The voice of young people
A Report on Children’s Attitudes to Diet, Lifestyle and Obesity
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This report, *The voice of young people*, focuses on children’s attitudes to diet, lifestyle and obesity, and it is unique in that it is from the children’s own perspective. It is one of a number of activities within Pfizer’s ‘Way2Go, for a healthier you’ anti-obesity initiative developed over the past number of years in partnership with The Department of Education & Science (SPHE), the Irish Heart Foundation, Dublin City University and the National Parents Council Primary.

Since the launch of ‘Way2Go, for a healthier you’ in 2005, Pfizer has actively engaged with psychologists, nutritionists, academics and experts in physical activity in order to contribute useful tools to existing structures that tackle childhood obesity in Ireland in line with the recommendations of the Report of the National Taskforce on Obesity (2005). Pfizer has spearheaded the ‘Way2Go, for a healthier you’ initiative as part of our commitment to improving health and recognising that childhood obesity presents one of the biggest public health challenges facing our nation. Obesity in children in Ireland has been identified as an emerging health concern, the consequences of which will be increased health problems such as diabetes, heart disease, high blood pressure and joint complications for the next generation.

As a support to the National Taskforce on Obesity (2005) findings, *The voice of young people – A Report on Children’s Attitudes to Diet, Lifestyle and Obesity* seeks to build on our knowledge of obesity by providing a voice to children in terms of their attitudes to health. More specifically the document presents the results of research conducted with Irish children aged 10-14 in relation to their diet, nutrition and exercise. The goal of the report is to bring children’s views into the dialogue about obesity and to seek their opinion on how this can be tackled.

Going forward, we will continue to develop the Way2Go programme in partnership with schools, parents and relevant organisations with the objective of improving the health of children in Ireland.

David Gallagher, Managing Director, Pfizer Healthcare Ireland

As a consultant in the ‘Way2Go, for a healthier you’ anti-obesity initiative since its launch in 2005, I am delighted to participate in this report, *The voice of young people – A Report on Children’s Attitudes to Diet, Lifestyle and Obesity*. Proper nutrition in childhood can reinforce lifelong eating habits that contribute to a child’s overall well-being and helps them grow to their full potential and maintain a healthy life. Obesity in children has reached epidemic levels, with many overweight children going on to become overweight adults.

The economic cost of obesity is substantial, though more importantly, the health consequences are far reaching and potentially life threatening. In addition, overweight children can suffer low self-esteem, depression, social isolation and discrimination. Ensuring children have a healthy, active lifestyle from an early age will contribute to this behaviour continuing into their teenage years.

Parents and schools can work together to provide the best opportunity for our children to grow and develop. Parents who model healthy eating and physical activity can positively influence their children’s health. A healthy, balanced diet combined with an active lifestyle is paramount in maintaining a healthy weight.

Paula Mee, Nutritionist, BSc, Dip Dietetics, MSc in Health Sciences, Dip Allergy, M.I.N.D.I.
Introduction

Background

The ‘Way2Go, for a healthier you’ anti-obesity initiative has been developed by Pfizer Healthcare Ireland in recent years in partnership with The Department of Education & Science (SPHE), the Irish Heart Foundation, Dublin City University and the National Parents Council Primary.

The project aims to highlight and tackle the rising problem of childhood obesity in Ireland. Since 2005, Pfizer has worked closely with a range of allied professionals, including psychologists, nutritionists, academics and experts in physical activity in order to make a positive contribution to efforts to tackle childhood obesity in Ireland. These efforts are in line with the recommendations of the 2005 report of the National Taskforce on Obesity.

Alongside the Taskforce findings, this report, The voice of young people – A Report on Children’s Attitudes to Diet, Lifestyle and Obesity aims to give a voice to children themselves in terms of their own attitudes to diet, lifestyle and exercise. The results of research conducted with Irish children aged 10-14 years on lifestyle, attitudes, eating habits as well as general levels of exercise and activity are presented in this document.

“The Taskforce believes that the views of children and young people should be sought in relation to its recommendations and in furthering the implementation of these.”

Childhood Obesity

Although there are some genetic and hormonal causes of childhood obesity, most excess weight is caused by children eating too much and exercising too little. If children consume more calories than they expend through exercise and normal physical development, they gain weight.

Pfizer identified an opportunity to proactively engage with schoolchildren in line with the aims of the National Taskforce on Obesity by conducting qualitative research with children between the ages of 10 and 14. In total, 12 focus groups were conducted with schoolchildren (6 groups with 5th Class Primary school students and 6 groups with 1st Year Secondary school students). The individual schools selected were broadly representative of the wider school population.

Key Findings

The findings make for interesting reading. According to the children interviewed, “being healthy” was something that was often closely associated with physical appearance, particularly one’s size. The research also confirmed the existence of strong prejudices and the enduring social stigma in relation to overweight and obese people (supporting the findings from previous research studies).

In addition, children’s emphasis on the importance of a healthy diet appears more tied in with concerns about “gaining weight” and the potential social consequences of same over and above health concerns.

Feedback from the schoolchildren points to the importance of the inter-relationship between the individual child, the school and the home environment in influencing attitudes and behaviour concerning children’s health.
Report Structure

This report seeks to firstly examine the issue of childhood obesity in a global, European and Irish context (see Section 3: Irish Children and Obesity), focusing on the prevalence of the condition and the subsequent economic and social consequences. Section 4 of the report (see Section 4: Lifestyle of Irish Children) draws on a range of secondary research sources (e.g., Health Behaviour in School-aged Children 2006) to demonstrate the current lifestyles and behaviour of Irish children. These sections aim to inform the reader as to the environment in which Irish children find themselves and the challenges they face.

Sections 5 and 6 focus on the primary research with schoolchildren, capturing young people’s views and experiences with regards to activity levels, eating habits and health issues.

This is followed by a conclusion (Section 7) that stresses the need for an inclusive approach to the problem of childhood obesity in Ireland with families, schools and children working together to foster a healthier environment and hence healthier lifestyles for all. Such an approach builds on the views of Dr. David S. Ludwig MD, PhD (Associate Professor in Paediatrics at Harvard Medical School) who compares the problem of childhood obesity with that of global warming, in that; “Like global warming, the obesity epidemic is a looming crisis that requires action before all the scientific evidence is in... but obesity differs in one important respect from global warming: simple solutions are available and with a comprehensive national strategy we may be able to implement them without great sacrifice.”

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Irish Children and Obesity

Defining Childhood Obesity

The World Health Organisation (WHO) uses the Body Mass Index formula (BMI = Weight [kg]/ Height squared [m²]) to estimate the prevalence of overweight and obesity within a population. Although such an approach is generally effective for most adults, applying the BMI formula to children as an obesity classification tool is more difficult because BMI in childhood changes considerably with age and differs between boys and girls.4

Estimations of BMI values in children/adolescents depend on comparisons with population reference data using cut-off points in the BMI for age and gender distribution (BMI percentiles). The current cut-off and reference data varies somewhat between the US and Europe. Hence the WHO notes that as yet there is no standard definition of childhood obesity applied worldwide and the organisation is currently developing an international growth reference for school-age children and adolescents.

A Global Problem

While there are some minor differences in the approach to measuring obesity among children, all of the different techniques chart a significant rise in the problem over the last decade. Applying WHO standards, data from 79 developing countries and a number of industrialised countries suggests that approximately 22 million children under five were overweight or obese.5

A European Problem

The figures for Europe are similar, where excess body weight is now the most prevalent condition, affecting one in six children. Moreover, in some countries one in three children are overweight or obese.5 Countries such as Italy (36%), Malta (35%), Spain (34%) and Greece (31%) have amongst the highest prevalence of overweight and obesity among children.7

The International Obesity Taskforce (IOTF) predicts that by 2010, 38% of school-age children in the WHO European Region (15 million children) will be overweight and 25% will be obese.8
An Irish Perspective

According to the Report of the National Taskforce on Obesity 2005, rates of overweight and obesity in Ireland have trebled over the last decade and there are now approximately 300,000 overweight and obese children in Ireland with another 10,000 children adding to this figure every year.1

Furthermore, the Irish National Teens Survey 2006 demonstrated that the combined proportion of overweight and obese teenage boys rose from 6% in 1990 to 19% in 2006 and from 15% to 17% amongst teenage girls in the same time period.9

It is estimated that overweight and obesity among Irish adults and children cause approximately 2,000 deaths a year and costs the State in the region of €4 billion annually.1 The health consequences can include hypertension, angina, heart attack, osteoarthritis and Type II Diabetes (T2D).1

A tangible medical concern associated with overweight and obesity among children is that of T2D. This is a condition historically found to develop in men and women of middle to old age, but is now emerging as a threat to both overweight teenagers and the overweight preteen age group. Moreover, international research conducted by Deshmukh-Taskar et al found that over 60% of children who are overweight or obese before adolescence are overweight or obese in early adulthood, greatly increasing the burden on health services (which are tasked with providing treatment to patients during much of their adult life).10
A Profile of Schoolchildren

According to the National Census of 2006 undertaken by the Central Statistics Office (CSO), there are 864,449 children aged 0-14 years old. Of these, slightly more than half are male (443,044), with females numbering 421,405. For the school year of 2005/2006, there were 457,889 children in primary school, and 332,407 children in secondary school.

Happiness in Context

In the main, Irish children aged 9-18 appear to be a contented group. According to the Health Behaviour in School-aged Children Study 2006, 92% of boys and 89% of girls aged 9-18 considered themselves to be happy (ie. quite happy or very happy) – consistent with the findings of the HBSC 2002 study. In addition, 89% of boys and 87% of girls considered themselves to be in good or excellent health, a slight rise on 2002, where the figures were 87% for boys and 84% for girls respectively. These attitudinal findings mirror those of the adult population documented in the Pfizer Health Indices of 2006 and 2007.

Alcohol Consumption and Smoking

The HBSC studies with children aged 9-18 (1998, 2002, 2006) also shed light on the lifestyle changes with regard to alcohol consumption and smoking in the last decade. In 2006, 47% of children reported that they never had an alcoholic drink as opposed to 40% in 2002 and 31% in 1998. The proportion of girls (52%) who reported that they never had an alcoholic drink was higher than boys (43%).

There is little change between 2002 and 2006 in the rates of children reporting having had an alcoholic drink in the past month, with the exception of 15-17 year old boys, where a small decrease emerged. Similarly, the proportion of children who reported having been ‘really drunk’ in the last 30 days remained stable between 2002-2006. However, although the figures have not increased over time, about half the children aged 15-17 years claimed to be current drinkers (ie. had an alcoholic drink in the last 30 days) and just over a third reported having been ‘really drunk’ in the last month.

In addition, the HBSC studies demonstrate a decrease in the smoking status of young people. In 2006, 15% of children reported smoking (ie. smoking tobacco monthly or more frequently), a reduction of 6% in the last eight years (21% in 1998). A higher number of girls aged 15-17 years reported smoking (28%) compared with boys of the same age group.

The rates of reported cannabis usage amongst this age cohort in 2006 was consistent with 2002 figures (12% reporting using cannabis in the last 12 months against 11% in 2002). Overall, 16% of children reported using cannabis during their lifetime, an increase from 2002 (12%). Cannabis usage remains highest amongst 15-17 year olds, with slightly more boys (8%) than girls (5%) claiming to have used cannabis in the last 30 days.
Television Watching

The Irish National Teens Survey 2006 with children aged 13-17 demonstrated that one in three spent in excess of two hours watching television on weekdays and two in three spent more than two hours watching television at the weekends.9

This in turn supports research conducted by the Broadcasting Commission of Ireland (BCI) which demonstrated that Irish children watch on average 2.72 hours of TV every day.16 Furthermore, the Irish National Teens Survey showed that weekend TV and computer game use was higher amongst children who were overweight or obese.9

Dietary Habits

The HBSC reports (1998, 2002 and 2006) also demonstrate a number of trends concerning the dietary habits of children. In 2006, 19% of children reported eating fruit more frequently than once a day, against 20% in 2002. The rate of fruit consumption was higher amongst girls (23%) than boys (16%).13

Between 2002 and 2006 a slight increase in reported fruit consumption emerged among girls but no change was evident amongst boys. A greater proportion of younger girls (10-11 years old) reported consuming fruit more than once daily; this was not observed among boys.13

In 2006, 18% of children reported eating vegetables more than once a day, illustrating a slight increase on 2002. The increase was more pronounced amongst girls. The proportion of girls (20%) reporting vegetable consumption more than once a day was greater than the proportion of boys (16%), and this was the case across all age categories. There was some evidence of a social class effect especially among girls, with those from higher social classes more likely to report frequent vegetable consumption.13

Such findings are broadly consistent with the Irish National Teens Survey 2006 which highlighted the low intake of fruit and vegetables, with one in three teenagers claiming not to consume fruit.9

Moreover the Irish National Teens Survey 2006 reported that the fat intake was too high in over 50% of all teenagers. In addition 82% of all students surveyed reported consuming carbonated drinks daily.9 Research suggests that each additional glass of sugar-sweetened drink that children consume each day increases the risk of becoming obese by 60%.17

In addition, the Irish National Teens Survey 2006 reported that four in five teenagers were not consuming the recommended daily intake of fibre, with three in four teenage girls reporting a diet insufficient in iron.9 Perhaps more worryingly the Irish National Teens Survey reported that one in three teenagers had tried to lose weight, comprising 50% of all girls and 25% of all boys surveyed.9

In addition, evidence suggests that not all children are eating at the recommended times. The 2006 HBSC survey documented that 14% of children reported not eating breakfast during the week.13 Similar to 2002 the rates increased with age with a higher proportion of girls than boys reporting not eating breakfast on weekdays. Children from the higher social classes were least likely to report never eating breakfast on a school day.13

Exercise

The 2006 HBSC report found that 53% of children were exercising more than four times a week (up from 48% in 2002),13 in line with the Department of Health and Children’s guidelines (ie. one hour of moderate intensity exercise most days of the week). Consistent with the previous HBSC reports, a higher proportion of boys (63%) are exercising than girls (43%).13

Furthermore, as girls move through their adolescent years they appear more likely to drop off from the recommended weekly exercise routine (58% of 10-11 year old girls reported taking the recommended weekly exercise as opposed to 28% of 15-17 year old girls).13

Inactivity levels in 2006 across teenage girls and boys were consistent with 2002 where 12% of children reported exercising less than once a week (8% boys, 14% girls).13
5 The Voice of Young People

Given the increasing problem of obesity in Ireland and in particular its sharp increase amongst Irish children, multiple intervention strategies (across 6 broad sectors: high-level government; education; social and community; health; food, commodities, production and supply; and the physical environment) were proposed by the National Task Force on Obesity 2005. Moreover, the 2005 report also pointed to the need for children’s education concerning diet and nutrition and the role of the family and school in facilitating young people to make healthy choices (ie. diet and exercise).

Aims & Objectives

With this in mind, the ‘Voice of Young People’ research was very much exploratory in its approach, with the broad aim to increase our understanding of how young people view their health in the context of their everyday lives.

In particular the research focused on 4 key areas:

1. General Attitudes to Health & Fitness
2. Understanding Food & Nutrition
3. Eating Habits
4. Activity Levels

For the purposes of this research a healthy lifestyle is that which meets The Department of Health and Children’s guidelines on diet and nutrition (ie. The Food Pyramid) and recommendations concerning exercise ("Children should do at least 1 hour of moderate intensity activity, most days of the week").

Sample Profile

In total, 12 focus groups were conducted with children across 6 separate schools (6 groups in Primary schools and 6 groups in Secondary schools). The schools were selected to be broadly representative of the larger school population with a broad geographic spread (Dublin, Newbridge, Cork), gender balance (5 of the 6 schools were mixed) and socio-economic mix. A total of two focus groups were conducted per school, the research with Primary schools was confined to 5th Class children, with the research with Secondary schools comprising 1st Year children.
(i) General Attitudes to Health & Fitness

The first theme explored via the research was that of children’s general attitudes to health. Two key questions were put to children:

- What does health and being healthy mean to you?
- Is it important to be healthy?

Children were given the freedom to interpret such questions any way they chose.

Physical Appearance & Health

Children’s concept of “health” and specifically “being healthy” is very closely aligned to being physically fit and active. In response to the question *what does being healthy mean to you?* the first response tended to be centred on physical fitness and an ability to play sports and engage in outdoor activities.

Interestingly children’s view of “being healthy” is also closely associated with physical appearance and particularly one’s weight and physical size. For children a “healthy person” is perceived to be slim while an “unhealthy individual” is viewed to be someone who is “overweight” or “fat”. Physical size and weight tended to be used by children as a barometer of a person’s state of health.

Other physical attributes children reported as evidence of a person’s health included healthy teeth, healthy gums, skin free from acne and strong bones.

“I mean if you were very unhealthy you’d just be like a couch potato, really fat and lazy and you might have loads of spots from the greasy food you were eating all the time.” *(Male, Primary school 5th Class, Cork)*

Diet and nutrition were also associated with health, with all children advocating the importance of eating the “right foods” and avoiding “unhealthy food” in their everyday diets. For children the “right food” tended to be viewed as “fruit and vegetables, pasta and meat” with “bad food” deemed to be “sweets, chocolate, crisps and sugar”. However, for many children the aim or importance of a healthy diet seemed to be more about avoiding “becoming fat” over and above any awareness or concern about the physical damage an unhealthy diet can have on the internal workings of the body (ie. cholesterol, heart disease etc).

The Importance of Health

All children acknowledged the importance of personal health and the majority clearly expressed both a desire and intention to live a healthy lifestyle. For children, “being healthy” allows them to live a more active and better quality of life whereby they can engage in and pursue the sports and activities they enjoy. Sports and active play are central to how this age group socialise with friends, hence personal health is deemed to be important to enable children to continue to meet with peers and engage in activities they enjoy.

Bullying and Stigma

Conversely, an unhealthy lifestyle is inextricably linked with being fat and overweight, “a couch potato” and therefore someone who is unable to actively socialise and participate in sports. A clear social stigma emerged around the issue of people who were overweight or obese. In particular, children reported (sometimes with real life examples) how very overweight people of their own age are a source of ridicule and bullying and often have difficulty making friends.
There is a guy who lives around our neighbourhood who is obese and everyone just calls him names because he is fat and he has no friends and he just stays in all day with his parents. (Male, Secondary school 1st Year, Dublin)

If you were unhealthy, people would laugh at you. (Female, Secondary school 1st Year, Cork)

Such findings support other research studies (Wardle et al) which demonstrated a strong prejudice against overweight people amongst schoolchildren including those as young as four years of age.

In fact, children spontaneously raised the issue of obesity as a consequence of following an unhealthy lifestyle. Interestingly, little sympathy emerged for people with obesity, being perceived as lazy, “spending all their time watching television” and were therefore deemed to be ultimately responsible for their predicament.

Children’s concerns about obesity appear to be more connected to the social consequences of the condition (in particular an inability to play with friends, engage in sport, peer rejection, fear of being “slagged about being fat”) than they do with the health consequences (shorter life expectancies, heart attacks etc).

You’d be overweight and people would be slagging you and some people get slagged so much they commit suicide. (Female, Primary school 5th Class, Cork)

Understanding Eating Disorders & Health

As evidenced above, all children were aware of the issue of obesity and understood that it arose from overeating. In addition, the majority were also informed about other eating disorders, namely anorexia, with a minority also commenting about the problem of bulimia. While children had a strong dislike of being fat, they also acknowledged the dangers of being “too thin”.

The majority of children understood that anorexic sufferers had a somewhat distorted body image, which affected their ability to understand how excessive dieting was damaging their health. Children perceived the consequences of anorexia or being “very thin” to be a lack of physical strength, limited energy and being insufficiently developed or “weak boned”. In addition children pointed to the fact that those suffering from anorexia were at risk of “not growing properly” and were aware that if unchecked the disease could result in premature death.

You can be anorexic, all the size zeros. (Female, Primary school 5th Class, Dublin)
You think you look really nice but loads of people are looking at them going no you’re too skinny

(Female, Primary school 5th Class, Cork)

Where you think you’re too fat, you keep asking if you’ve lost weight, you’re not taking in the proper nutrients... you would have to go to Dr Phil, he would shout at you, your family would be very worried about you

(Female, Primary school 5th Class, Cork)

The awareness of issues such as eating disorders amongst this age cohort is consistent with research conducted with 9-11 year olds in the UK by Dixey et al in 1998.

(ii) Food and Nutrition

At a basic level children appear to have a good understanding of food and nutrition. A high level of consistency emerged in the food ‘sorting’ exercise of the type of foods children view to be “healthy” and those deemed “unhealthy”.

Moreover, the food sorting exercise in itself generated interesting debate amongst the children as to why specific food items should or should not be classified as healthy, unhealthy or “in the middle” (ie. neither healthy nor unhealthy) respectively. These discussions demonstrated an appreciation of issues such as calorie content, grease and fat, sugar and salt content and caffeine levels etc.
Healthy vs Unhealthy Food

Each group consistently categorised “unhealthy food” to be that which is high in any of the following:

- Grease and fat
- Sugar
- Salt
- Caffeine

The foods that were deemed to belong in this group included crisps, chocolate, biscuits, cakes, chips, fried battered fish, hamburgers and butter.

For many children the primary impact or concern about eating such foods was a change in physical appearance, most notably, “becoming fat”, “getting loads of spots” or “rotten teeth”. In fact, in a number of the groups (including groups with Secondary school children) the issue or impact of eating such foods on their internal health (i.e. cholesterol, heart disease etc) did not spontaneously register as important. Following probing of such issues in situ, a number of children, albeit a minority, commented on the potential consequences of “high cholesterol” or premature “heart attacks”.

It appears that children’s emphasis on the importance of a healthy diet is more tied in with avoiding any negative effect on their physical appearance (i.e. gaining weight etc) and the potential social consequences (peer rejection, etc) over and above health concerns.

“No offence to anyone who has a big tummy but if I had a big tummy I don’t know what I’d do, I’d run very fast I think!”

(Female, Primary school 5th Class, Dublin)

“You wouldn’t be able to do anything...people would think you’re unhealthy, you should start being healthy as a kid so that way you stay healthy as you grow up”

(Male, Secondary school 1st Year, Kildare)

This may be due to the fact that health issues such as cholesterol, heart disease etc are less tangible than immediate changes to physical appearance, particularly when the changes to one’s physical appearance, (increased weight, acne etc), may serve as a point of ridicule or rejection amongst one’s peers.

Children again held a consistent view of the food they viewed to be “healthy”. Typical foods in this category were fruit and vegetables, milk, meat, fish, pasta and brown bread. Interestingly, many children struggled to communicate why such foods were healthy over and above the fact that “they are good for you, contain protein and other things, they are low in fat, good for your heart, good for healthy bones”. 
Information Gaps in Diet & Nutrition

Children’s inability to articulate any information as to why specific foods are healthy may be the result of a number of factors namely:

- They lack the vocabulary to communicate information they have retained and understand
- Their knowledge of nutrition is limited to knowing that certain foods are healthy and unhealthy but they do not as yet understand why.

This issue appears important as it may indicate a gap in children’s learning or knowledge levels in nutrition. Almost all children were aware of the concept of the food pyramid, recognising it as a guide to healthy eating. However, although awareness of the food pyramid was high, understanding of the pyramid appears to vary somewhat amongst children in different schools, with some Primary school children more informed than their second level counterparts.

In general, children were aware that the foods at the top of the pyramid were those that should be consumed less frequently while the foods at the bottom of the pyramid were those to be consumed more frequently as part of a balanced diet.

“*The stuff that you should eat a lot of is at the bottom and the stuff you shouldn’t eat is at the top*” *(Female, Primary school 5th Class, Dublin)*

“*I know that the bottom is the most healthy and the top to be the least healthy because it’s like a tiny triangle and that’s how much you should eat at the top and it’s wider at the bottom so you eat more, you need enough sugar and salt and bad stuff to keep you going but only in small amounts*” *(Female, Primary school 5th Class, Dublin)*

More specifically, the majority of children were informed about different types of food in the pyramid (ie. bread and pasta, dairy, fruit and vegetables, meat & chicken etc). However, it was in the area of the **recommended daily consumption of each food group that the greatest information deficit in understanding was evident amongst children**. In particular, very few were informed as to the correct number of portions from each food group to consume daily.

In response to questions on the appropriate daily intake of fruit, vegetables, dairy and other food groups, children in each group often volunteered a range of disparate answers, with many seeming to attempt a guess at the appropriate answer. Although a minority of children were correctly informed as to the recommended number of daily portions from each food group, such children tended to be focused in specific schools.

This apparent information deficit in understanding of the recommended daily consumption of each food group contrasts with the findings from research conducted with English schoolchildren in 2007 (aged 10 -12 years) where 76% were aware of the correct number of portions of fruit and vegetables to consume daily. This poses an interesting question as to whether Irish children are less informed about nutrition than their English and European counterparts.
(iii) Eating Habits

The exploration of children’s individual eating habits proved particularly informative. A number of commonalities emerged across many of the groups, indicating potential societal shifts.

Erosion of Family Meal Times

The concept of set family meal times, ie. a specific time for dinner whereby all the family sit together, appears less common than heretofore. In almost all groups a number of children pointed to the fact that very often, owing to work commitments, a father or mother will eat dinner at a later time to the rest of the family. In such circumstances the relevant parent’s work commitment necessitates that he/she arrive home from work most weekdays at a time after the serving of family dinner, where he/she will in turn eat alone.

“My mum and my sister, we would eat together but my dad would usually just be in from work and would be asleep on the couch, he usually eats later”

(Female, Secondary school 1st Year, Cork)

Conversely, the majority of children reported eating at least one meal together as a family at the weekend.

Flexible Eating Arrangements

Evidence also emerged across many of the groups of some parents permitting their children to eat family dinner in conjunction with watching television. Although this was by no means the everyday norm for most children, such behaviour was commonly reported by a minority of children in many of the focus groups. This supports findings from previous research by Foley-Nolan and Millar in 2004 with Irish families concerning eating patterns, with the majority of families reporting eating evening meals together but where 36% routinely ate evening meals in front of the television (rising to 45% at weekends).21 Moreover, a relatively common practice appears to be parental permission for children to watch their favourite programme, or a specific event (ie. soccer match etc) during dinner time. However very often such behaviour necessitated the student eat their dinner in the television room apart from other members of the family.
“I usually eat dinner at the table but if I wanted to watch a soccer match I would be allowed bring my dinner into the TV room and eat in there.”

(Male, Secondary 1st Year, Kildare)

Emergence of Takeaway Days

In a considerable number of focus groups (particularly with children from lower socioeconomic backgrounds) children reported eating two and sometimes three takeaway dinners per week. Almost always such takeaways comprised what might be labelled “fast food” with the most common meals selected including: Chinese takeaways, pizzas, and “The local chipper”.

Very often there appears to be select days (usually Friday or a weekend night) whereby a parent or parents choose not to cook, hence it was understood by the family that dinner was to be ordered from a nearby eatery.

“My ma never cooks on a Friday so we just get a takeaway usually it would be a Chinese or maybe a pizza.”

(Male, Secondary school 1st Year, Dublin)

Suboptimal Nutrition

A consistent issue to emerge across many of the groups was the apparent suboptimal daily dietary habits of children in terms of nutrition. In general, the majority of children’s eating habits (while in school) appear to revolve around the school timetable and can be broadly classified into the following eating occasions:

- Breakfast
- Small school break
- Big school break (lunchtime)
- After school snack (±)
- Dinner
- Supper (±)

Although children do report eating between meals (commonly referred to as “grazing”), this practice appears more common at weekends when children are not adhering to a more structured timetable.

In exploring children’s responses concerning their typical eating habits, it appears that many children’s daily diets come up short in terms of the recommended intake of fruit and vegetables.

Interestingly, only a minority of children spontaneously mentioned the daily consumption of fruit at any of the above specific eating occasions. Moreover, for many children fruit or vegetables do not appear to be present in their everyday lunch boxes. Also, a considerable number of children reported eating sweets or chocolate every day particularly at “break time” in school or at the weekends.

Of particular interest was the finding that in schools where a selection of lunch options are offered to children, more often than not it appears that children will gravitate towards food high in sugar and salt (i.e. chips, pizza, Pot Noodle etc) over and above food with a higher nutritional content.

The apparent limited daily consumption of fruit and vegetables together with children’s reports of the daily consumption of sweets is consistent with the findings from the 2006 Irish Health Behaviour in School Survey conducted with children aged 9-18.

This study highlighted that only 19% of children consumed fruit more than once a day with 18% reporting the recommended daily consumption of vegetables. In addition, 39% of children consumed sweets daily.13
Below is a more detailed examination of each of the meal occasions to emerge from the research.

**Breakfast**

Most children reported eating cereal for breakfast. The majority appear to eat options with less sugar content but evidence also emerged of a number of children choosing brands with a higher sugar content. Children who tended to choose cereals which were higher in sugar tended to be from lower socioeconomic backgrounds. Such children appeared unaware as to any difference in the nutritional value of their selected cereal and that of other brands/options.

Of perhaps greater concern was the fact that a minority of children reported regularly skipping breakfast and in some cases such children reported eating no food until lunchtime each day.

These findings again support data from the 2006 HBSC study where 14% reported not eating breakfast during weekdays.\(^\text{13}\)

**Small School Break**

The shorter school break emerged to be a time where children may consume part of their lunch. Very often part of a sandwich or a supplementary item (ie. a bag of crisps, snack bar etc) will be eaten. A minority also reported eating fruit during this break period.

**Big School Break**

Big school break tended to be the time when children eat lunch, which for most children (ie. those who chose to bring their own lunch to school or schools without a self-service canteen facility) tended to be a sandwich and a drink. On a positive note, no evidence emerged of the regular consumption of carbonated drinks during this time period, with water, milk or juice the most common options.

However, very few children reported the inclusion of any salad or vegetable component in their daily lunch boxes. Typically, sandwiches comprised a slice of meat or cheese and, in a number of circumstances, a plain roll. In many such circumstances children’s lunch boxes also appear to be without fruit, hence the total nutritional content of the lunch would appear less than ideal.

In instances where children chose to eat their lunch in the school canteen, evidence suggests that when confronted with a number of meal options (including food high in sugar and salt and other healthier options) children will select food high in sugar and salt over and above the more healthy options.

“I usually just go for chips or pizza for lunch as I don’t really like the other food”

*(Female, Secondary school 1st Year, Dublin)*

In one particular group the majority of children reported regularly eating “Pot Noodle” (a ready made snack low in nutritional value) for lunch. In addition, all children reported choosing not to eat the supplementary vegetables which were offered as a nutritional boost as part of the lunch.

“I never eat the vegetables because they’re hard; people tend to just throw them at each other instead. If you go into the ref after lunch all you see is a load of vegetables on the ground because nobody eats them”

*(Male, Secondary school 1st Year, Dublin)*
After school snack
Many but not all children appear to have an after school snack immediately on returning home. Usually such snacks include items such as toast, cereal, soup, crackers and sometimes fruit. After school snacks appear more common amongst boys than girls particularly if there is a substantial time lag between arriving home and dinner time.

In addition, given that most boys tended to partake in some activity (i.e. active play, sport etc) prior to dinner, such snacks appear necessary to provide adequate energy.

“I’m always starving after school so I’ll grab something before going out to play football”
(Male, Secondary school 1st Year, Kildare)

Dinner
In general, food served during family dinner tends to deliver a balanced diet. Children reported a mix of dishes almost all of which incorporated portions from all the relevant food groups (meat, vegetables, pasta, rice etc). Notwithstanding the examples where takeaway options were selected, it appears that the majority of children were eating a balanced evening meal.

Supper
Again, supper appears to be a snack that is eaten by a moderate number of children. In general boys appear more likely to eat this meal which may be the result of a larger appetite arising from higher activity levels. This meal usually comprises something light (i.e. toast, cereal, yogurt) eaten approximately 1 hour before bed time.

Interestingly, fruit was not commonly reported to be eaten as part of this eating occasion.
Role of the School Environment

The findings suggest that the school environment and school policy play an important role in influencing children’s eating and dietary habits. One specific example of the role the school environment can play in determining children’s consumption of snack items was evidenced in the placing of a “locking system” (ie. a timing device which restricted access to drinks outside school break time) on the vending machines offering a variety of carbonated and non-carbonated drinks. Children reported that restricted access to such drinks limited the extent of “impulse purchasing” hence confining purchases only to break/meal times.

“Since they banned the machines (vending) from giving out drinks outside of break time I find I’m not drinking fizzy drinks as much because I can’t just grab a drink whenever I am passing the machine, I have to wait until break time” (Male, Secondary school 1st Year, Kildare)

(iv) Activity Levels

In general the research indicates that the majority of children aged 10-14 years appear to be active, that is they meet or exceed The Department of Health and Children’s guidelines on exercise (1 hour of moderate intensity exercise most days of the week).

Such findings may appear to contradict other research studies, most notably the 2006 HBSC study where 47% of children aged 9-18 years were not participating in the recommended level of weekly physical activity. However, the same report also points to the fact that exercise patterns decrease with age particularly amongst girls (dropping from 58% of 10-11 year old to 28% of 15-17 year olds).13

Hence it is important to note that this age cohort (10-14 years) may in fact become less active as they progress through second level education as academic pursuits place greater constraints on children’s time for activities and sports.

The majority of group participants (children) appear to be engaging in activities approximately 1-2 hours per day, comprising a mix of activities throughout the week, namely a school team sport, a dedicated sporting hobby (swimming, horse riding etc) casual sport with friends and active play (chasing, skipping etc more common amongst Primary children).

“I play football, here for the school team and with my club, I also play with my friends almost every day, we just cycle around the estate” (Male, Secondary school 1st Year, Dublin)

However, evidence also emerged of a minority of children who were both “under active” (moderately below the recommended activity guidelines) while a smaller cohort emerged to be “severely under active” (considerably below the recommended activity guidelines).

“I would do swimming once a week” (Female, Secondary school 1st Year, Kildare)

“I do dancing on a Wednesday after school” (Female, Secondary school 1st Year, Cork)

The page opposite shows a more detailed examination of the breakdown of children’s activity levels across the research sample. We are mindful that this qualitative project is not seeking to quantify response categories but to provide a general overview of children’s responses in each activity grouping.
## Activity Levels

| Very Active | Approximately 1/3 of all children in this category  
| | Averaging 2-3 hours activity/exercise per day  
| | Participate in several sports both in and outside school  
| | Enjoy casual sports/play with friends |
| Active | Approximately 1/2 of all children in this category  
| | Averaging 1-2 hours activity/exercise 5 days per week  
| | Participate in a number of sports both in and outside school  
| | Enjoy casual sports/play with friends |
| Under Active | A minority of children in this group  
| | Averaging 1-2 hours activity/exercise 2 days per week  
| | Tend to participate in a single sport once or twice weekly  
| | Tend to engage less in casual play with friends  
| | More likely to be girls than boys |
| Severely Under Active | The smallest minority of children in this group  
| | Averaging 1-2 hours activity/exercise for the entire week  
| | Tend to participate in a single sport if at all  
| | Tend not to engage in casual play with friends  
| | Tend not to enjoy sport or activities  
| | More likely to be girls than boys |

In exploring activity levels across both Primary and Secondary school-aged children, a number of interesting findings emerged namely:

- Children with a wider interest in many sports tended to play more sports and were hence more active than children who tended to enjoy a single sport
- Children who were involved in team sports tended to be more active than those who only participate in individual sports (i.e. horse riding, swimming etc) for a number of reasons:
  - The structured timetable of practice days and match days encourages at least 2 days where the recommended level of activity is reached
  - Many team sports can often be played on a casual basis in a modified manner (i.e. two people kicking a ball etc)
- Casual play (i.e. skipping, chasing, hide and seek, football in the back garden etc) is an integral means by which this age cohort exercise.
Children’s Recommendations

The final component of the research focus groups encouraged students to think creatively about practical steps they can employ to live healthier lives. The natural inclination of most students was to think only of dietary changes as the majority perceived themselves to be very active.

Ideal Healthy Day

Children were asked to create their “ideal healthy day” focusing on the changes they can implement at four individual stages throughout the day namely:

- **Morning**
  - Healthy Breakfast
    - Porridge or Weetabix
    - Brown bread vs white bread
  - Substitute fruit for less healthy snack (ie. crisps, chocolate)
  - Eat a piece of fruit with lunch
  - Eat a piece of fruit as a snack
  - Use brown bread for toast

- **School time**
  - Walk/cycle to school
  - Walk dog
  - Skipping for 10 minutes
  - Active play outside during short break and lunch break
  - Participate in school sports

- **Afternoon**
  - Eat 2 portions of vegetables with dinner
  - Play with friends outside
  - Participate in sport

- **Evening**

The exercise proved very fruitful in focusing children’s ideas about practical dietary and activity changes they can implement at each stage of the day. Below are the key suggestions children volunteered.

<table>
<thead>
<tr>
<th></th>
<th>Dietary Changes</th>
<th>Activity Changes</th>
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</table>
| **Morning** | Healthy Breakfast  
- Porridge or Weetabix  
- Brown bread vs white bread | Walk/cycle to school  
Walk dog  
Skipping for 10 minutes |
| **School time** | Substitute fruit for less healthy snack (ie. crisps, chocolate)  
Eat a piece of fruit with lunch | Active play outside during short break and lunch break  
Participate in school sports |
| **Afternoon** | Eat a piece of fruit as a snack  
Use brown bread for toast | Play with friends outside  
Participate in sport |
| **Evening** | Eat 2 portions of vegetables with dinner |                               |

Competition Component

In addition to the in-group exercises, the participating groups (ie. Primary school 5th Class, Secondary school 1st Year) and all children in the relevant year in each school were afforded an opportunity to participate in a competition where they were asked to complete a form (in conjunction with all their family members) detailing the top 10 tips they as a family can engage in together to be more healthy.

The exercise was designed as a fun and enjoyable family activity but also to encourage all family members to think seriously and creatively as to how they might implement simple plans to achieve a healthier family lifestyle. No direction was provided to children in the completion of the task (ie. definitions of health etc) over and above that the project was to be completed in conjunction with all family members. Hence the aim was to encourage broader creative vs narrow implementation strategies for all participants.

Although the competition component cannot be classified as formal research, all of the student/family responses were captured and coded accordingly. On the next page are the top 10 recommendations for healthy families as described by Primary school children and Secondary school children respectively. This information also delivers useful insights into how simple and practical solutions can be implemented within the family environment to encourage healthy behaviour.

Encouraging family involvement in the competition task seeks to take account of the role parents play in encouraging a healthy lifestyle for their children. Hence, involving family members in finding creative solutions to the issue would appear critical to setting positive behavioural patterns early in children’s development. Furthermore, it encourages all family members to think of practical and concrete steps they can take individually and collectively to become healthier. Without parental or family members support, it is likely to prove difficult for a child to sustain healthy eating habits and activity levels.
Findings

Interestingly, the findings demonstrate a high level of consistency between Primary and Secondary school children in terms of the suggestions offered. In short: regular exercise, daily fruit and vegetable consumption, reduced consumption of “junk foods” (including sweets), eating a healthy breakfast, eating healthy family meals, drinking plenty of water and spending less time watching television were suggested by both groups.

Top 10 suggestions for a healthy family (Primary Schools)

- Exercise regularly
- Eat plenty of fruit and vegetables (5 portions a day)
- Walk instead of drive to school and work
- Less fast food, sweets and junk
- Drink plenty of water
- Eat healthy home cooked meals
- Don’t smoke
- Eat a healthy breakfast
- Spend less time watching TV or on the computer
- Spend time exercising together as a family

Top 10 suggestions for a healthy family (Secondary Schools)

- Exercise daily
- Eat plenty of fruit and vegetables
- Eat well, a balanced diet
- Drink 6/8 glasses of water daily
- Eat less takeaway and junk food
- Healthy family meals – meat and fresh vegetables
- Play sports – join a team or club
- Less sweets and sugar
- Eat a healthy breakfast
- Spend less time watching TV and spend time talking/bonding with the family

Secondary school children suggested joining a team or club and spending time talking/bonding with the family as important tips for a healthy family. The emphasis on family bonding time for second level children may suggest a recognition amongst parents of the increasing need children have for emotional support as they approach their teenage years.
Conclusions

The levels of overweight and obesity in this country continue to rise and are expected to reach epidemic proportions in the next few years. The voice of young people – A Report on Children’s Attitudes to Diet, Lifestyle and Obesity seeks to contribute to the formulation of an effective programme that relevant groups might implement.

Care must be taken not to draw generalisations from this qualitative project (albeit robust in its sample design) to the larger child population. However, many of the findings do appear to substantiate those from other research projects. Other key findings do appear to warrant further research, most notably:

- The close association children perceive between physical appearance and health
- The strong social stigma attached to the issue of obesity and the apparent negative prejudices towards sufferers of the disease
- The emphasis children place on physical appearance as the primary aim of maintaining a healthy lifestyle (over and above concerns about their internal health, diabetes, heart disease etc)
- The apparent information gap in children’s understanding of diet and nutrition particularly with regard to the recommended daily consumption of specific food groups
- The erosion of family meal times
- Suboptimal daily eating habits and nutrition amongst children
- Higher activity levels amongst children who favour team vs individual sports
- The importance of casual play as an integral mechanic for children to achieve the recommended daily level of exercise
**The Individual-School-Family Dynamic**

Perhaps the key conclusion to be drawn from the research is the important inter-relationship between the individual child, the school and the home environment in establishing and reinforcing positive attitudes and behaviour concerning personal health.

The research suggests that health information alone is insufficient to sustain children’s adherence to a healthy diet. Throughout the research multiple examples emerged of children who understood the importance of healthy diet and the difference between healthy and less healthy food but, when faced with a choice, select the latter.

In addition, such behaviour appears more marked where children have easy access to less healthy food alternatives (ie. food high in sugar and salt etc).

This would appear to tell us that awareness and knowledge of healthy eating and activity levels must also be bolstered by a home and school environment that encourages children to select healthier lifestyles (ie. via limited access to fast food, active encouragement of team sports etc). It stands to reason that “healthy” behavioural patterns established and reinforced in childhood are more likely to be sustained in the long-term. Conversely, poor diet and activity levels fostered in childhood are likely to prove more difficult to break in later years.

The importance of environmental factors in combating the problem of obesity is addressed in detail in the report of the National Taskforce on Obesity 2005 which states “…Creating environmental changes that support long-term changes in individual eating and activity habits are necessary for both adults and children if the current trends in obesity prevalence are to be tackled successfully”.1

Perhaps a concrete starting point to tackling obesity is to develop a forum where individual parents and schools can share knowledge and ideas concerning the practical challenges of encouraging children to embrace a healthy lifestyle. From such a dialogue a common but practical approach could be agreed and implemented by all parties.
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