables did not necessarily produce behaviour change. Children are aware of the importance of healthy eating but their knowledge of what is healthy may not always result in quantifiable changes in consumption suggesting a gap between children's intentions and actual behaviour.

"I mean these children they really know what's healthy, what's good for them, so they've got the

knowledge even if they don't necessarily choose to follow it, they know, they've got the understanding." Teacher, School 1

"The fact that it was about widening children's eating experiences I think is one of the real strengths. Now, whether it's successful or not I'm not sure but it's clearly got to make sense to try that because I genuinely think it's an issue, children make value judgements based on little or nothing or hearsay and if you can get out of that, or at least try to that's got to be positive." Teacher, School 3

The prizes given to children as rewards for tasting the fruit and vegetables were regarded as a particularly positive aspect of the intervention. The prizes were perceived to be well-developed and age-appropriate. Teachers suggested that the prizes encouraged children to try fruit and vegetables.

"The children were highly motivated by the prizes. The prizes, I thought, were very well planned in terms of; they were very well pitched in terms of the age appropriateness of them and in addition, in terms of the materials that we used were actually also very well pitched. Quite often when organisations come into schools, primary schools, they will have programmes that are run and due to their not having full knowledge of, the range of if you like, emotional and intellectual abilities of children, sometimes these programmes don't always match their abilities and age ranges." Teacher, School 2

"Simple things like the prizes were really good, little things. I think the prizes, and it's hard to think of lots of different prizes worked well and kids loved them and so that was good." Teacher, School 4

Teachers also commented on the effectiveness of the DVD episodes shown to the children during the intervention phase. These were enjoyed by the younger children in particular, perhaps reflecting the developmental stage of this age group. It was suggested that these were not as appropriate for older children.

"They loved the little film clips on the DVD. They loved the fact that they were other children telling them about fruit and vegetables and they put it into the villain and the superhero

situation and they, they got it spot actually because that's what children like, the baddies and the goodies. The younger ones, responded to we've got a letter from the Food Dudes like wah! I think the older ones perhaps thought...you're having us on here." Teacher, School 6

"The children really liked it, I mean that's important. They buy into the whole experience. The characters may be a little bit twee but they work really well, particularly with the younger children. I'd say the upper juniors start saw it as a little bit patronising. I know it's not age related but I think probably more powerful with the younger children than the older ones possibly." Teacher, School 4

Challenges to implementation and maintenance of healthy heating

The time required to implement the programme was a significant challenge for teachers, particularly the difficulties associated in incorporating the programme into the busy school day. There was also recognition of competing priorities with regard to academic aspects of the curriculum.

"We had some issues with the running of it, it is, on occasions something that is in the way of teaching literacy ... when I'm putting something else in the curriculum they see it as taking away, as stripping away." Teacher, School 2

"The problem is that we have a very busy timetable and all primary schools have a curriculum that barely fits into the time that we're given to deliver it and so it was very difficult trying to fit it in to the day." Teacher, School 6

"Timetables are really tight in school and you're giving up some time. You've got to allocate that time and it becomes every day and it can impact on other things even though it's 10 or 15 minutes whatever but that is still a significant time." Teacher, School 4

The *Food Dudes* intervention was viewed positively by the majority of school teachers, however it was suggested that the programme should be rolled out on a cyclical basis rather than as a one off intervention thus encouraging

children to revisit the importance of eating fruit and vegetables as part of a healthy diet.

"What might concern me is that really children should be educated like this on a regular basis so every subsequent year group should be educated in years to come so really it probably needs building into the curriculum, on a rolling programme." Teacher, School 2

"Whether someone could invest some time revisiting, sharing those same messages again but in different ways, in assemblies, in classes would have been good."
Teacher, School 4

"It needs to be something we need to do again and again and again. If it is just seen as a one-off, it won't work. Anyone who's taught primary school children will know that for a child to learn how to write a simple sentence can take years and the same applies to attitudes to healthy eating. It's not a one off lesson or one-off week." Teacher, School 2

Discussion

This study explored the perceptions and experiences of primary school teachers responsible for implementing the *Food Dudes* programme in one West Midlands city. Overall, teachers were positive about the programme and agreed that they would participate in the programme if it were to be rolled out in the future. Teachers perceived the programme to have a beneficial impact upon children's awareness of healthy eating and the opportunities provided to taste new foods. The materials associated with the programme, particularly the rewards given to children, were also potent. This is important as the use of incentives to change behaviour is only likely to be effective if these are highly desirable to the child (Lowe et al., 1998).

However, a number of barriers to implementing the programme were identified. The time required to implement the programme was highlighted as a significant challenge. As Langille and Rodgers (2010) identified, schools may have difficulty implementing health promotion programmes due to competing priorities, particularly raising standards of academic attainment. Consequently, it is

important that health promotion initiatives such as the *Food Dudes* programme consider the needs and interest of teachers and are incorporated into the primary curriculum (Pérez-Rodrigo & Aranceta, 2003). The need to maintain children's interest and consumption of fruit and vegetables in the long term was also recognised by teachers. Sustaining behaviour change is a crucial issue within health promotion programmes and as such may require more than just a one-off intervention found to be efficacious in a controlled research environment (Altman, 2009). This highlights the importance of continual education to children regarding healthy eating and the integration of nutrition education into the primary curriculum to reinforce these messages once the programme has come to an end.

In conclusion, the perceptions and experiences of teachers involved in implementing the *Food Dudes* programme should be taken into account when developing and refining the programme. Further work is required to develop ways in which the programme could be integrated into the curriculum to support the maintenance of healthy eating behaviours.

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Communicating about sexual matters within the family : Facilitators and barriers

A worksite-based parenting programme, to promote parent-adolescent communication about sexual health, was found to be effective in increasing communication between parents and their children (Schuster et al 2008). More recent research has found that children also have a preference for talking to their parents as well as learning from other sources (Turnbull, van Schaik & van Wersch, 2010). However, it has often been found that parents demur from discussing particular topics (e.g. sexuality) with their children because they feel embarrassed and experience discomfort when doing so (Burgess, Dziegielewski & Evans-Green, 2005; Dilorio et al 1996; Feldman & Rosenthal, 2000; Kahlbaugh, Lefkowitz, Au & Sigman, 1997; King & Lorusso, 1997; Lefkowitz et al 1998; Rosenthal & Feldman, 1999; Jordan, Price & Fitzgerald, 2000; Kakavoulis, 2001; Walker, 2001).

Sex is now more openly discussed even compared to a generation ago. Communication about sexual matters in Britain is attempting to mirror other European countries such as the Netherlands, France and Germany where teenage pregnancies and sexually transmitted infections are lower (Lewis & Knijn, 2001; Van Loon, 2003; Bailey, 2005; Gallup-Black & Weitzman, 2004).

The sexual health and well-being of young people in Britain remains a concern and in recent years, the UK government have provided strategies for taking a holistic approach to addressing the sexual health of young people. Schools, parents and health professionals have been encouraged to take a comprehensive approach to educating and keeping young people safe from the consequences associated with risky sexual behaviour (Department for Education and Skills, 2001; Department for Education and Skills, 2002; Sex Education Forum, 2003).

Guidance published by the government (Department for Education and Employment, 2000) has suggested that parents are the most important group who are able to teach children about sexual matters whilst providing the emotional and physical support in preparation for adult life. Novilla et al. (2006) have suggested that parents are able to influence their children's attitudes by forming beliefs and values concerning identity, relationships and intimacy. Previous research in developmental psychology, in particular Bowlby (1973, 1979) suggests that attachments with parents influence children's cognitions, which not only shape their behaviour, but also their friendships and romantic relationships in the future. Although these types of parent-child relationship that are characterised by parental warmth, support and parent-child closeness can have a protective effect over young people's behaviour (Hartup, 1996), parents have a valuable role to play in educating their children about sexual matters. It has been suggested that parents are the primary sex educators of their children (Turnbull, van Wersch & van Schaik, 2008). Technology and media sources are used to initiate and support communications about sexual matters between parents and their children (Goldman & Bradley, 2004; Krafchick & Biringen, 2002). This study aims to assess the facilitators and barriers that may affect communication regarding sexual matters within a sample of families living in the North East of England.

Method

Design

This study used the modified grounded-theory method of Strauss and Corbin (1990). Semi-structured interviews were used to explore the facilitators and barriers that allow for communication about sexual matters within

families.

Participants

Parents and their children were recruited through purposive sampling from the boroughs of Middlesbrough, Redcar and Cleveland in the UK. Families were recruited by word-of-mouth and by placing an advertisement in local libraries, sporting venues and locations where families were most likely to spend time together. In total, 20 families took part in the study. These were 20 mothers (mean age = 39, SD = 6), 6 fathers (mean age = 42, SD = 7), 16 adolescent males (mean age = 12, SD = 4) and 10 female adolescents (mean age = 14, SD = 7). No participants reported having any learning disabilities (such as dyslexia) and all spoke English as their native language.

Materials and procedure

In order to identify and explore the facilitators and barriers for effective communication about sexual matters within families, a standard set of interview questions were used to gather data from the families who participated in the research. These questions were based on previous research findings concerning communication. As a result of the findings from earlier interviews, the set of questions were expanded upon and then used as a guide for data collection in later interviews, which provided the qualitative data for this research study.

Results

Facilitators

Various facilitators of communication were identified. Family relationships start with the foundation of love, trust, respect, commitment, support and stability. Parents show these qualities from early in their child's life, allowing for expansion and forming good relationships between family members. This was evident in this study in families who discussed sexual matters openly. It was found that trust was paramount. Numerous statements from children revealed that if they trusted their parents, then they were more likely to talk to them about sexual matters and their personal experiences. For example, a 14-year old boy reported:

"When I tell my mum things I know my mum will keep it a secret. If I need to know something

that is private I know I can trust her as well not to say anything ... I can trust my mum and I know she will talk to me about things ... I am closer to my mum and I trust her a lot more."

A further quote came from a brother (aged 15) and sister (aged 13):

"For me it is because I can trust them and you talk to them on more of a personal level because they are your parents' (Son) ... 'You can trust your parents, but you can't trust your friends because they will talk about you behind your back; mum wouldn't do that to me."
(Daughter)

Trust inadvertently demonstrated honesty within families. This was illustrated by a 14-year old boy when referring to talking to his parents.

"She (his Mother) probably knows more about it and I can trust her as well' (Son) ... 'I think you also know that when you do ask questions I am always going to tell you the truth' (Mother) ... 'Yes, that was also what I was trying to say, but it is also not just to do with being honest it is also that I trust you not to tell anybody else' (Son)... 'Aw, you trust me do you son?' (joking) (Mother) ... 'Well I have to really, you are my mum ... Pretty much the same reasons for talking to my mum; I can also trust my dad.'" (Son)

It was found that children who regarded their parents as role models were likely to mimic their parents' behaviour by reciprocating the openness of discussing sexual matters within families. In addition, parents' knowledge also facilitated communications concerning sexual matters. It was revealed that if children perceived their parents to have the knowledge to teach them, communication regarding sexual topics were enhanced. This was emphasised by the occupation of parents as illustrated by a 12-year old son, who stated:

"She (the Mother) is a nurse, so she knows about it and she has been there eighteen years, which is quite encouraging ... (talk to) mum, because dad's a butcher ... He is just thick! ... Being a nurse she would know stuff that the school wouldn't."

A further quote to illustrate children's perception of their parents' knowledge came from the dialogue between a father and their 15-year old son:

"He (the Father) just seems to be more knowledgeable about what I am going through' (Son) ... 'I think we can give him the knowledge that he needs know and then he will learn things for himself, so I think I do to equip him with the information that he needs to know or I would find out if I didn't know something that he asked or wanted to know more about." (Father)

Parents also reported that if they did not know about particular sexual issues then they would find the required information so that they could educate their children. This was demonstrated by a mother who reported talking to other parents who were perhaps more knowledgeable than her. The mother reported:

"... if I don't know the answer I will find it out and then explain it to you properly, don't I? I know other mums with kids in their early teens so I will drop it into the conversation when talking to them as though I don't know and then I will tell her so nobody knows that I am asking for her (the daughter). This way she doesn't get embarrassed and she still finds out the answer to what she asked me about." (Mother)

Another parent reported:

"I don't know if I would be able to answer all of their questions, but I would be honest with them if I did not know, but I would then either go to the library or on the Internet to find out the information they needed to know more about ... I think she comes in and asks questions, but then I will ask her questions to make sure she has the correct knowledge on something, but with him he is that bit older and has the knowledge so I concentrate more on the emotional side with him. I just know that as parents we have a responsibility to give our children the knowledge they need for becoming adults."

These statements reinforce the role of parents in that they want the best for their children and are committed and supportive towards their needs. When parents spent time with their children, conversations about sexual matters

were increased. Dialogue from one family revealed:

"We have this thing on a night time when we all eat together and we go around the table so everybody gets their chance to say what they have done in that day and what has made them laugh? You have to laugh every day because it is the... mother and son say at the same time: 'The Law'. This is a little thing that we do as a family and I suppose this is where I would say we talk openly about sexual matters in that it opens up the conversation to talk about anything and everything."

Further quotes to illustrate how spending time together increased communication about sexual matters came from two fathers and their sons (both aged 15). One particular father and son reported:

"I just talk in general to my dad about almost anything and everything ... when we are out biking' (Son) ... 'I think we tend to have quite a lot of conversations when it is just me and him when we are out bike riding ... we spend a lot of time together alone, and these conversations are mixed in with something else like riding a bike so it takes the emphasis of the fact that we are talking about sex ... masturbation ... that is one of the things we have had a good conversation about when we went biking at Whitby, so he does know things." (Father)

Dialogue from a further family revealed that fathers and sons discuss sexual matters. They reported:

"We were coming back from football that night' (Son) ... 'What was that about?' (Mother) ... 'Him asking about body piercing and why do people get them on their genitals and nipples' (Father) ... 'It can help increase the sensation when having sex, just for some people you know' (Son) Father and son laughed 'And how would you know?' (Mother) ... 'Dad told me' (Son) ... 'I told you I would answer any questions' (Father) ... 'You could have told me' (Mother) ... 'I did, it was months ago.'" (Father) (The family laugh together.)

Families in general were also found to discuss sexual matters when spending time together at

meal times and on an evening when watching television. One mother stated that conversations about sexual matters occurred '*...when watching TV together or whilst making meals.*' These conversations were expanded upon mainly between mothers and daughters when having quiet times together when they could be alone. A statement to illustrate this came from a mother that demonstrated the close relationship she had with her daughter. The mother reported:

"I talk to her about things and she wants to talk to me. I know she had been out with her boyfriend last week and when she came home I was in bed reading and she came up and sat on the edge of the bed. I asked if she was alright and whether she had had a good time. She then just came and got into the bed for a cuddle and she cried for the next twenty minutes because they had finished. Now why she didn't just go to her room and cry by herself I don't know; I think she just prefers to share things with me. I feel it is quite an honour, but at the same time that is the way I have always been with her in the fact that I do openly discuss things with her, so that might be why she did it but I think we are quite close anyway."

Formal sex education at school was also found to generate conversations about sexual matters in several families. Children reported talking to their mothers about sexual matters when coming home from school. This happened mostly as a result of mothers initiating these conversations by asking children to identify what sex education their children had learnt. This provided children with the opportunity to elaborate on things they had been told, and allowed parents to explain in more detail than teachers.

Barriers

The research also identified barriers that prevented sexual matters being discussed within families.

Discussions on sexual matters between parents and their children were restricted if children perceived their parents to not have the up-to-date knowledge to teach them. A good example of this lack of education was expressed by two brothers (aged 13 and 15) who reported:

"I don't want to talk to them about sex. They can't even get the terminology right" (Son 2) ... 'Don't get us wrong we love our parents but they do come across as rather out-dated' (Son 1) ... 'Yes, like something from the ice-age' (Son 2) ... Laughter ... 'Sorry that is a family joke. We labelled dad as the mammoth off ice-age because he is starting to put on weight and he has too much hair on his head.'" (Son 1) (More laughter)

A 'lack of sexual knowledge in parents indirectly led to embarrassment, which-in turn-affected children as they too were embarrassed when discussing sexual topics in the company of their parents. This was demonstrated by dialogue of one of the families:

"Mum gets embarrassed talking to us about sex" (Son) ... 'I do not' (Mother) ... 'I think sometimes it is embarrassing; we are just unsure of the terminology you use, because it was different for us and you lot are a lot more open about things than we were.'" (Father)

Regardless of knowledge, other parents were also found to experience embarrassment. As in the family with the two brothers as discussed above who stated:

"Aw that would be so bad. Mother talking about sex!" (Son 2) ... "Dad talking about sex!" (Son 1) ... "I think they are embarrassed" (Son 2) ... "No, you mean they are an embarrassment when talking about sex" (Son 1) ... "Dad does and I think that is to do with our embarrassing scenario when I was 11. Poor man, but mum just puts her head down and shuffles away." (Son 1)

The mother from this family suggested this embarrassment was based on how she was taught when she was younger. However, the mother said she would talk to her children if they '*... wanted to talk*' to her, but agrees with her sons that communications about sexual matters ceased after the following embarrassing event:

"I can only really remember one thing which generated conversation and that was when they went up into secondary school. My eldest came

home and was quite quiet, but we knew that he had had his first sex education lesson. I told my husband with him being of the same sex that it was his job. So anyway he went and asked our son about school and he mentioned this video on sex. My husband had sort of asked what things were shown on the video and our son had said 'a penis, oh and boobs'. My husband replied well you know what these are; you have seen me and your mum naked. The son replied 'yes well this woman on the video had proper boobs, not like mum's'. Well I was mortified, my husband laughed hysterically and our son's last words were 'giving birth is also disgusting and I do not want to have this conversation again'. Since then we have respected his opinion and never questioned him in such a way."

The embarrassment felt by children was also heightened when parents asked probing questions about their personal relationships. This was illustrated in the two families who did not discuss sexual matters openly. One particular family revealed:

"Yes, possibly, but I think you get embarrassed because of the questions I ask when you tell me things' (Mother) ... 'Yes, I know but you keep nosing into my private life and I don't know what to say." (Son)

It appeared that when parents asked their children questions about sexual matters that this was seen as an invasion of their privacy, which consequently acted as a barrier for discussing sexual matters openly within families.

Parents who were perceived to be controlling and domineering towards their children also prevented these matters being discussed. In an interview with a mother and daughter, the daughter firstly claimed she did not discuss sexual matters with her mother. However, when being challenged by her mother in a sharp tone and condemning manner, the daughter changed her view that reflected those of her mother. The daughter appeared embarrassed throughout much of the interview and looked towards her mother for approval before answering questions. A similar case of dominant behaviour was seen in an interview between a mother and their son whereby the son claimed to not discussing sexual matters

with his mother and felt embarrassed when the topic came up in his mother's presence. Although the mother disagreed and claimed to discuss sexual matters openly with her son she passed comments, such as:

"I know I might sound like I control what he learns but it isn't like that ... I think the thing is I am a bit of a dictator."

The mother demonstrated her dominance over her son throughout the interview by answering most of the questions or by speaking on behalf of her son. This could be seen as a supportive and protective act on behalf of the mother; however, it appeared to make the son uncomfortable because he did not know how to answer the questions, which is why he only gave short replies to the questions.

A final barrier for not discussing sexual matters openly within the family was the pressure of younger siblings being present. One of the girls who participated in the study reported that her younger brother 'interrupts the conversations' (daughter, aged 15). Parents, on the other hand, felt that communications about sexual matters were restricted because the content of conversations they had with their older children would be inappropriate in front of younger siblings. One mother reported:

"We are sometimes restricted on what we discuss with me also having only an eight-year old daughter. There is no way we could talk about some things with her being around so I think sometimes the moment has passed if they mention something and I can't elaborate on it because of my 8-year old daughter and her friends being in the house."

To overcome these barriers parents would resume conversations with their older children at a time when they could be alone. For example, one mother revealed:

"This house is very busy in that there is always lots going on, so people are coming in all the time, not just children it can be adults picking up one of the kids for football or something like that, but if I was talking to her about something I would stop talking if someone came into the room because what we are talking about is personal, but we will talk about it later. I also go

to bed early and when I tuck her in I will ask if there is anything she wants to talk about, so we would come back to what we were talking about and discuss it in more detail then."

A further quote illustrates that parents talk to their older children about sexual matters when younger siblings are not present came from a mother who revealed:

"I get chance to talk about things on a night time. We have half-an-hour when your brothers have gone to bed, so we generally talk about things like this then."

Discussion

One of the most important findings from this research was that children want to talk to their parents about sex and sexual matters just as parents want to talk and educate their children about sexual topics. Although the latter finding contradicts previous research findings (Burgess et al 2005; Dilorio et al 1996; Feldman et al 2000; Kahlbaugh et al 1997; King & Lorusso, 1997; Lefkowitz et al 1998; Rosenthal & Feldman, 1999; Jordan et al 2000; Kakavoulis, 2001; Walker, 2001) it has been suggested that parents are the primary sex educators of their children (Turnbull et al 2008) based on the emotional and physical support they provide to prepare their children for adult life (Novilla et al 2006).

Facilitators that influence communication

Firstly, parents' openness and honesty about sexual matters with their children together with an apparent close and trusting relationship between parents and their children. The openness and honesty was reciprocated by children who were then more likely to talk to their parents seeing them as a role model and trusted companion. These findings support previous research, which emphasised the valuable role parents can have helping their children develop, grow and remain healthy through the close and trusted relationship they have developed. Furthermore, Bowlby (1973, 1979) suggested that the attachment parents have with their children could influence their cognitions and shape their behaviour towards relationships in the future.

Secondly, parents' knowledge was revealed as an important facilitator. Some parents admitted to not having the up-to-date

knowledge to teach their children, but they still wanted to ensure their children had the sexual knowledge they needed. As a means of achieving this, parents would seek the information for themselves first. It is understandable that when parents play this supporting role a closer relationship will be formed between parents and their children.

Thirdly, this research revealed that sexual matters were discussed more openly when parents and their children spent time together. Results showed that when spending time together at mealtimes, sharing a sporting activity or having private conversations together reinforced the close relationship that they shared. Although it was also found that television and the formal sex education provided at school generated conversions about sexual matters, parents were reported to provide their children with a secure environment where they could openly discuss sexual matters.

Barriers that influence communication

Four barriers that inhibited conversations on sex and relationships were identified. Although a lack of parental knowledge restricted communication of sexual matters, this was amplified because it caused embarrassment within families. This not only applied to parents, but also to the children. Although parents suggested this embarrassment stemmed from the way they were taught by their own parents, children reported becoming embarrassed when parents asked personal questions about their private relationships. In one sense it is difficult for children to talk about their personal relationships if they do not have a close relationship with their parent(s) or if they get embarrassed when talking about personal relationships with their parents. However, in another sense parents may ask questions to identify if their children need support or help in understanding what they are experiencing. In either case, it is important to realise that the embarrassment felt is moving from one generation to the next, which could have implications when the children become parents themselves.

Dominant and controlling behaviour of parents also inhibits discussions of sexual matters within families. In the present study it was shown that if parents had these

mannerisms, their children were shy and reserved, only giving socially desirable answers because they were uncomfortable to express themselves. Relating this to discussing sexual matters, it would come as no surprise that children may refrain from discussing sensitive issues associated with sex in case they were condemned or ridiculed by their parents for doing so. This may also have implications for the relationship children have with their parents in the future, as children are not being provided with the knowledge that allows them to make responsible choices and decisions over their sexual health and personal relationships.

Younger siblings were also found to affect conversations concerning sexual matters, acting as a barrier for open communication within families. However, avoiding subjects of a sexual nature in front of younger siblings could perhaps not only prevent them learning from older siblings, but prevents an open culture for discussing sexual matters within families.

Conclusion

This research has demonstrated that parents do discuss sexual matters with their children. Close and connected family relationships allow for a trusting relationship to develop and for sexual matters to be discussed openly. Although this research has identified and explored the facilitators and barriers that influence this communication, future research could focus on the age at which children want to talk to their parents. By doing this it would be possible to concentrate on the factors that allow for sexual matters to be discussed at an earlier age when children and young people are developing and at a time they are most likely to benefit from communication with their parents.

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Annechen Bahr Bugge

Young Norwegians' food choices, healthy eating and weight control: Commentary on the *Food: Now and Then* report

As in many other countries, young people's food habits have been a central issue in the Norwegian public debate in recent years and many interested parties have been participating in the debate.

If we look more closely at how young people and their eating habits are portrayed by politicians, researchers and opinion leaders, they are typically being portrayed as rebellious and troublesome. One example of this is the following front page from Norway's largest newspaper: 'Norwegian children and young people are fat and lazy' (VG February 14th 2007). This claim was based on the fact that children and young people exercised less than before and ate more unhealthy food. To what extent do such claims square with empirical data: Is it true that young people generally eat unhealthy food? And is it true that young people do not care what they eat or drink? And how do Norwegian studies correspond with findings in the British report *Food: Now and Then* (SHEU, 2012).

Attitude and action

In the *Food: Now and Then* report, it is questioned whether young people "really" are considering their health or just saying what they think is right. The dataset showed clear correlations between health considerations and healthy eating. This also appears in various Norwegian studies (Bugge, 2010; Bugge, 2011; Bugge & Lavik, 2012). As an example, almost all young people expressed knowledge of the dietary advice that one should eat five servings of fruit and vegetables daily. However, on average, the Norwegian participants only ate 2.7 servings daily (Bugge & Lavik, 2012). A popular interpretation of such findings is that there is a discrepancy between people's attitudes and what they actually eat. Nevertheless the SHEU study showed that those who expressed interest in healthy eating had the highest eating frequency of fruit and vegetables. This study also showed that young people who were concerned about healthy eating had a lower intake of fizzy drinks, chocolate, snacks etc. All in all, Norwegian studies support the SHEU report's conclusion that opinions about food and eating have an effect on behaviour.

Increasing interest in healthy eating

From the SHEU report, it emerges that most young people considered their health when choosing food, at least sometimes. More females than males responded (very) often or always. Norwegian studies show that young people have become increasingly concerned about having a healthy diet (Bugge, 2010; Bugge, 2011; Bugge & Lavik, 2012). More than half of the young stated that they were interested in healthy eating. Males were, however, far less concerned with this than females. The most important motivational factor for healthy eating was to achieve good health. The young people scored higher, however, than adults on motivational factors such as good looks and avoiding overweight.

Young people's preferences and priorities

On the question about what was important when buying food, young people scored much higher on low price/cheap products than the other age groups. Seven in ten young people said this was particularly important. Six in ten emphasised that the food was healthy. Females were far more concerned with the health aspects when buying foods than males.

Surveys show that, among young Norwegians, eight in ten indicated that they

preferred to avoid foods and drinks high in sugar, while six in ten said the same about foods and drinks high in fat (Bugge & Lavik, 2012; Bugge, 2012).

Fast food was found to be much more appealing among young people than adults (Bugge, 2010). 43 per cent expressed a preference for hamburgers and similar dishes. In the age group 40-59, the figure was 13 per cent. However, much has changed since hamburgers were introduced in Norway in the 1980s. From the responses of the young informants, it is evident that the food-cultural status of such foods is becoming increasingly problematic.

Many positive development trends in young people's diet

With regard to the many negative descriptions of young Norwegians' eating habits, the results that emerge in various studies are quite surprising. In later years, we have seen many positive results (Bugge, 2010; Bugge, 2011; Bugge, 2012; Bugge & Lavik, 2012). For example, there has been a significant reduction in the consumption of fizzy drinks, and a considerable increase in the consumption of water. Furthermore, we have also seen an increase in consumption of fruit and vegetables. Still, there are many young Norwegians who, despite health authorities' advice, have a far higher intake of chocolate, sweets, sweet pastries, salty snacks, fast food and fizzy drinks.

Healthy food is in vogue

As in the SHEU report, Norwegian figures show that young people have a much higher consumption of meat than fish. Furthermore, it emerges that young Norwegians also have a significantly lower frequency of eating fish than adults. The exception is salmon. Over the last decade, however, sushi has become a popular dish among young Norwegians. Its popularity must be seen in light of the growing interest in healthy eating. The younger age groups had a significantly higher frequency of eating sushi than the older age groups (Bugge, 2012).

Smoothies were also introduced to Norwegians during the last decade. Today, the product is largely marketed to health conscious young consumers. The figures clearly show that smoothie is primarily something that appeals to the younger age groups. Young people have a

significantly higher consumption of this than the older age groups (Bugge, 2012).

Gender differences

Similarly to the British report, several Norwegian studies show that female's and male's eating habits are rather different (Bugge, 2010). There are, for example, many differences in what girls and boys are eating during the school day. Far more females than males drink water and eat fruit and vegetables (salad) for lunch. There are also far more girls who eat yoghurt or whole grain crackers. Conversely, far more males drink fizzy drinks and ate sweet pastries and fast food during the school day.

Attitudes to personal weight

Norwegian studies show that being healthy and slim are ranked highest on the youth's popularity (status) scale (Bugge, 2010). The fact that the value of a slim and healthy body has escalated among young Norwegians are also supported by findings in several studies (Bugge, 2012).

According to Norwegian statistics, 15-20 per cent of young Norwegians are overweight or obese. However, studies show that many more (53 per cent) of the young stated that they had too much body weight. Furthermore, there were as many as 71 per cent who said they were trying to get a leaner body. The Norwegian studies thus correspond with the SHEU report: Many young people seem overanxious about their weight. Furthermore, it seems that many people who are within the normal BMI target are dieting (Bugge, 2012).

Conclusion

Norwegian studies of young people's eating habits show a much more optimistic picture than the impression created in the media. Furthermore, we see that the Norwegian studies are also consistent with recent British studies of young people's food choices.

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Wendy Wills

The food and eating practices of young people in Scotland and England: Commentary on the *Food: Now and Then* report

The *Food: Now and Then* report (SHEU, 2012) makes for fascinating reading and I would hope that these commentary pieces offer, in response, some additional insights, drawing on other research, including qualitative studies, which can provide more depth about the 'why' questions which surveys are often unable to answer. In addition to qualitative work that I have been involved with over the last decade, exploring young people's food and eating practices, this commentary is informed by findings from a new survey module, funded by Food Standards Agency Scotland (FSAS), which aimed to investigate children and young people's food and drink purchasing behaviours 'beyond the school gate' (Scottish Government, 2011) in 2010; this is the first time such questions have been asked of a representative sample of children and young people in Scotland. The full report will be published by FSAS in summer 2012 (Macdiarmid et al.).

Buying lunch

Food: Now and Then shows that a minority of young people (2-9%) bought lunch from a takeaway or shop during the school day. The FSAS Survey of Food and Drink Purchasing around the School Day suggests that a much larger proportion of secondary school students purchase food outside of school and that takeaway-type outlets are not as popular as other retail food outlets like supermarkets (Macdiarmid et al.). The FSAS survey also shows the proportion of children who have access to food and drink outlets around the vicinity of their school (i.e. outlets within walking or cycling distance of school); the findings suggest that children and young people from more deprived areas are more likely to walk or cycle past food and drink outlets during the school day (Macdiarmid et

al.). The FSAS survey also suggests some of the reasons that young people leave school at lunchtime, including perceiving a wider choice of food to be available and preferring the taste of 'non-school' food (Macdiarmid et al.). Qualitative research in Scotland (Wills et al., 2005) has highlighted that some young teenagers like to get away from the school environment at lunchtime (including having a dislike of queuing for food), and this also sheds some light on why a minority of young people choose to go home for lunch during the school day (Wills et al., 2005). Young people who go home at lunchtime may also be some of the most marginalised students.

Missing breakfast

Food: Now and Then highlights an interesting relationship between lack of breakfast eating and the consumption of crisps, sweets and fizzy drinks. *Food: Now and Then* suggests that around a third of young women do not eat breakfast before school; this is significantly higher than was found in the 2010 FSAS survey (Macdiarmid et al.) and an earlier FSAS survey of children and young people, in 2006 (Macdiarmid et al., 2009)). The proportion of girls who skip breakfast is similar, however, to the proportion suggested by the Health Behaviour in School-Aged Children (HBSC) survey in England (Brooks et al., 2011). Collecting data in the home (which the FSAS surveys did), rather than the school setting (as HBSC and the SHEU surveys do) could affect what children and young people report about breakfast eating. Analysis of HBSC data suggests that eating breakfast is related to better psychological wellbeing, regardless of factors like family affluence or family structure (Toda et al., 2002) therefore it is important to understand what factors influence the reporting

of breakfast eating.

Snacking habits

The *Food: Now and Then* authors ask whether the frequent consumption of fizzy drinks, crisps and confectionery is related to what children and young people eat/find in their school packed lunches. The FSAS Food and Drink Purchasing survey shows, however, that fizzy drinks and confectionery are the items most frequently purchased *by young people themselves* before/after school and outside school at break or lunch time (Macdiarmid et al.), thereby suggesting that lunch boxes are not the only way that young people gain access to such food/drink. Young people from more deprived areas are more likely to consume crisps, confectionery and fizzy drinks (diet and non-diet varieties) (Masson et al.).

Given that *Food: Now and Then* asks about water consumption it is worth noting that the FSAS Food and Drink Purchasing survey found that around as many secondary school students were purchasing bottled water as were purchasing diet/low-calorie fizzy drinks. A greater percentage of young people were purchasing non-diet fizzy drinks than either water or diet fizzy drinks (Macdiarmid et al.).

Weight and health

It is encouraging that *Food: Now and Then* shows that many young women are happy with their weight though more worrying that many of those who want to lose weight are already within the limits of a 'healthy' body size. Qualitative research has shown that there is significant anxiety amongst girls who perceive themselves as 'too fat' despite a 'healthy' Body Mass Index (BMI) (Wills et al., 2006). Many young teenagers with a BMI classifying them as overweight or obese, however, have positive things to say about their bodies therefore the relationships between body weight and wellbeing are complex and not clear cut (Wills et al., 2006). *Food: Now and Then* highlights that 'health' is not something that many children or young people think about when deciding what to eat. Our qualitative studies, which have a focus on the 'lived experience' of socio-economic status, show, however, that middle class young teenagers are more likely (than working class young people) to be 'moulded' by their parents to consider the healthiness of the

food they consume with a view to protecting their longer term health and wellbeing (Backett-Milburn et al., 2010; Wills et al., 2010; Wills et al., 2011). This health consciousness-raising also relates to middle class parents expecting their off-spring to keep their body weight to a 'respectable' standard, though parents across the socio-economic spectrum often struggle to discuss weight with their children (Wills et al., 2009).

Food: Now and Then is an incredibly rich and useful resource in terms of the insights it offers about children and young people's food choices across the years. Whilst the wealth of data it provides has breadth and depth it can usefully be supplemented with data from other surveys and also from qualitative studies to try and tease out the reasons that young people eat in the way that they do.

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