Promoting HBSC data use using the School Health Research Network (SHRN) in Wales: A model for building relationships and stakeholder engagement across countries

Professor Simon Murphy
Director DECIPHer, Co-Director National Centre for Population Health and Wellbeing Research, Lead for Public Health Improvement Research Network and the Schools Health Research Network

Aims

- To introduce a theoretical framework on which to build relationships for stakeholder engagement at multiple levels

- To discuss the potential benefits of a network approach to the collection and utilisation for a wide range of groups including:
  - Academic researchers
  - Policy stakeholders, including national and regional government
  - Practitioners, notably schools
  - Young people

- To reflect on the operationalisation of the framework across case study countries, including shared experiences of challenges and benefits, along with future directions collaboration.

Structure

The School Health Research Network in Wales: Development and Implementation

Y RHWYDWAITH YMCHWIL
IECHYD MEWN YSGOLION

SCHOOL HEALTH
RESEARCH NETWORK

School Health Research Network Aims

- Develop an infrastructure to provide timely and robust health and wellbeing data for national, regional and local stakeholders
- Co-produce high quality school-based health improvement research
- Increase the quality, quantity and relevance of school-based health improvement research and reduce research burden on schools
- Build capacity for evidence-informed practice and facilitate the translation of research evidence into practice

Diffusion 2013 to 2018

Phase 1: 2013 Pilot

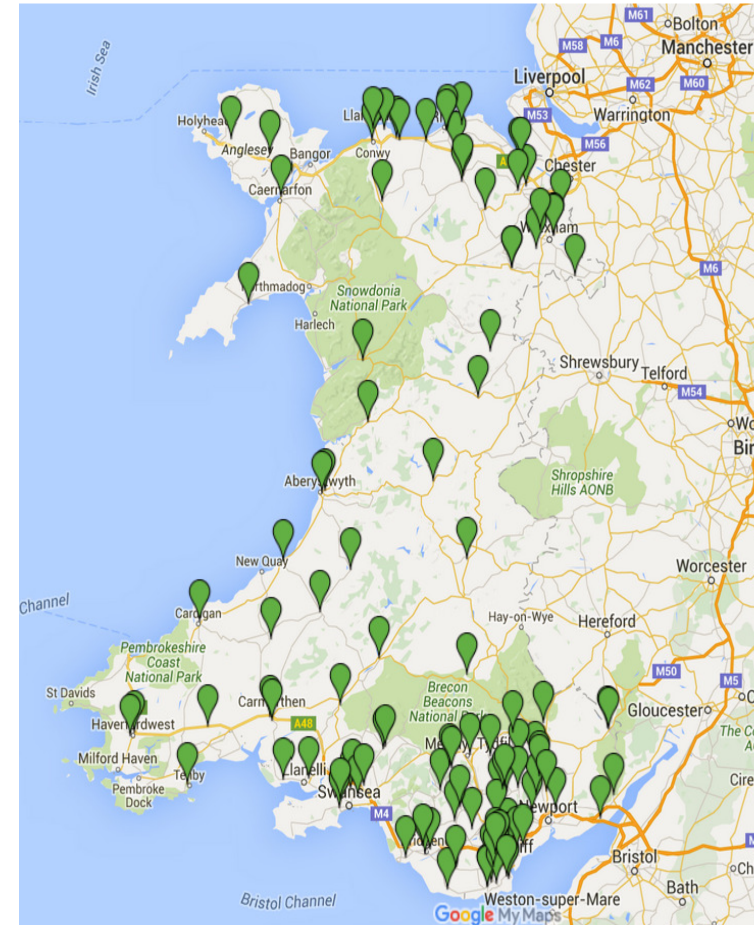
- Recruitment of 61 (of 82) HBSC schools

Phase2 : 2015 Scalability

- 53% (N=115) of all maintained secondary and middle schools

Phase 3 : 2017 Diffusion

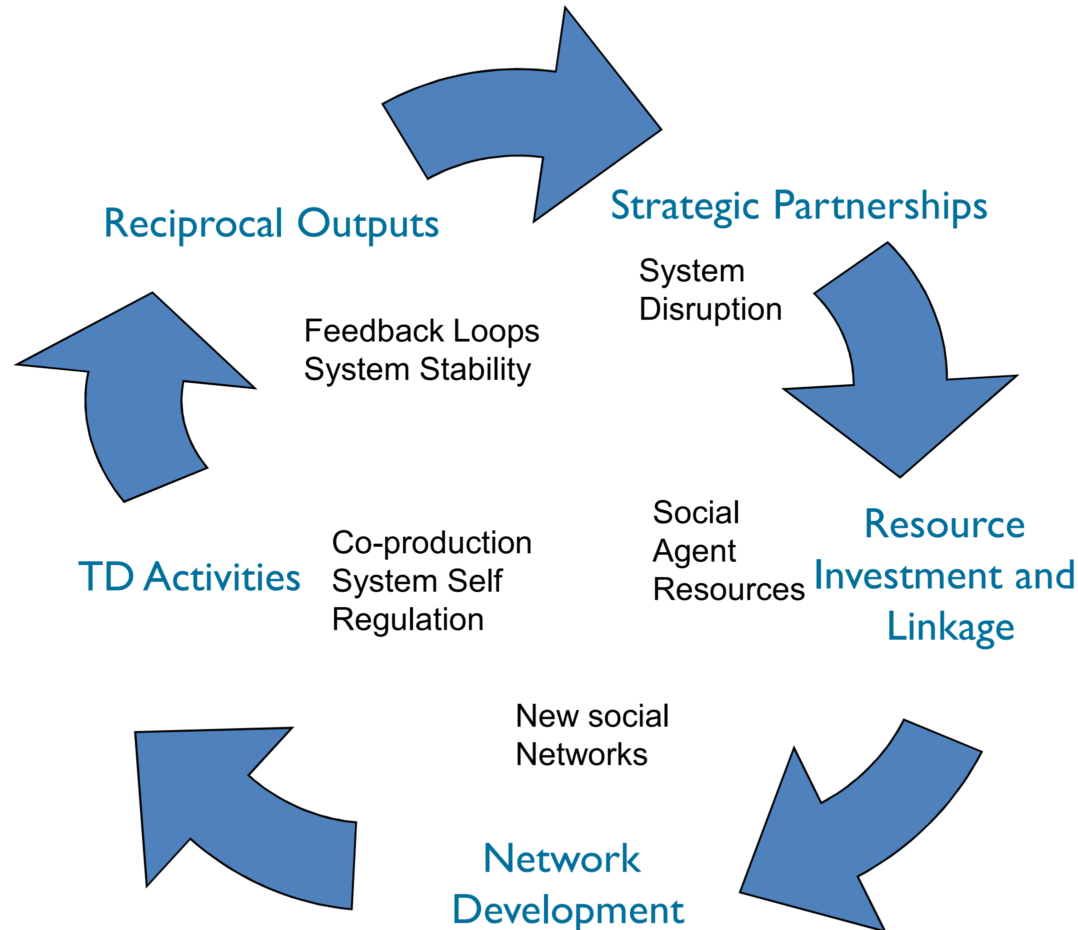
- 100% (N = 212) secondary schools recruited with WNHSS. HBSC conduct embedded
- Longitudinal and data linkage pilot - 50% consent



School Health Research Network Structures

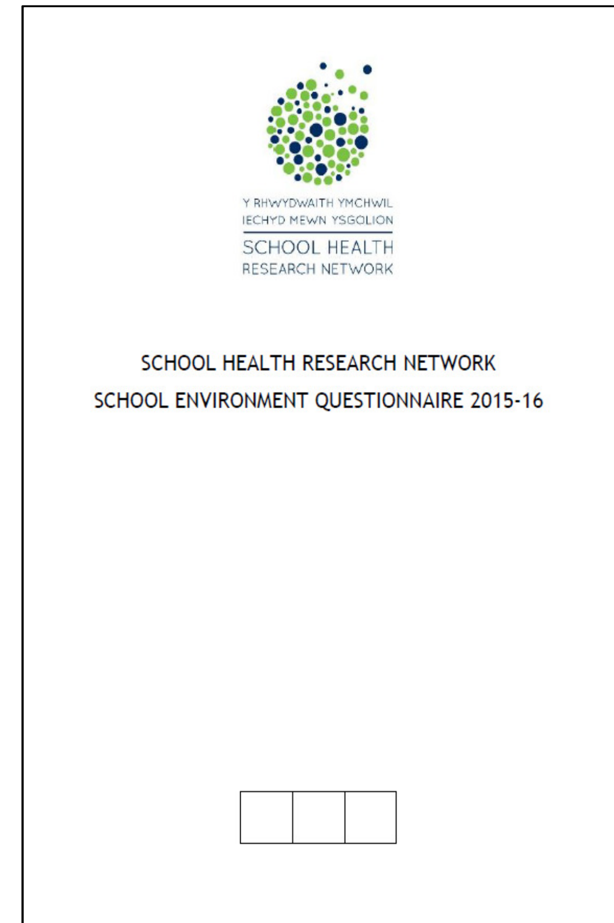
- Strategic partnerships established – Welsh Government (Health and Education) and Public Health Wales (Welsh Network of Healthy Schools Scheme)
- Established core SHRN team for cross academic/policy/practice working – network manager, survey researcher, co-ordinator, linked DECIPHer resources.
- Development of data infrastructure via HBSC survey 2013
- Network and capacity development activities
- Adoption process for SHRN supported studies – portfolio of 46 funded studies (c.£15 million)
- Reciprocal outputs for partners

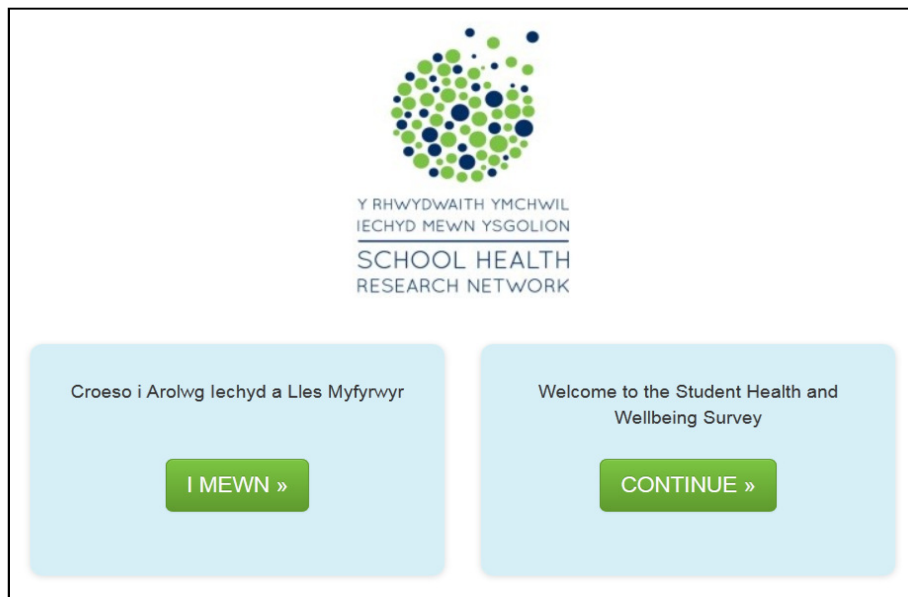
Transdisciplinary Action Research Interventions for Systems Change



Data Infrastructure - Network Surveys

- Biennial pupil/school survey – HBSC, scientific, policy, practice, public priorities
- 2017 – 112,045 responses from 11 to 16 year olds in (over 60%). The largest dataset of its kind in Wales





Reciprocal Outputs

School and Regional level data for local action, evaluation and research ideas

Population level data on trends, health need planning and international comparison

Practice level data to support WNHSS and system improvement science

Infrastructure to support new studies (recruitment, sampling, baseline/context data)

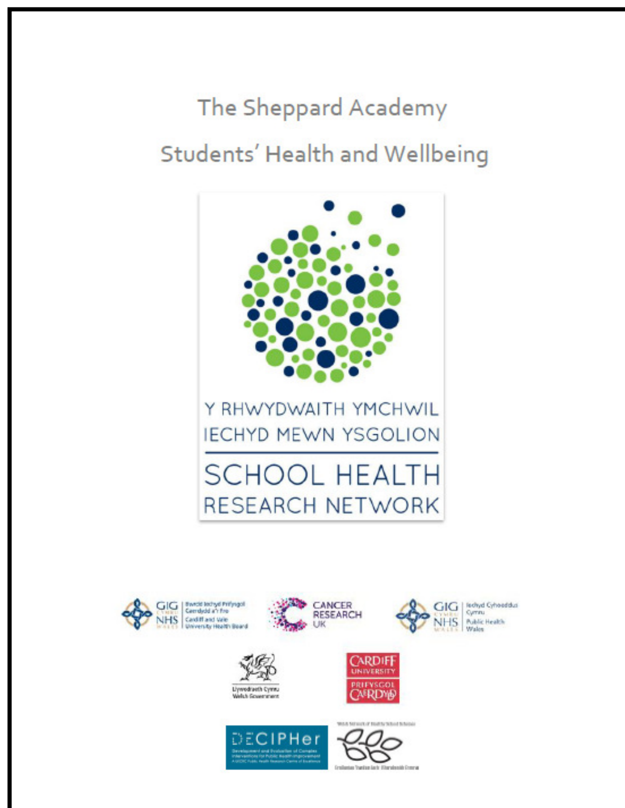
Infrastructure to support natural experiments (Future Generations, Violence and Women, Curriculum Review)

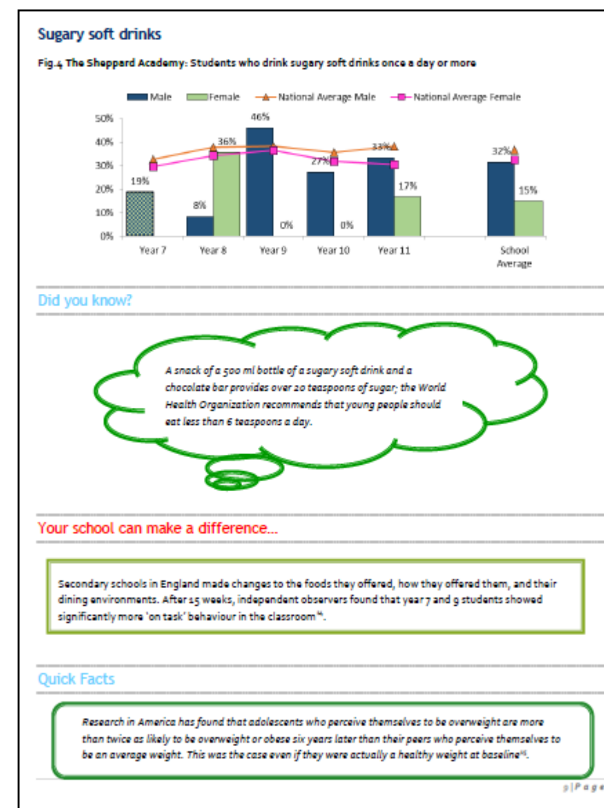
Pupil Survey

School Survey

Student Health and Wellbeing Reports

Tailored benchmarked reports of student health and wellbeing (Gender/age) for each school for action planning and monitoring. Regional and National reports





Evaluation of the Health Promoting School

Moore et al. BMC Public Health (2016) 16:138
DOI 10.1186/s12889-016-2763-0

BMC Public Health

RESEARCH ARTICLE Open Access

Variations in schools' commitment to health and implementation of health improvement activities: a cross-sectional study of secondary schools in Wales

Graham F. Moore*, Hannah J. Littlecott, Adam Fletcher, Gillian Hewitt and Simon Murphy

Abstract

Background: Interventions to improve young people's health are most commonly delivered via schools. While young people attending the lowest socioeconomic status (SES) schools report poorer health profiles, no previous studies have examined whether there is an 'inverse care law' in school health improvement activity (i.e., whether schools in more affluent areas deliver more health improvement). Nor have other factors that may explain variations, such as leadership of health improvement activities, been examined at a population level. This paper examines variability in delivery of health improvement actions among secondary schools in Wales, and whether variability is linked to organisational commitment to health, socioeconomic status and school size.

Methods: Of the 82 schools participating in the 2013/14 Health Behaviour in School-aged Children (HBSC) survey in Wales, 67 completed a questionnaire on school health improvement delivery structures and health improvement actions within their school. Correlational analyses explore associations of delivery of health improvement activity among schools in Wales with organisational commitment to health, socioeconomic context and school size.

Results: There is substantial variability among schools in organisational commitment to health, with pupil emotional health identified as a priority by 52 % of schools, and physical health by 43 %. Approximately half (49 %) report written action plans for pupil health. Based on composite measures, the quantity of school health improvement activity was greater in less affluent schools and schools reporting greater commitment to health. There was a consistent though non-significant trend toward more health improvement activity in larger schools. In multivariate analysis deprivation (OR = 1.06; 95 % CI = 1.01 to 1.12) and organisational commitment to health were significant independent predictors of the quantity of health improvement (OR = 1.60; 95 % CI = 1.15 to 2.22).

Conclusions: There is no evidence of an 'inverse care law' in school health, with some evidence of more comprehensive, multi-level health improvement activity in more deprived schools. This large-scale, quantitative analysis supports previous smaller scale, qualitative studies/process evaluations that suggest that senior management team commitment to delivering health improvement, and formulating and reviewing progress against written action plans, are important for facilitating the delivery of comprehensive interventions.

Keywords: Socioeconomic status, School, Adolescent, Child, Health behaviours, Inequalities

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Do stronger school smoking policies make a difference? Analysis of the health behaviour in school-aged children survey

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Background: Associations of the strength of school smoking policies with cigarette, e-cigarette and cannabis use in Wales were examined. **Methods:** Nationally representative cross-sectional survey of pupils aged 11–16 years (*N*=7376) in Wales. Senior management team members from 67 schools completed questionnaires about school smoking policies, substance use education and tobacco cessation initiatives. Multi-level, logistic regression analyses investigated self-reported cigarette, e-cigarette and cannabis use, for all students and those aged 15–16 years. **Results:** Prevalence of current smoking, e-cigarette use and cannabis use in the past month were 5.3%, 11.5% and 2.9%, respectively. Of schools that provided details about smoking policies (66/67), 39.4% were strong (written policy applied to everyone in all locations), 43.9% were moderate (written policy not applied to everyone in all locations) and 16.7% had no written policy. There was no evidence of an association of school smoking policies with pupils' tobacco or e-cigarette use. However, students from schools with a moderate policy [OR = 0.47; 95% (confidence interval) CI: 0.26–0.84] were less likely to have used cannabis in the past month compared to schools with no written policy. This trend was stronger for students aged 15–16 years (moderate policy: OR = 0.42; 95% CI: 0.22–0.80; strong policy: OR = 0.45; 95% CI: 0.23–0.87). **Conclusions:** School smoking policies may exert less influence on young people's smoking behaviours than they did during times of higher adolescent smoking prevalence. Longitudinal studies are needed to examine the potential influence of school smoking policies on cannabis use and mechanisms explaining this association.

Introduction

Tobacco use is commonly initiated during youth.[1] Hence, recent decades have seen growing emphasis on preventing uptake of smoking among young people.[2] Interventions to influence adolescent smoking are often delivered via schools because they provide opportunities to reach most young people, while the norms and environments of schools' can influence risk behaviours.[3,4] The 'Health Promoting Schools' framework, endorsed by the World Health Organization,[5] consistent with Ottawa Charter principles emphasizing the need to go beyond simplistic health education and toward creating healthier environments,[6] advocates multi-level approaches to health improvement, focused on integration of health into the curriculum alongside changes to the school's social and physical environment. Environmental change interventions have demonstrated significant positive effects on a range of outcomes, including tobacco use.[7]

One key strategy for changing school social environments is through written policies. These can play an important role in establishing and communicating a school's ethos, in terms of norms for acceptable and unacceptable ways for staff, students and others to behave within the school environment.[8] Changing school policy has been described as low cost, realistic and easy to address[9] and many schools have adopted formal written smoking policies.[10] Earlier studies investigating school substance use policies have shown that universal smoking bans and restrictions are associated with a lower likelihood of smoking behaviour and smoking prevalence among youth.[11] For example, Moore *et al.*[9] found that having a written smoking policy for all students, teachers and other adults on school premises was associated with lower likelihood of daily and weekly smoking.

However, weaker associations between school smoking policies and tobacco use have been observed in more recent studies.[11] In part this may be because school smoking policies have become more common and more consistent in their universality, perhaps limiting variance in practice between schools.[9,12,13] However, national policies to 'denormalize' smoking, and limit its visibility to children, such as smoke-free legislation, may mean that schools operate within a macro-system in which smoking is already heavily denormalized,[14] while adolescent smoking rates are now at an all-time low.[15,16] Given the growing denormalization of smoking in front of children,[17] adults may now be less likely to use tobacco on or near school grounds than during earlier studies. Furthermore, young people who continue to smoke in contemporary society do so despite it being widely stigmatized within society and hence may be less influenced by norms within the school environment. As such, the capacity for strong policies to achieve further gains in reducing youth smoking may have diminished over time.

However, no previous studies have looked beyond effects on smoking and toward understanding secondary effects on other substances. Smoking clusters with other risky behaviours[18] and is often considered a 'gateway' into future use of illicit substances such as cannabis.[19,20] However, while smoking tobacco is increasingly denormalized, strong government policies on tobacco have been accompanied by mixed messages on cannabis, and it is unclear whether cannabis use has declined at the same rate as tobacco use. Internationally, legislation surrounding cannabis use has become more rather than less permissive, including legalization in some jurisdictions. Perhaps arising from these mixed messages, there is some

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Morgan et al. BMC Public Health (2016) 16:569
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BMC Public Health

RESEARCH ARTICLE Open Access

Predictors of physical activity and sedentary behaviours among 11-16 year olds: Multilevel analysis of the 2013 Health Behaviour in School-aged Children (HBSC) study in Wales

Kelly Morgan[1]*, Britt Hallingberg[1], Hannah Littlecott[1], Simon Murphy[1], Adam Fletcher[1], Chris Roberts[2] and Graham Moore[1]

Abstract

Background: The present study investigated associations between individual- and school-level predictors and young people's self-reported physical activity (total activity and moderate-to-vigorous activity) and sedentary behaviours.

Methods: Individual-level data provided by the 2013/14 cross-sectional survey 'Health Behaviour in School-aged Children (HBSC) study in Wales' were linked to school-level data within the 'HBSC School Environment Questionnaire'. The final sample comprised 7,376 young people aged 11-16 years across 67 schools. Multilevel modelling was used to examine predictors of total physical activity, moderate-to-vigorous physical activity (MVPA) and sedentary behaviours (screen-based behaviours).

Results: Taking more physical activity (less than 5 days vs. 5 or more days per week), engaging in higher levels of MVPA (less than 4 hours vs. 4 or more hours per week) and reporting 2 or less hours of sedentary time were predicted by several individual level variables. Active travel to school positively predicted high levels of physical activity, however, gender stratified models revealed active travel as a predictor amongst girls only (OR:1.25 (95 % CI: 1.05 - 1.49)). No school-level factors were shown to predict physical activity levels, however, a lower school socio-economic status was associated with a higher level of MVPA (OR:1.02 (95 % CI:1.01 - 1.03)) and a lower risk of sedentary behaviour (OR:0.97 (95 % CI:0.96 – 0.99)). A shorter lunch break (OR:1.33 (95 % CI:1.11 - 1.49)) and greater provision of facilities (OR:1.02 (95 % CI:1.00 - 1.05)) were associated with increased sedentary activity. Gender stratified models revealed that PE lesson duration (OR:1.18 (95 % CI:1.01 - 1.37)) and the provision of sports facilities (OR:1.03 (95 % CI:1.00 - 1.06)) were predictors of boy's sedentary behaviours only.
(Continued on next page)

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Network and Capacity Development

- Termly Newsletter, Webinars and Research Briefs for WNHSS activity
- Network Events in North, South and West Wales
- Briefings for key stakeholders
- Research Literacy workshops and workforce development
- Developing pupil engagement infrastructure

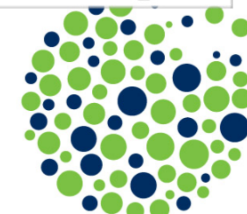
Y RHWYDWAITH YMCHWIL IECHYD MEWN YSGOLION
SCHOOL HEALTH RESEARCH NETWORK

Electronic cigarette use in young people in Wales

School Health & Wellbeing Research Brief, November 2016

School practices important for young people's sexual health

School Health & Wellbeing Research Brief, February 2018



System integration and adoption

‘It is enormously beneficial for us to get a raft of data which can be considered by staff, pupils and external agencies to analyse and organise programmes accordingly.’ ***Headteacher***

‘Privileged – glad that the school is on board and supportive. Priority to see/hear about new initiatives and ideas that will fit into healthy schools.’ ***In-school Healthy Schools Coordinator***

‘Being a member of SHRN gives us as a school, access to up to date and relevant research, support and information.’ ***Assistant Head***

When working within a system that has become so data driven it is great to be part of a like-minded network with wellbeing at the forefront.’ ***Assistant Head***

http://www.shrn.org.uk/school-impact/

School Health Research Network (SHRN) – a government perspective

Dr Chris Roberts, Social Research & Information Division, Welsh Government

Gwyddor Gymdeithasol mewn Llywodraeth
YMCHWIL GYMDEITHASOL Y LLYWODRAETH
GSR
GOVERNMENT SOCIAL RESEARCH
Social Science in Government

Why did Welsh Government invest in SHRN?

Recognition something had to change

- Falling HBSC response rates
- Fit between policy process and four yearly HBSC data cycles
- Frustration at lack of granular data
- Multiple competing surveys at local level
- Population groups we knew little about
- Importance of student voice to inform policy making
- Greater emphasis on research impact
- Pressure to demonstrate value for money

Gwyddor Gymdeithasol mewn Llywodraeth
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Policy benefits of SHRN include…

- Move to two yearly data collection cycle increases responsiveness to policy environment e.g. gambling to support CMO report
- Data being utilised at multiple levels – from school planning to monitoring national well-being indicators and curriculum reform
- Developing research infrastructure in various ways
  - Research ready schools
  - Data can be used for policy evaluation (e.g. whole school approach to emotional wellbeing and mental health) and secondary analysis by partners (e.g. energy drinks)
  - Economic impact of the data being used to lever research funding into Wales e.g. recent natural experiment linked to Tobacco Products Directive

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Methodological benefits include…

- Significant improvement in response rate - reciprocity?
- Large sample (100,000+) facilitates analysis at local level and among specific sub-samples e.g. ethnicity, looked after children, those with caring responsibilities
- Large sample allows split sample approach to maximise topic coverage – three versions of the questionnaire (n between 30,000 and 100,000)
- Integrated data linkage testing – allows linking with administrative data e.g. health records, educational attainment
- Aligned with increased recognition of systems level approaches to understanding (and evaluating) policy

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What facilitated the development of SHRN?

- SHRN aligned to Welsh legislation e.g. Well-being of Future Generations (Wales) Act 2015 – including cross-cutting policy
- Builds on existing research-policy-practice relationships
- Right people in the right posts – understanding of the school system and policy landscape
- Commitment to ‘impact’ among all partners, while maintaining academic standards
- Acknowledgement of risks and need for compromise (e.g. managing competing demands, publication timing – local/national and maintaining scientific coherence)

Gwyddor Gymdeithasol mewn Llywodraeth
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SHRN – examples of the do's and don'ts of influencing policy

Do high quality research

- Robust research
- Presented in timely fashion e.g. to schools shortly after data collection
- Network facilitates studies using range of methodologies

Communicate well

- Clear dissemination strategy
- Findings for different audiences
- Range of outputs, from scientific papers to policy briefings

See Oliver and Cairney (2019)

Building relationships with policy makers (and practitioners)

- Policymaker involvement at earliest opportunity
- Team with skills required e.g. teaching experience
- Ground rules established – clarity across partners

Be 'entrepreneurial'

- Reciprocity – benefits to all partners
- Media friendly approach
- Senior academic representation on various steering groups.
- Collaboration with knowledge brokers
- Maximising awareness e.g. impact awards

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SHRN – Cardiff University Innovation in Health Care award 2018

https://www.youtube.com/watch?v=qypwIQfmqMY

The School Health Research Network (SHRN): Regional, school and academic data use

Dr Honor Young

Lecturer

DECIPHer, Cardiff University

Data use: regional, school and academic

- SHRN is embedded within the school health improvement system at the local level.
- We work closely with both education and health sectors in Wales, supporting schools to work with regional health bodies, such as local authority services and the Welsh Network of Healthy School Schemes.
- We also work closely with schools to support their practical use of the data, as well as keeping us up-to-date with their use of the SHRN data
- Academic use for reports and publications and study recruitment

Regional data use: Local Authority and Welsh Network of Healthy School Schemes (WNHSS)

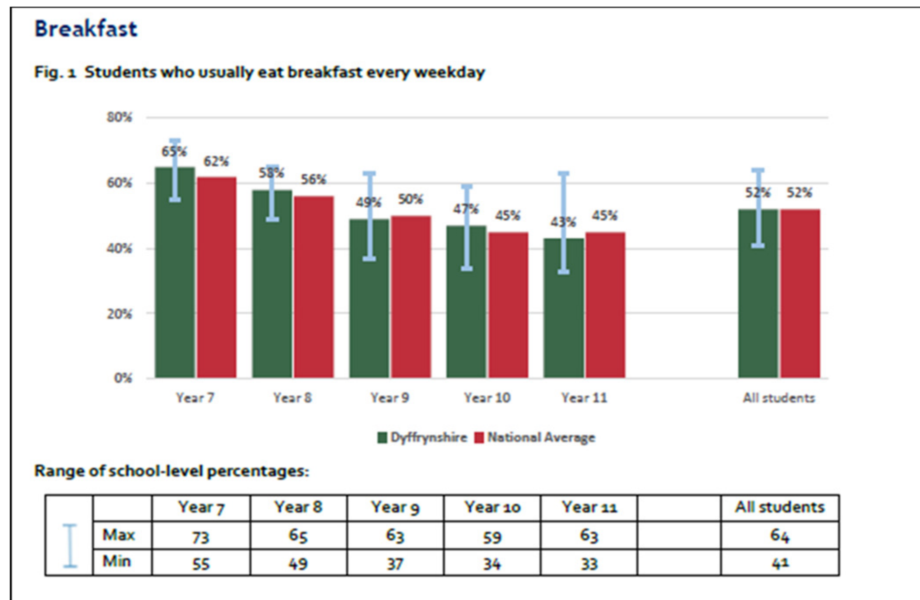
- **Local Authorities** provide local leadership and services for their communities (including education); 22 in Wales

- **The Welsh Network of Healthy School Schemes (WNHSS)** encourages the development of local healthy school schemes within a national framework. These schemes support the development of health promoting schools in their area:

“A health promoting school is one which actively promotes, protects and embeds the physical mental and social health and wellbeing of its community through positive action.’

Regional data use: Local Authority and Welsh Network of Healthy School Schemes (WNHSS)

- Local authority Student Health and Wellbeing Reports released in 2018.
- Shared among local health and educational service leads.
- Encourage local authorities and schools to work together to promote healthy school environments, including curriculum and health action planning
- Encourage healthy school coordinators to join webinars and attend network events to strengthen their evidence-informed support for schools.



		Year 7	Year 8	Year 9	Year 10	Year 11		All students
	Max	73	65	63	59	63		64
	Min	55	49	37	34	33		41

School data use

- Range of dissemination methods to schools
  - Student Health and Wellbeing reports (School and Local Authority level), webinars, research briefings, network events

- Invite schools to keep us up-to-date with their use of SHRN data

- Share with you some examples of how SHRN data has been used to support a whole school approach (part of Health Promoting School model and a large focus of new curriculum reform in Wales)
  - Self-evaluation
  - Basis of school health action planning
  - Support curriculum, ethos, environment

School data use: School in South Wales

- **Sharing data:** All staff, senior leadership, progress and subject lead, support staff, parents, Governors, pupils and School Improvement Group
- **Staff use:** Identified concern relating to New Psychoactive Substances; discussed local issues with Police Liaison Officer and Personal and Social Education (PSE) lead and delivered talks to years 9 &10 (13-15years old)
- **Parent use:** Incorporated results into a parent newsletter and information pack (helped by Healthy Schools to include Government guidelines)
- **Pupil use:** Shared results with pupils in assemblies; launched an anti-bullying campaign; reviewed and changed canteen provision.
- **School Improvement Group:** Shared summaries from the report across the group and prioritised three common areas for PSE resources/assemblies to share

School data use: School in North Wales

- **Sharing data:** All staff, senior leadership, pastoral leads, Health Schools, Governors and parents (via newsletter)
- Identified key areas (e.g. sleep); **Students** - assembly on sleep organisation and techniques using drama; sleep drop-in for advice and guidance; **Staff** – review PSE curriculum and themes of the week; **Community** – focus group on their perspective on the topic
- **Pupil initiatives:** Assemblies and themed weeks;
- **Whole community approach:** Community input, student friendly policies, staff training
- **Local Authority Action:** Pupils and staff feed into their County Action Plan

Ebbw Fawr PE
@EFLC_PE
Following

Y9 girls discussing results from 'Health and Wellbeing survey' @SHRNWales and the reasons why girls don't participate in sport out of Sch time compared with the rest of Wales. 🤔 #Wellbeing #PhysicalActivity

St David's Chester
@stdavidschester
Follow

Some of our school council representatives are at a conference today analysing the data from our SHRN report. They are making some excellent contributions towards the Flintshire Schools SHRN action plan. Workshops this afternoon from @theredcardwales and @TheProudTrust

11:01 AM - 16 Nov 2018

3 Retweets 5 Likes

Tweet your reply

Ebbw Fawr 3-16
@ebbwfawr
Following

Using our @SHRNWales data on energy drinks 🥤 to raise awareness in our learners in the restaurant today #learningtoachievetogether

Nerys Davies
@NerysDavies
Following

Using our @SHRNWales data to inform our students over lunch about the importance of 💤 😴 sleep! #learningtoachievetogether

1:45 PM - 15 Nov 2018

7 Retweets 19 Likes

Alun School
@alunschool
Following

Alun School Council members at @SHRNWales event. Working with, @CastellAlun, @hawardenhs, @flinthigh, @MaesGarmon, @stdavidschester, @theredcardwales and @TheProudTrust #FutureLeaders #DecisionMakers

Ebbw Fawr PE
@EFLC_PE
Following

Y9 girls discussing results from 'Health and Wellbeing survey' @SHRNWales and the reasons why girls don't participate in sport out of Sch time compared with the rest of Wales. 🤔 #Wellbeing #PhysicalActivity

2:07 PM - 23 Nov 2018

2 Like

Data use: Academic data use

- Biennial cross-sectional data
  - Data analysis and academic publications
  - Health evaluation (e.g. Health Promoting Schools Model)
  - Support school recruitment (targeting / access to schools)

- Piloted consent for longitudinal data collection and data linkage with health and education data in 2017
- Introduced as standard process with consent from schools (data linkage), parents (both) and pupils (both) in 2019
  - Support longitudinal data analysis as well as exploring more complex associations between health and educational outcomes

Research paper

OPEN ACCESS

Have e-cigarettes renormalised or displaced youth smoking? Results of a segmented regression analysis of repeated cross sectional survey data in England, Scotland and Wales

Britt Hallingberg,[1] Olivia M Maynard,[2] Linda Bauld,[3] Rachel Brown,[1] Linsay Gray,[4] Emily Lowthian,[1] Anne-Marie MacKintosh,[5] Laurence Moore,[4] Marcus R Munafo,[2] Graham Moore[1]

HBSC data as a tool for SHE developments

Vivian Barnekow

WHO and old friends

HBSC since early nineties

Health promoting schools (SHE) since 1992

Convincing recommendations

- **What gets measured gets done –** data driven

- **WHO High-level Conference: Working together for better health and well-being**

Declaration: Partnerships for the health and well-being of our young and future generations.

We commit to act together for the health and well-being of our young and future generations

Example: schools and preschools promoting health and well-being for all children and adolescents

support and expand settings approaches to health and well-being such as the Schools for Health in Europe network

- **SDG** agreed by heads of states

World Health Organization
REGIONAL OFFICE FOR Europe

Organisation mondiale de la Santé
BUREAU RÉGIONAL DE L' Europe

Weltgesundheitsorganisation
REGIONALBÜRO FÜR Europa

Всемирная организация здравоохранения
Европейское региональное бюро

REPORT
FROM THE IMPLEMENTATION OF THE PILOT PROJECT “A STUDY FOR HEALTH BEHAVIOR IN SCHOOL - AGED CHILDREN - SCHOOLS FOR HEALTH IN EUROPE” IN THE REPUBLIC OF MACEDONIA

(December 2018 - February 2019)

Prof. Elena Kjosevska, M.D. Ph.D, Chief of Department for
Health Promotion, Analysis and NCD Prevention
Institute of Public Health of Republic of North Macedonia

OBJECTIVES OF THE PILOT PROJECT

The main goal was to evaluate the effectiveness of the national data of the HBSC study and SHE tools that should contribute in assessing of health and well-being in the schools.

1. **Specific objective**: To determine the relevance and usefulness of HBSC data in the assessment of the health and well-being in the school.

2. **Specific objective**: To assess the significance of the HBSC questionnaire, the SHE tools and the Evaluation List - Framework for monitoring health and well-being in terms of how they can monitor the successful or unsuccessful implementation of health principles in schools.

METHODOLOGY OF WORK

The pilot project started to be implemented on December 21, 2018 in the Republic of Macedonia, with **the first meeting of the project team** with the following agenda:

1. Presentation of the results of the HBSC study on the topics: Students who love the school, Alcohol, Violence, Social Media Addiction, Eating habits
2. Agreement on completing the school level questionnaire
3. Agreement on the activities to complete the SHE tools
4. Agreement for realization of activities with focus groups - teachers and students.

Two schools were selected in Skopje:

Primary School “Kuzman Josifovski Pitu” which was involved in the HPSN from 2000-2007

Primary School “Krume Kepeski”, which was not part of the HPSN

The tasks were as follows:

- Materials were translated into Macedonian

- Spreadsheets, graphics and analysis of the data were prepared according to the HBSC study from 2018 with selected topics: Alcohol, Violence, Students who love the school, Social media addiction, Eating habits.

- The schools were visited (contacted with the coordinators from the schools , information and directions for the activities in the schools were given, at the same time materials were distributed).

- The activities in the schools were conducted in the period from January 23 to January 30, 2019.

- The pilot project covered two classes with 13 year old students in each school, or 8th grade, a total of 45 students in one and 55 students in the other school.

- After each presentation of the HBSC data, a discussion on all five topics was developed. Also, the researchers shared the SHE Rapid Assessment Tool to the selected group of students and discussed the importance of the same.

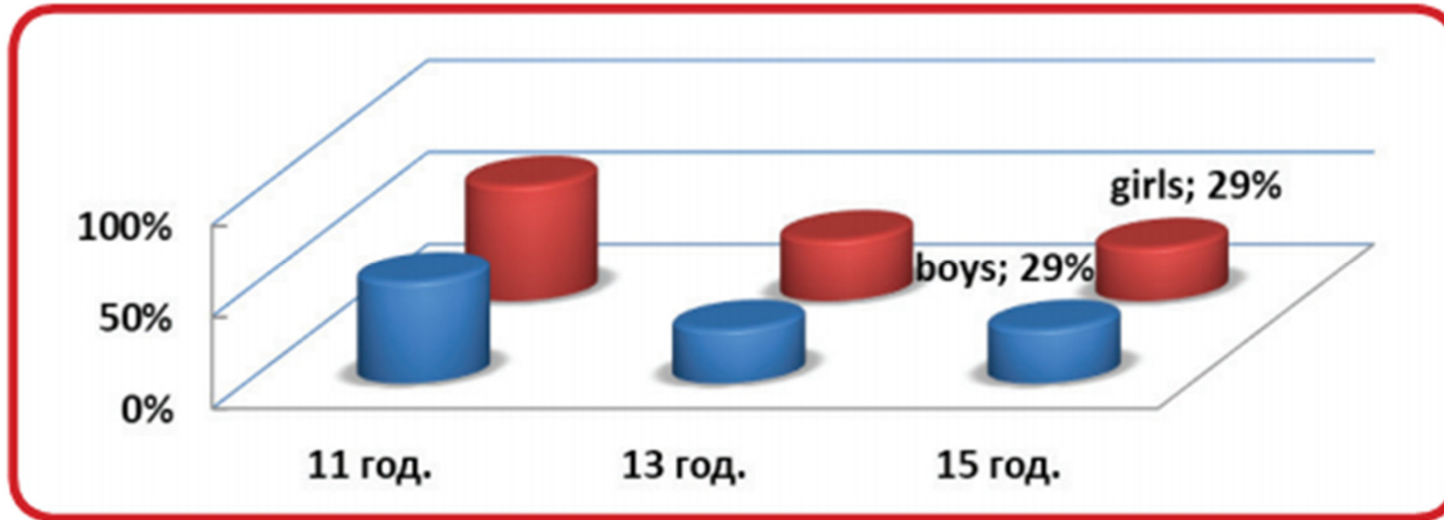
- School coordinators responded to the School level questionnaire and the Rapid assessment tool.

- Two focus groups of 8 people were organized in each school. One focus group had 6 teachers, the school coordinator and the director, while the second focus group had 8 students, randomly selected from the classes where the activity was previously discussed. A discussion was developed and feedback from the focus group members.

RESULTS FROM THE IMPLEMENTED PILOT PROJECT IN THE SCHOOLS

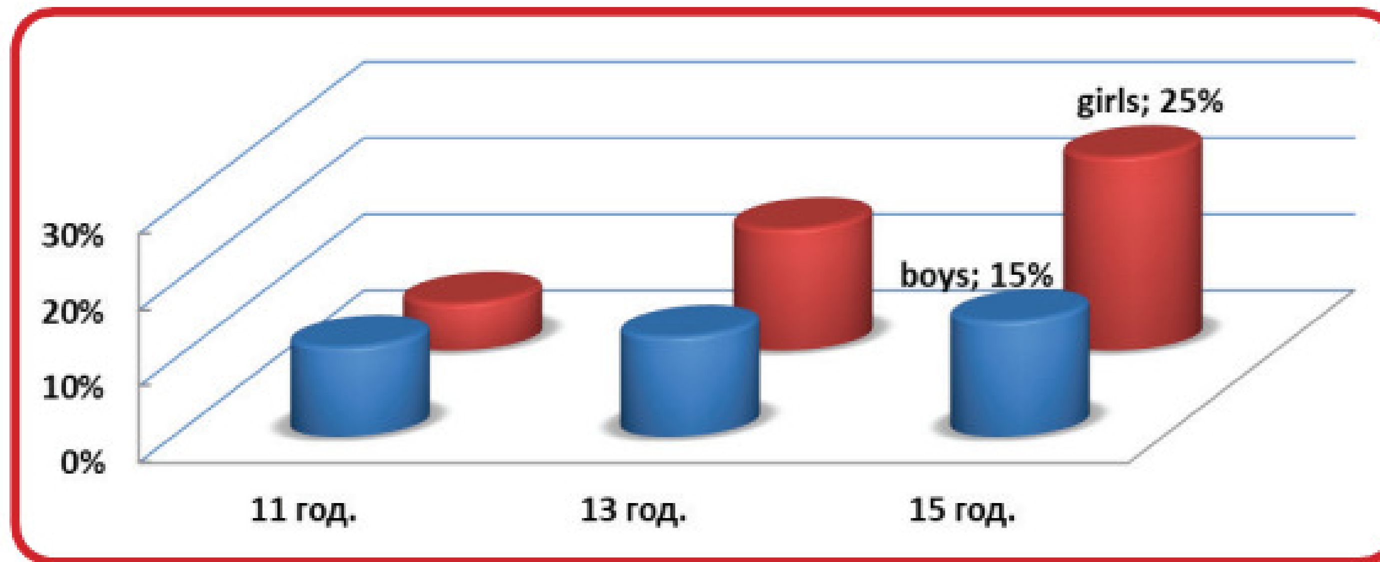
ANALYSIS OF SOME DATA FROM HEALTH BEHAVIOR IN SCHOOL-AGED CHILDREN STUDY 2017/2018 IN THE REPUBLIC OF MACEDONIA

Health topic: Students who love the school



The results of the schools do not differ much from the HBSC study conducted in 2018 year. Namely, the overall percentage of students who like the school is slightly lower and is 27%, compared to 31% of the study, and there is not much difference between girls and boys. Students want to go to school because of friendship, but not for learning. They are afraid of tests, they want more interactive teaching, learning through projects, using technology, visiting outdoors, in institutions (practical learning).

Health topic: Social media addiction



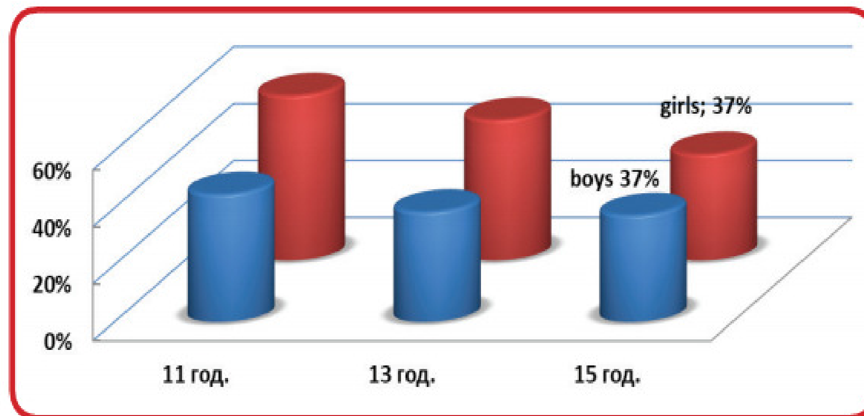
Students from both schools expressed distrust about the results of the conducted study 15%, and according to their statements about 70%, use daily social networks. <u>All students unanimously said that the percentage of media addiction is not realistic, i.e. is much greater than 15%. They think that the average is 50% and something more</u>, but some say a percentage of 80%.

According to students' statements, most responsible for so much are their parents who cannot allow long use of the phone, and they should be a good example for the children themselves (and not to sit all day with the mobile) " - a student statement.

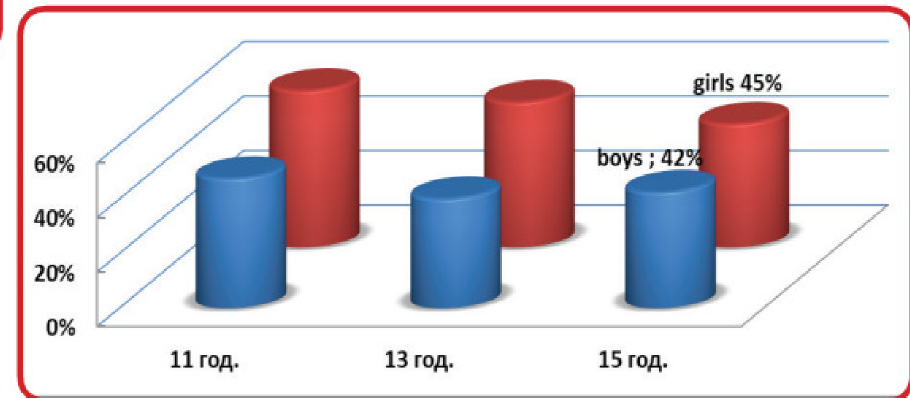
Health topic: Eating habits

All students said that the percentage of fruits and vegetables was higher than in the study. <u>All students consume fruit every day and eat vegetables that is positive, but they also say they eat sweets every day and drink carbonated drinks, which is worrying.</u>

- Students who consume fruit every day

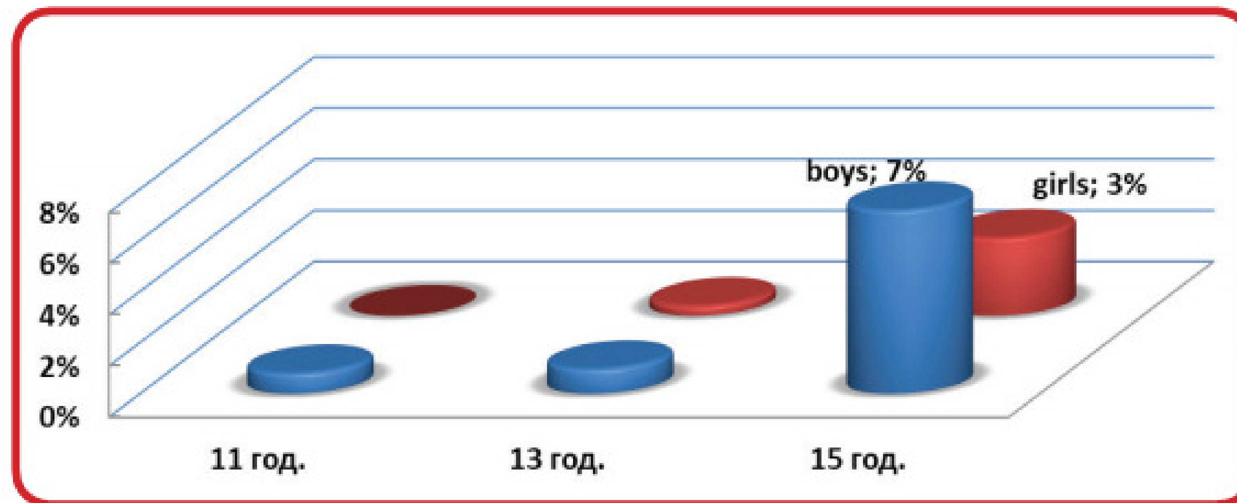


- Students consuming vegetables every day



Health Topic: Alcohol

- Students who were totally drunk more than once in the last 30 days

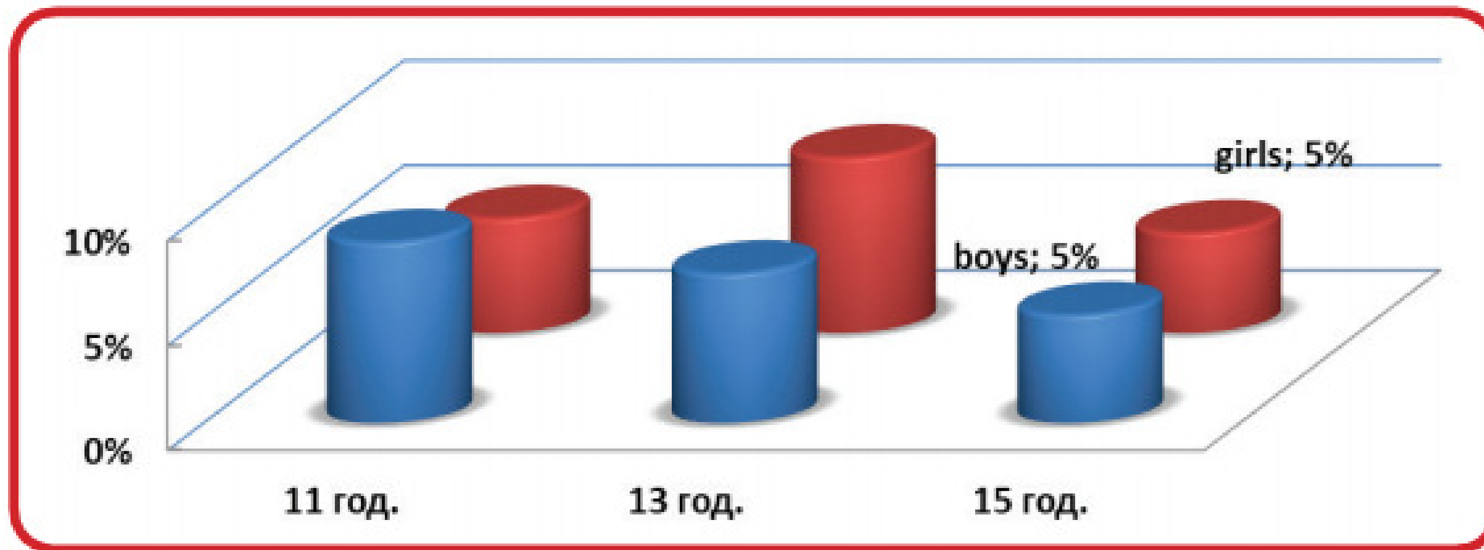


There is no occurrence of totally drunk students in the last 30 days. The results of the study according to them are real and represent 1% for students at the age of 13.

- Students who were drunk more than once in a life - There is no such occurrence in the school, but the results of the study find that they are real and they are around 3%.
- Statement from a student: "Parents shall give their children to drink alcohol at home to reduce curiosity and if they already decide to drink to know what kind of alcohol they drink."

Health topic: Violence

- Students who were mistreated more than 2 to 3 times in the last month



For this topic, students believe that the percentage of the conducted study is realistic and pointed out that in their school the violence prevailed with about 10%, but they said that there was no physical violence, but only verbal.

CONCLUSION OF THE CHECK OF THE HBSC DATA

- According to students’ statements, HBSC data referring to students who love the school, the use of alcohol and violence is realistic;
- Data on social media addiction, consumption of fruits and vegetables, sweet and carbonated drinks are not real, and the percentage of students who use them are higher;
- Consider that all five topics are important and priority for further work.

VERIFICATION OF SHE TOOLS

Verification of the SHE Tools was made by the two selected student groups from the different schools.

Aim of this verification - to measure the health and wellbeing of the school community during the implementation of health promotional principles.

Data analysis of the SHE Tool for Rapid Assessment showed that students think that **areas of priority are orientation, health policy and the school physical environment.**

CONCLUSION

- **The projected goals and objectives of the project were fully realized**, **confirming the usefulness of the application of the HBSC data, SHE tools and the Evaluation Framework for assessment of health promotion in schools.**

- It was concluded that the **health topics are not sufficiently processed** during the implementation of the curriculum, **students and parents are not involved in the planning and preparation of health activities** according to the needs of the school community.

- Students and teachers **expressed readiness to apply the tools** when assessing the current state of health promotion at the school.

- but also **planning and applying the Healthy Healthcare concept to the basic principles of work that will provide higher quality of education, satisfaction of students and staff in the school, a sense of belonging and a sense of responsibility to the school and community.**

Thank you

Introductions

- Welcome to members of HBSC and also SHE
- Please take 5 minutes to introduce yourself to your group
  - E.g. name, country and organisation/affiliation

Workshop discussion

- What are your experiences of policy use of HBSC data?
- What are your experiences of school use of HBSC data?
- Are there advantages or disadvantages of incorporating policy / schools in the use of HBSC data?
- How might you engage policy / schools to incorporate the data collected as part of HBSC? For example, what steps might you take
- Group feedback to share main points from your discussion