Children as agents of their own health: exploratory analysis of child discourse in Spain

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SUMMARY
The promotion of children’s decision-making is one of the principles of health-promoting schools, and the empowerment of children means that they are enabled to influence their lifestyles and living conditions. The aim of this study was to find out the suggestions of Spanish school pupils in Year 3 and Year 6 of primary education to promote their own health and the health of the people closer to them, through their ideas about health. We analyse the discourse on health in the school environment from focus groups of primary school pupils aged around 8 and 12 of five schools in the town of Alicante (Spain). The groups were organized according to the type of school (public, private), the socioeconomic status of the neighbourhood (residential, working-class) and gender (single-sex, mixed groups) to ensure both the highest intergroup diversity and intra-group homogeneity. The findings show that primary school pupils have a wide and diverse notion of health. The application of the focus group technique has proved useful in eliciting information from groups of primary school pupils, and involving students in health-promoting programmes because it allows them to identify the social and interpersonal determinants of health. There is a firm basis to consider school pupils as health agents, particularly regarding interventions within the school environment itself. With the support of teachers, it is possible to train school pupils as community health agents, and increase their control over their own health.

Key words: child; schools; health promotion; Spain

INTRODUCTION
There are important reasons to involve children in activities related to their own health: from ethical and democratic reasons to positive results in their health (Kalnins et al., 1992; De Winter et al., 1999; Jensen and Simovska, 2005). Children’s participation can be promoted in both research and health promotion initiatives.

With respect to research, determining the perceptions of children about health and their opinions about certain health issues is a key prerequisite to identifying which priorities, health promotion initiatives and social spheres related to health are important to them (Jensen, 2002). In the literature about children’s ideas regarding health and illness, we find two types of studies. The objective of one type, in the context of traditional health education, is to adapt the programmes to children so they can understand them, and to improve the results of such programmes (Natapoff, 1978). The former approach uses the questionnaire technique, which comprises a series of questions written, and then analysed from an adult perspective (Pridmore and Bendelow, 1995). Another type of study, in the health promotion context, aims to encourage the participation of children in the research process. In these studies, researchers trying to encourage children’s participation
often use tools such as the ‘draw and write technique’ (MacGregor et al., 1998) or photographs (Nic Gabhainn et al., 2007) to facilitate the expression of their emotions, and also to include in the research children with special needs, or with writing and reading difficulties. Focus groups are also used to explore the ideas and perceptions of children regarding specific issues about health, such as diet and nutrition (Hesketh et al., 2005; Burgess-Champoux et al., 2006; Dorey and McCool, 2009; Gavaravarapu et al., 2009), physical activity (Sansolios and Mikkelsen, 2001; Fereday et al., 2009), obesity (Canavera et al., 2008–2009), accidents (Green and Hart, 1998) and mental health (Roose and John, 2003).

This type of study deals with health issues close to the context of their daily life, and in environments such as the school (Alderson, 2000), the community (Kalnins et al., 2002; Piko and Bak, 2006) or the health system (Roose and John, 2003; Knighting et al., 2011; Coyne et al., 2011; Mukattash et al., 2011).

However, the literature review shows fewer studies that report and analyse the population’s general notion of health through their own discourse, with which they communicate on a daily basis with the people in their environment. We should also bear in mind that such notion of health is culturally influenced by its social construction, and may also be different between boys and girls, as well as between boy and girls from different socioeconomic backgrounds.

As for health promotion initiatives, the school is the environment where most of the programmes that are aimed at pupils take place. In this context, different strategies have been proposed to promote children’s participation in health education and health promotion activities. One of the strategies is the investigations–visions–actions–changes approach put forward by Jensen (Jensen, 1997): the other is Simovska’s model that distinguishes between two different qualities of student participation: token and genuine (Simovska, 2004). The promotion of children’s decision-making is one of the principles of health-promoting schools, and the empowerment of children means that they are enabled to influence their lifestyles and living conditions. This school health model goes beyond the traditional health education approach that turns children into passive recipients of the experts’ recommendations on individual behaviours regarding health (drug use, alcohol, tobacco, diet and physical activity, among others).

In Spain, children were considered until recently a population group with few health problems and needs, which made them almost invisible in research (Colomer-Revuelta et al., 2004). A review of studies on health education and health promotion initiatives in Spanish day-care centres and primary schools published in scientific journals between 1995 and 2005 (Davó et al., 2008) showed that the development of health-promoting schools is slow, and the traditional health education model is still applied in many schools. This review found a total of 26 papers about children and health education and promotion. A small number of studies (\( n = 5 \)) reported health promotion initiatives that met all the health promotion criteria established by the World Health Organization (WHO, 1997). A couple of initiatives included health education in the school curriculum and/or work values and attitudes in the school environment (\( n = 3 \)). Tobacco (\( n = 11 \)) was the main subject.

The aim of this study was to know the suggestions of Spanish primary school pupils in Year 3 and Year 6 to promote their own health, and the health of the people closer to them, through their ideas about health. Our objective is to identify in the children’s discourse helpful ideas to encourage their participation in health promotion initiatives in the school.

**METHOD**

We have analysed the discourse on health in the school environment with focus groups of primary school pupils.

The focus groups were conducted between February and June 2006. The participants in the focus groups were pupils in Year 3 and Year 6 of primary education (aged around 8 and 12, respectively) of five schools representing the variety of the school system in the town of Alicante (Spain). They were organized according to the type of school (public or private subsidized by the state, as is the case of most private schools in Spain, so in this paper, they will be referred to as ‘private schools’), the socioeconomic status of the neighbourhood (residential, working-class) and the gender of the pupils (single-sex, mixed schools) to ensure the highest intergroup diversity, and at the same
time, intra-group homogeneity. The participation of each school was requested through a letter of introduction and an interview with the principal. Once the school agreed to take part in the study, which involved getting permissions and the consent of parents and teachers, we proceeded to organize the groups. In most cases, participants were selected randomly by using the list of pupils enrolled in the class or by choosing desks at random (with particular attention paid to include children sitting in the front and back rows). In the case of schools located in neighbourhoods with a low socioeconomic status, the teaching staff objected to this random selection so pupils with behaviour problems would not be included. Each group had a minimum number of 8 participants and a maximum of 10. The focus groups were also ethnically diverse. One of the groups included a good number of Roma pupils (seven), while most of the remaining groups had one or two pupils that were immigrants, or children of immigrants (Table 1).

Each focus group began with an introduction of the moderator and the participants. She explained to them that their objective was to talk about health, and then started with some open questions, trying to obtain a free-flowing discourse, without structure, that is, the moderator tried to guide the discussion as little as possible. In any case, she had a series of open questions ready to encourage further discussion: What is a healthy boy/girl like? How do you feel when you feel healthy? Do you think your classroom is a healthy place? What information would you like to have regarding health?

The focus groups’ discussions lasted between 45 min and 2 h. They were recorded and transcribed, and later analysed with ATLAS.ti software. Our analysis began with a repeated reading of the transcriptions. The first step of the coding process was guided by a priori thematic structure based on the main topics that structured the questionnaire, which included open questions about (i) health and disease; (ii) health in the school; and (iii) suggestions to improve their health, and the health in their environment. Then, two observers carried out a process of open coding that was later reviewed by a third observer who helped us to validate the process and discuss the criteria that allow the assignment to the designated subcategories (Strauss and Corbin, 1990). The open coding process generated nine subcategories: (1. A) multidimensional perception of one’s own and other people’s health; (1. B) notion of health; (1. C) multidimensional perception of disease; (2. A) factors affecting health in the classroom; (2. B) factors affecting health in the playground; (2. C) learning about health in the classroom; (3. A) suggestions to become healthy and avoid disease; (3. B) suggestions to improve health in the pupils’ environment; (3. C) possibility of acting to improve health. Quotations were organized in tables of concepts according to the school year, gender, type of school, and socioeconomic status.

## RESULTS

### Health and disease

The notion of health of the pupils comprises a group of widely defined components. It includes physical, mental, emotional well-being and spiritual aspects.

This is a holistic concept of health, although when physical health is discussed, it shares some elements with a biomedical notion of health. It is defined as absence of disease, and described by means of personal attributes regarding look, height, strength and functional capacity.

When you’re not ill. You’re healthy, and don’t need to take medicines or anything else (6th year, girls, G6 private).

You don’t have wounds (3rd year, girls, G4 state).

You’re taller, stronger because of what you eat (6th year, boys, G2 private).

When you’re ill, you don’t have much energy (6th year, boys, G2 private).

### Table 1: Typology of the focus groups

<table>
<thead>
<tr>
<th>Number</th>
<th>Gender</th>
<th>School</th>
<th>Type of neighbourhood</th>
<th>Year</th>
<th>Age group</th>
</tr>
</thead>
<tbody>
<tr>
<td>G1</td>
<td>Mixed</td>
<td>Private</td>
<td>Residential</td>
<td>3rd</td>
<td>8–9</td>
</tr>
<tr>
<td>G2</td>
<td>All boys</td>
<td>Private</td>
<td>Residential</td>
<td>6th</td>
<td>11–12</td>
</tr>
<tr>
<td>G3</td>
<td>Mixed</td>
<td>State</td>
<td>Working-class</td>
<td>6th</td>
<td>11–12</td>
</tr>
<tr>
<td>G4</td>
<td>All girls</td>
<td>State</td>
<td>Residential</td>
<td>3rd</td>
<td>8–9</td>
</tr>
<tr>
<td>G5</td>
<td>All boys</td>
<td>State</td>
<td>Residential</td>
<td>3rd</td>
<td>8–9</td>
</tr>
<tr>
<td>G6</td>
<td>All girls</td>
<td>Private</td>
<td>Working-class</td>
<td>6th</td>
<td>11–12</td>
</tr>
</tbody>
</table>
Health is achieved through certain healthy lifestyles. The children’s discourse refers mainly to diet, physical activity, hygiene, rest and leisure.

Showering, playing sport, working a little (6th year, girls, G3 state).

Playing sport, having a healthy diet and sleeping at least 8 hours a day (6th year, boys, G2 private).

When children speak about disease, they allude to health problems, accidents, injuries and death.

When I have the flu (3rd year, girls, G1 state).

Falling down or injuring yourself and lying in hospital (6th year, boys, G3 state).

When you break your hand or your wrist (3rd year, boys, G5 state).

When somebody dies (3rd year, boys, G1 state).

The pupils introduce also some thoughts about mental health, emotional well-being and spiritual health.

You can develop your mind better because it’s clear (6th year, boys, G2 private).

You can be more free (3rd year, girls, G4 state).

You feel happy (3rd year, boys, G5 state).

You’ve depression (6th year, boys, G2 private).

When I go to church and pray I feel good because I speak with Jesus (3rd year, girls, G1 private).

Health status is associated with a series of determinants: the relationship with family, friends, classmates and teachers; and even the natural environment, and social injustice. Interpersonal relationships appear in the group discussions associated with well-being when they are friendly, and with uneasiness when there are conflicts, and negative or distant attitudes.

When I take a walk with my parents I feel very good (3rd year, boys, G1, private).

I feel bad when I get angry with a friend (6th year, boys G3 estate).

Environment and social injustice are factors that the participants associate with uneasiness and absence of health. They perceive disease in social or economic situations that are difficult or unfair for them or other people. On the other hand, being healthy is seen as a lifelong resource that provides opportunities, present and future.

Health is when we go to the countryside and breath fresh air (6th year, girls, G6 state).

You feel bad when you see a disabled child being abused, or laughed at, or they make fun of an older person or someone poor (6th year, boys, G3 state).

When my father loses his job (3rd year, girls, G1 private).

A healthy child can play football and a lot of games. And when they are racing, children that are healthy keep going longer (6th year, girls, G3 state).

If children make the most of their health, they can make a good career, and not have problems with the job (6th year, boys, G2 private).

**Health in the school**

For pupils, school activities can have an influence on personal well-being or uneasiness, and at the same time, carrying out those activities is a health indicator.

When you’re doing your schoolwork (3rd year, boys, G1 private).

When you don’t study and you have an exam, or you don’t remember anything and then you get a cold sweat! (6th year, girls, private).

Pupils also consider that the physical characteristics of the school, as well as the hygiene and the environment, have an influence on health.

I don’t think the school is healthy because it’s very dirty (3rd year, boys, G1 private).

It’s not healthy because there are a lot of classes, and the playground is very small (6th year, girls, G6 private).

To have a healthy back you need to sit properly, and my chair is very low (6th year, boys, G2 private).

Interpersonal relationships also play an important role when pupils describe health in their school environment.
When I play with my friends I feel very well (3rd year, boys, G1 private).

Our school isn’t healthy because our teacher ignores people. Our teacher doesn’t smile (6th year, boys, G2 private).

My playground isn’t healthy because the children make fun of me, call me names, throw stones at me (3rd year, girls, G1 private).

Suggestions to improve their health and the health in their environment

It becomes obvious several times during the group discussions that school pupils are able to look after their own health independently. Their suggestions, in line with their notion of health, include elements of the biomedical model, although they also make suggestions connected with a holistic concept of health. To promote health and/or to prevent disease, the pupils combine self-care patterns related to physical well-being such as rest, diet and medication, with patterns that promote mental and emotional and environmental health.

To be healthy you have to stay home and take medicines (6th year, girls, G2 private)

When my sister hits me, I tell my parents. It makes me feel good not to hit her back (3rd year, boys, G1 private).

When my uncle died, I tried to forget about it to feel better. If not, I’d cry (3rd year, girls, G1 private).

To be healthy, we have to look after ourselves, eat well, exercise ....Laughing is very good, and also crying (6th year boys, G2 private).

We should have more forests (6th year, boys, G2 private).

The pupils’ suggestions about how to improve health in the classroom and the playground are related to improvements in the infrastructure, their own behaviours and attitudes, as well as those of the teaching staff, and conflict resolution.

The suggestions dealing with changes in the infrastructure emerge in the discourse of sixth year pupils. Regarding the classroom, they identify factors such as the importance of enlarging the space available, adapting the equipment to the children, organizing the classroom according to the characteristics of the children and improving cleanliness and the good condition of the classroom by means of heating or air conditioning, as required.

The classroom should be a bit larger because it’s cramped. Better ventilated and more comfortable (6th year, boys, G2 private).

Air conditioning and heating (6th year, girls, G6 private).

The chairs, even though they’re not comfortable, should be suitable for the children’s height, so if the children are short, they shouldn’t have a tall chair. A heater for the winter, because we freeze, and can’t move our fingers (6th year, boys, G2 private).

As well as the hygiene, which they see as their responsibility, pupils also identify several elements in the playground that can be improved, such as the number of litter baskets, toilets, and also the cleaning service. They talk about questions such as improving the surface of the sports areas (‘fix the rough surface’) to prevent accidents, or reduce their consequences, and they also make references about organizing the use of the playground to avoid confrontations between children of different ages.

The playground would be healthier if we didn’t throw things on the ground (3rd year, boys, G5 state).

The playground should be bigger because there’s little room (6th year, girls, G6 private).

We can avoid hurting ourselves depending on how we play (6th year, boys, G2 private)

The change of behaviours and attitudes refers mainly to the relationship between teachers and pupils, and among the latter. The psychosocial risks that arise from these relationships are the most relevant aspect to be modified.

Teachers should like children so they can teach well (6th year, boys, G2 private).

The older children shouldn’t be so rude, and stop shoving us (6th year, girls, G3 state).

Participants understand that professionals must take care of health but at the same time, they identify a role for themselves in the health of the community. This becomes more apparent when talking about the school environment rather than about the wider social context.
With regard to their opportunities to get involved in their own school environment, the older pupils (sixth year) express different ideas about their role in health promotion within the school.

The main responsibility for allowing the participation of children in the decision-making is ascribed to the school's principal. The pupils state that it is up to he/she to offer the children the opportunity to make their own suggestions.

It'd be nice if the principal or the director of studies came four times a year to ask us what we want, take note of the things we’re interested in, and if they think that's good, they should try to include it in their budget (6th year, boys, G3 state).

We could make our suggestions to the principal, but she never pays attention to us (6th year, girls, G6 private).

The teachers in our school are all a bit serious, and the principal is a bit serious and unfriendly (6th year, boys, G2 private).

Pupils describe the decision-making as a process in which they take no part, and from which they are excluded.

In my opinion, only one teacher listens to me. They don’t let you express yourself, give your opinion. We do have good ideas but they don’t pay attention to us. It’s difficult because we’re children, but if a child has a very clear idea and says it, then I think they do. It’s just because we’re children, they don’t listen to you because you’re underage. The only way is to get the support of the grown-ups, or to be on TV (6th year, boys, G2 private).

Because we’re children we make no sense. They tell us to think things through before we do them or say them (6th year, girls, G6 private).

On the other hand, the result of the decisions taken in school, although brought about by their own ideas, is not considered satisfactory by the participants because they feel that teachers and older children end up stealing those ideas and making them their own.

Last year we asked for an awning, and they got it, but it takes half or a quarter of one of the playgrounds, and that’s where the teachers sit, and also the older children, that always get there before us, but if they listened to us and they wanted, they would get another awning (6th year, girls, G6 private).

They also realize that the most relevant decisions are taken on a political level, in which they are not allowed to take part, such as, for instance, in health care and environmental policies.

And also the doctors. A person has something serious and they [the doctors] put them on a waiting list for two years, and another has a lip that bleeds a little, but many times, and they get an operation right away. They leave the important stuff for last (6th year, boys, G2 private).

More parks to get more health (6th year, boys, G2 private).

The politicians are important because they have power. We are as important as they are, but we don’t have power, and nobody pays attention to us (6th year, boys, G2 private).

**Age, gender and socioeconomic differences in the discourse of health**

The differences between Year 3 and Year 6 children are limited to very specific aspects. For instance, references to mental health emerged only in the discourse of pupils in 6th year.

There would be fewer depressions (6th year, boys G3 state).

Year 3 pupils see school tasks as activities that may bring about well-being or uneasiness, whereas Year 6 children only associate those activities with the latter.

Children are healthy when they work a lot in the school (3rd year, boys, G5 state).

When I don’t do the schoolwork and then I must hurry up (6th year, girls, G6 private).

Likewise, pupils in sixth year relate uneasiness to conflicts with peers, whereas children in third year also include family conflicts.

When you get angry with your best friend (6th year, girls, G6, state).

When my parents and me get angry over a silly thing (3rd year, girls, G1 state).

Furthermore, Year 6 pupils associate uneasiness, not only with their own experiences but also with the experiences of others.
Girls and boys have different perceptions about health. Boys use aspects related to child development, such as height and strength, to identify a healthy child. However, girls do not stress particular details, and see ‘looking good’ in general as a sign of health.

You’re strong (3rd year, boys, G5 state).

A healthy child looks good (6th year, girls, G6 private).

When they refer to illness, boys consider their accidents and injuries as something normal, whereas girls think that they do not have accidents, and believe that it is something typically masculine.

Sometime you fall down, or you’re running and you sprain your ankle but that’s normal (6th year, boys, G2 private).

We don’t have accidents, but boys do (6th year, girls, G6 private).

When girls talk about the causes of illness and uneasiness, they show feelings of guilt that do not become apparent in the boys’ discourse. Girls believe that they get sick because they do not look well after themselves and/or because of their bad behaviour.

Not looking after yourself. Eating things that aren’t healthy, not exercising and sitting in front of the TV (3rd year, girls, G3 state).

When you’re in a bad mood with somebody and then you feel guilty (6th year, girls, G6 private).

When we behave badly (3rd year, girls, G3 public).

Furthermore, girls identify the sexist behaviours of boys as one of the causes of uneasiness.

Boys don’t pay attention to us girls, they’re always doing their own thing, silly things, they hit us. –Not always.- Or they only pay attention to you to insult you. They’re chauvinists. Boys play soccer, girls don’t (6th year, girls, G6 private).

Pupils in sixth year make suggestions about possible illness from a general point of view, which some girls blame to a certain extent on the person that suffers from it. By contrast, third year boys express ideas based on their own experience.

Looking after yourself so you don’t get ill, and if you’ve fallen down, not doing stupid things so you don’t get even worse (6th year, girls, G3 state).

When I had the flu, all I did was eating, and sleeping and taking syrup (3rd year, girls, G1 private).

Only pupils of religious private schools located in residential neighbourhoods report experiencing well-being when they carry out religious activities. They believe that solidarity produces well-being, and it is also a quality of healthy people.

I feel happy when I speak with Jesus (3rd year, girls, G1 private).

Helping others makes me feel good (3rd year, boys, G1 private).

You’re healthy when, with your good health, you can help others get better (6th year, boys, G2 private).

However, the Roma pupils in the focus groups, who study in a private school in a working-class neighbourhood, associate illness with behaviours related to their economic condition. They consider help as a duty and obedience an attribute of healthy children.

You can end up doing drugs (3rd, boys, G5 public).

If you pick up a lollipop from the ground because you’re poor you can poison yourself (3rd, boys, G5 public).

Healthy children must help their granny to clean the house (3rd, boys, G5 public).

Healthy children do as their parents tell them (3rd, boys, G5 public).

**DISCUSSION**

Primary school pupils have a constructive concept of health in which they are aware of the role they play to make changes on a personal level, and in the school environment, and to a lesser extent, in the wider social context. They perceive that such role is subordinated to the role played by teaching staff and health care professionals, and by adults in general, who do
not make it easier for them to have a more active role (expressing their opinion, making decisions, choosing contents, etc.). They implicitly criticize the ‘adultcentrism’ they perceive, but at the same time they accept it to a certain extent. This marginal position, also pointed out by Kalnins et al. (2002) and Coyne et al. (2011), shows that student participation is still limited to the classroom. It is also more closely related to the idea of taking part in activities within the classroom than learning about decision-making or acquiring competences to carry out health promotion initiatives within their community (Jensen, 2000).

Our analysis of children’s discourse shows too that they have a wide and diverse notion of health. Depending on the case, it may go from the idea that health is the absence of disease to a notion that also includes physical, psychic and social factors (Natapoff, 1978; Consejería de Sanidad y Servicios Sociales, 1998), which sometimes comprise social justice or even transcendent (religious) questions.

The results of our research are also consistent with those of some international studies. Children identify a healthy child through physical aspects related to child development (height, strength or being fit) and the functional capacity that those aspects enable (Natapoff, 1978; Consejería de Sanidad y Servicios Sociales, 1998; Piko and Bak, 2006). They equate health with absence of disease, and believe that health is the result of certain lifestyles (Consejería de Sanidad y Servicios Sociales, 1998; Pridmore and Bendelow, 1995; Piko and Bak, 2006; Knighting et al., 2011). This notion may be influenced by the prevailing biomedical model, which aims to alter individual behaviours (Piko and Bak, 2006). Nevertheless, the components of a holistic concept of health are also to be found in their discourse. In keeping with the findings of a study conducted in the region of Madrid, emotional and mood elements (joy, sense of freedom or sadness) are associated with well-being (Consejería de Sanidad y Servicios Sociales, 1998). Another element that children include in their perspective of health is the natural environment (Pridmore and Bendelow, 1995; Piko and Bak, 2006). School pupils also associate performing school tasks with well-being, an aspect that is not mentioned in Natapoff’s study (Natapoff, 1978). Moreover, in contrast to the findings of Piko and Bak (2006) the children that took part in our study identify determinants of health related to social aspects that include interpersonal relationships (family, peer group), as MacGregor et al. (1998) also found, and elements in the social environment (situations of social injustice).

The opinions gathered during our study show certain differences regarding age, gender and socioeconomic status of the pupils that may be relevant when it comes to putting forward health promotion strategies in the school. One of the differences between Year 3 and Year 6 pupils concerns mental health, expressed as clarity of mind or depression, and only found in the discourse of the older children (11- to 12-years-old). According to Natapoff (Natapoff, 1978), such differences are caused by the process of child development since mental health involves abstract thinking, which first appears in the preadolescent stage. However, other studies point out that children as young as age 10 are already able to understand and identify the mental health needs of children in their age group (Rosse et al., 2003). Our research found differences in how children of different ages express uneasiness and illness. Children in Year 6 are less egocentric than pupils in Year 3 because their discourse transcends their personal experiences (their illnesses) and the experiences of people close to them (family). They seem to be more aware of the problems of others, which becomes apparent in some of their suggestions to improve health related to social issues.

Among the gender differences identified in the present study, we find the social construction of body image. As the research conducted in the region of Madrid (Consejería de Sanidad y Servicios Sociales, 1998) already highlighted, girls relate body image to certain aesthetic sense, whereas boys think in terms of strength and stamina. Another important aspect is their different perception of risk. As in other studies (Starfield et al., 1995), girls perceive a lower risk of accidents than boys. Furthermore, girls also tend to feel a greater sense of guilt in relation to self-care, and associate the attitudes of rejection and discrimination shown by boys with their own attitudes and behaviours. This is a tendency, which suggests that certain gender stereotypes are still present in the family environment or in the hidden agenda of schools. There are few differences between public and private schools (Boruchovitch and Mednick,
One of them is the identification of health with religious activities and solidarity, which is probably due to the fact that the Catholic Church owns the private schools that took part in the present research. However, the most significant difference is their reference to behaviours influenced by their economic situation (alcohol abuse, illegal drugs), which other studies already pointed out (Knighting et al., 2011), also in deprived schools (Backett-Milburn et al., 2003).

The focus group appears (Porcellato et al., 2002) to be a useful technique for producing information with groups of primary school pupils (third and sixth year), although some questions should be taken into account. Conducting the focus groups in the school environment, during the classes, and with pupils who already know each other because they are in the same class may have influenced the group dynamic, particularly, by reproducing interaction patterns similar to those common within the school context. For instance, school pupils that showed more leadership skills in the focus group are likely to show them in their class as well. Likewise, the relationship between the moderator that conducted the group and the participants may have reproduced the relationship between teachers and pupils (for example, the participants may have waited for the moderator to lead the group, to be asked questions to contribute to the conversation, etc.). As primary-aged children are often very keen to please, it is very important to work with a skilled interviewer able to pose open-ended questions to the focus group and to avoid influencing the answers. In some cases, in schools located in neighbourhoods with a low socio-economic status, the teaching staff made one condition: they wanted to select the pupils that would participate in the focus groups. Therefore, more communicative pupils were more likely to be selected. The time available to conduct the focus groups was limited by the school timetable (between 45 min and 2 h), which sometimes did not allow the group to finish the discussion, and some discussions had to be stopped when the pupils were still actively contributing to it. However, our experience shows that, although such limitations may have influenced the group dynamic, the discourse was rich, flexible, often away from conventional academic/school ideas (not categorized in any subject matter) and free (not guided). This technique can be useful to involve students in health promotion programmes because it allows them to identify the social and interpersonal determinants of health (Nic Gabhaim and Sixsmith, 2006).

As a result of the sample size and the non-random sample used in this study, the focus groups were not statistically representative, and therefore, the external validity of our conclusions cannot be guaranteed. However, because the school system shows very similar organizational patterns in the whole of Spain (curriculum, training of teaching staff, economic, material and human resources, teaching methods, assessment system, legal frame and mixed schools), the repetition of the study in other parts of the country is likely to lead quickly to data saturation, or to very similar results.

In terms of implications for public health, the results indicate that children are health agents able to identify their health problems, the health problems of other people, as well as the problems of their immediate environment. They are also able to propose solutions to tackle them (Aldrich, 1987; Kalnins et al., 2002; Roose and John, 2003; Coyne et al., 2011; Mukattash et al., 2011; Sebire et al., 2011). Gathering this information from the children themselves not only shows us how they interpret health and disease so we can adapt health promotion programmes to their level of understanding, but also enables us to connect with the problems they regard as important so we can promote their participation as agents of change (Onyango-Ouma et al., 2004; Simovska, 2004).

The results show that pupils have opinions, perceptions and notions about health at a supra-individual level (especially, the school). There is a firm basis to consider training school pupils as community health agents and agents of change, particularly regarding health promotion initiatives within the school environment itself, as an explicit objective of the health curriculum. It seems advisable that the objective of training school pupils as health agents must try to overcome short-term, or too simple views, as suggested by Kalnins (Kalnins et al., 2002). The support of teachers is essential to encourage this process, and acknowledge the freedom of the children to take part in it and make their own decisions (Mwanga et al., 2008). Such support should not be limited to the classroom. Instead, it should also be applied to the analysis and decision-making about the school itself and
the pupils’ environment (family, town and natural environment). By promoting the participation of children, they and their schools may become a health asset in their community.

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