Promoting health education in groups of schools

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The use of the Health Related Behaviour Questionnaire to survey a group of schools in the same area has benefits for the schools involved and also for health-care professionals seeking to promote curriculum change. Comparisons between catchment areas often reveal surprising differences, while the links created between schools and Authority personnel can be of continuing value.

There are two survey methods, funded by the Health Education Authority and developed at Exeter University, to support curriculum review and planning in schools in Health and Social Education. These are based on (1) the General Health Related Behaviour Questionnaire, currently in Version 11 and originating in 1979, and (2) Attitudinal Surveys amongst Parents, Teachers, Children and Health Care Professionals concerning the priorities for the curriculum based on questionnaires under the title *Just a Tick*. (This methodology had its origins in the mid-1970s and an earlier title of *Just One Minute* was widely used from 1977 to 1982.)

The methods of enquiry are of particular use to individual schools and were originally designed for this purpose. Both methods have been widely used, reviewed frequently, and revised periodically over this long time-span, and their value, validity and stature have grown. Table 1 shows how the numbers of pupils using the Health Related Behaviour Questionnaire have grown since 1980. In step with this, improved ways of using the discovered data have developed.

Comparing schools and groups of schools

It was inevitable that the concept of using a well-established, standardised survey method would be used in comparative surveys between different localities in one region or between different regions in the country and indeed between countries. Comparative studies have been or are being carried out at a national and international level as follows:

Just a Tick The use of this enquiry instrument in the HEA Primary Schools Project 1984-88, involved 128 schools in 11 regions in the UK.

Health Related Behaviour Questionnaire Comparison between selected schools was carried out in the USA and the UK in 1985, and a project involving 20 schools in Belgium and the UK is currently in progress. In the course of these two projects, and in the hope of promoting this work elsewhere, translations of the Health Related Behaviour Questionnaire have been made and used in Belgium, France, Hungary, Poland, the USA and Yugoslavia.

Respondents	1981	1982	1983	1984	1985	1986	1987	Total
No. of schools	44	48	71	70	87	97	169	586
No. of pupils	9,432	8,011	10,674	15,204	13,529	19,753	27,628	104,231

Table 1. Use of the Health Related Behaviour Questionnaire since 1980.

Organiser	*Date*	*Schools*	*Years*
Cornwall and Isles of Scilly H.A.	1982	10	10
Wigan H.A.	Mar. 1982 onwards	15	25
Western Isles Health Board	Jul. 1985	7	8
West Suffolk H.A.	Mar.–Dec. 1986	9	9
Tameside & Glossop H.A.	Apr. 1986 onwards	2	8
Canterbury & Thanet H.A.	Jun. 1986	6	11
Winchester H.A.	Jul. 1986	3	11
N.E. Essex H.A.	Sep. 1986 onwards	10	50
Notts. Curriculum Development Support Service	Sep. 1986 onwards	10	20
Scunthorpe H.A.	Sep. 1986 onwards	8	9
Avon Council on Alcoholism	Oct. 1986 onwards	21	18
Hampshire Education Dept. with I.O.W. Health Promotion Unit	Jan. – Feb. 1987	8	9
Wiltshire Education Dept.	Jan. – Feb. 1987	10	13
Somerset Education Authority	Mar. 1987 onwards	6	12
London Borough of Enfield	Jun. 1987	19	19
Exeter H.A.	Jun. 1987 onwards	6	10
Central Birmingham H.A.	Jul. 1987 onwards	8	8
West Devon Understanding Alcohol Project	1987	28	28
Essex L.E.A.	1987–8	24	48
Kirklees L.E.A.	1987	26	31
Staffs. Drug Education Project	1987	11	11
Cleveland L.E.A.	1988	?	?
Cumbria Alcohol Advisory Service	1988	16	29
Darlington H.A.	1988	12	40+
West Devon L.E.A.	1988	30	60
Newcastle University	1988	?	?
Surrey L.E.A.	1988	?	?
West Sussex L.E.A.	1988	?	?
Tameside & Glossop L.E.A.	1988	10	19
Wolverhampton L.E.A.	1988	21	21

Table 2. Details of the organised group surveys of schools using the Health Related Behaviour Questionnaire.

In addition to studying differences between schools in different regions or even different countries, examining the differences between schools in the same region is being seen as a most effective way of promoting health-education strategies. At a local level, more than thirty Local Education Authorities or District Health Authorities have now been involved or are being involved in supporting and co-ordinating work amongst groups of schools within their geographical region of responsibility, using *Just a Tick,* the Health Related Behaviour Questionnaire method, or both.

Group surveys in the UK

The details of co-ordinated surveys either completed, in process, or planned, are displayed in Table 2. A typical life-history of a group survey is as follows:

1. Initial planning An officer from the LEA or the District Health Authority (or perhaps both, working in concert) approaches the Unit for details of the materials and services available. Often the initial stimulus is promoted by an in-service day with Heads or senior staff. The questionnaire service will be explained at the meeting, possibly by a member of the Unit staff who can draw on our experience with other group surveys.

2. Support material is supplied in the form of general guidelines, supervisor's notes, and other documentation. Sometimes a stock of questionnaires with specially-printed covers is provided.

3. Survey work is then carried out. Properly handled, as recommended in the guidance notes, the survey itself heightens awareness within each school of the need for information, and raises the status of the proposed health education programme.

4. Data processing is carried out at Exeter University. This work is highly professional and is well supported by the University's computer personnel. The 'turn-around' time for the process is short (4-6 weeks is the aim).

5. Analyses of data are returned with guidelines to assist interpretation of the tables. The format of the analyses is different for the two surveys:

In the case of the Health Related Behaviour Questionnaire, the levels of each behaviour for boys at different ages and for girls at different ages are displayed in separate bound documents.

In the case of *Just a Tick,* the topics as rated by pupils, parents, school staff and governors, and health-care personnel, are displayed in separate bound documents.

But in both cases...

(a) Each school receives its own profile.

(b) The survey co-ordinator receives comparative analyses.

6. Implementation is where the 'real work' begins. The amount of information returned in the summarised results is considerable, but many more analyses are available on further request. Support from Exeter personnel at seminar work shortly after the initial analyses have been received can facilitate the process of moving from interpretation to action. This is a priority in our work.

Outcomes of the surveys

The outcomes of the use of the surveys in schools can be very far-reaching. The immediate outcomes of the two questionnaires studies may be very different, reflecting their different content, although the ultimate aim – to promote good practice in schools – is the same for both. The following comments refer to use of the Health Related Behaviour Questionnaire.

Individual Schools In addition to the benefit of seeing their own pupils' profile in relation to those of other schools in their area, the following effects may result from 'domestic' contemplation of the results:

1. Timing of courses may be changed.
2. Courses or lessons may be dropped from programmes.
3. New courses or lessons may be designed.
4. Recent survey material is often used as a focus in class.
5. Useful outside support for work is often identified.
6. The selection of methods and materials may be influenced.

Table 3. The percentage of 14-15 year old boys who had used the different sources of alcohol during the week prior to the survey (Differences between the communities are apparent.)

Source of alcohol	*School identification*				
	A	B	C	D	E
Supermarket	6	6	21	15	8
Pub	29	12	21	7	16
Home	35	21	50	37	28
Disco or party	12	15	13	5	12
Sample size	52	52	56	41	50

Groups of schools The behaviours reflect the communities served by the individual schools, and considerable variation can be discovered. The examination of comparative data may be conducted in two main ways...

1. Collectively by teachers from the contributing schools, which promotes confidence, co-operation, and access to shared resources including professional people;
2. By health-care planners. For example, specialists in community medicine have been provided with additional epidemiological evidence to prompt health promotion, intervention, and health-care provision as a result of surveys promoted by their Authorities.

As an example of the differences in behaviours discovered in neighbouring communities, Table 3 shows the use of different sources of alcohol by 4th-year pupils. This variation between communities doubtless reflects attitudes towards drinking at home, as well as the availability of the other sources. Typically it fits sensibly into the statistical evidence gathered through Health Service records, and enhances the position of those planning health-care provision. The epidemiological evidence available from the behaviour surveys as a resource is considerable.

It is worth noting that the strategy of repeating surveys of 11-, 13- and 15-year-olds at 2-year intervals, in schools served by individual District Health Authorities, will result in a very powerful longitudinal study.

The range of use of the data, and its effects

The Unit staff have learned much from conducting follow-up seminars after data has been returned to schools and, in general terms, these insights and discoveries are summarised above. However, the wide variety of uses is often discovered accidentally – for example, on a visit to one school for another reason it was learned that the most popular exercise offered in the 2nd year IT (Information Technology) course involved groups of children preparing a radio programme based on the raw detail of ten tables of boys' and girls' behaviours selected from the 200 tables resulting from the Health Related Behaviour survey in that school. The tasks of co-operation, comprehension, interpretation and communication undertaken and enjoyed by these youngsters may be somewhat distant from the usual concept of health education or promotion. The discovery of use in this way was, however, a delight to the Unit staff.

A selection of comments from teachers using the survey data in their work in schools follows:

J.M. (*English*): "Discouraging to see such little contact with newspapers. How can we encourage more? Daily papers in schools? Much work in the curriculum already uses magazines and newspapers."

S.W. (*General Studies*): "Roughly expected patterns portrayed. Less heavy smoking among 5th years than anticipated. Decision to increase emphasis on anti-smoking situations during Active Tutorial Work in Years 1 and 2. Material used in lesson time as discussion base in Year 4." (Questions 43 and 44: smoking.)

J.N. (*Home Economics*): "Information passed to school canteen service. The mass of information will be used as a data source to be implemented at a later date. Poor eating patterns continue despite guidance given in school H.E. programmes which all pupils receive. Pupils know what is good for them but still choose inappropriate food." (Questions 38-41: diet.)

J.L. (*P.E.*) "The in-school activities were known. Out-of-school activities were interesting or surprising in range and amount undertaken. Little club representation out of school. Led to club notice board being set up indicating locations, addresses etc. of local clubs.

"It would be useful to have questions regarding attitudes to PE and games as well."

C.H. (*Child Care*): "All data were presented in class for further analysis and debate. The believed levels were explored before revealing the survey levels. Promoted vigorous discussions, good or bad practice, health issues.

"Differences between sex and age groups were highlighted, e.g. deodorant use between boys in Years 1 to 5. Could have implications in basic hygiene taught in Home Economics to Year 1." (Questions 24-29: personal hygiene and medicines.)

C.B. (*School Nurse*): "Immunisation and vaccination figures were heartening – especially rubella uptake – but still room for improvement."

S.N. (*Commerce*): "Pupils have given the impression that computers *have* made an impact in their home life to a greater extent than that revealed by the printout.

"The GCSE syllabus allows for considerable analysis of personal saving and spending; the details supplied by the survey are good starting points for further work and discussion."

The Sidmouth Conference

In order to learn more of the actual use and potential use of the survey methodologies a conference is being held in East Devon (March 15-18) to share the experiences of professional people who:

(a) Know most about the questionnaire, its content and its evolution (Unit staff);

(b) Have supported groups of schools and the follow-up work (Local Education Authority Advisers, Health Education Officers);

(c) Have co-ordinated surveys in their own school (experienced teachers);

(d) Have worked with the data with their staff colleagues (experienced teachers);

(e) Have worked with the data and parents (Heads, Advisers, Unit staff);

(f) Have worked with the data with young people in the classroom (experienced teachers);

(g) Have insights into co-ordination at a national level (representatives from HMI, DHSS, HEA, and DES).

Summary

The rapidly-growing use of group surveys is not only strengthening links between schools and LEA or DHA officers, but is also creating a network of Authorities using this common method of implementing health-education initiatives in their schools. An initial function of *Education and Health* was to promote contact between school staff, but it may be that a new service, building upon this, will be to serve the growing network of groups across the UK.