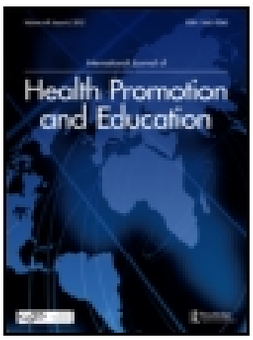

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Health education in schools: factors influencing parents' views of the home–school relationship in France

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ABSTRACT

Ensuring that schools, families and communities work in partnership to reduce the gradient in health, well-being, and resilience of children and young people is considered a priority among public health objectives. This study aimed to explore the factors having an influence on the home–school relationship in general and in the field of health. Emphasis was put on socio-economic factors. A questionnaire was administered to parents of fourth- and fifth-graders attending 37 primary schools in France. Demographic and social characteristics, and views on the home–school relationship and on health education were analysed. The majority of parents (67%) were satisfied with their relationships with their child's school, but 22% of parents indicated the reverse. Lower socio-economic status (SES) parents were more satisfied with the home–school relationship than higher SES parents were. Parents acknowledged that health education belongs at school, but they did not see it as important a school subject as mathematics or language. They were also critical about school staff members' health education competence (5.07 ± 2.38 on 10). Parents with lower SES had a closer relationship with their child's school than parents with higher SES did. This suggests that schools can play a key role in the reduction of health inequities. Nevertheless, enhancing a school's potential to become a healthy setting appears to be challenging since parents considered both the status of health education and school staffs' competence in teaching health issues low.

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Health; school; parents; teachers; the home–school relationship

Introduction

Childhood has a determining influence on subsequent life chances and health through skills development, education and occupational opportunities (WHO 2008). Ensuring that 'schools, families and communities work in partnership to reduce the gradient in health, well-being, and resilience of children and young people' (Marmot et al. 2010, 24) is a public health priority worldwide, especially in France (French Ministry of Health 2016; Public Health France 2017). A reciprocal and meaningful relationship between home and school requires active work from all stakeholders.

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Despite the importance of the home–school partnership and institutional instructions for working together as a team, such a partnership is not necessarily easy to obtain, and challenges to concrete family involvement exist on a large-scale (LaRocque 2013; Mérini, Victor, and Jourdan 2010; Sormunen, Tossavainen, and Turunen 2011). Especially in multicultural settings, a lot of emphasis has been put on involving parents in their children's educational processes with good results (Reynolds et al. 2015; Hajisoteriou and Angelides 2016). While we know that health inequalities among individuals begin to form in early childhood (Halldórsson et al. 2000; Tandon et al. 2012; Mercer et al. 2013), the roles of two primary health learning environments for school-aged children – home and school – are essential also in terms of health. Home, being a child's first learning environment, has a substantial role in children's healthy development. Along with homes, schools have long been settings in which the health of children has been paid attention to (WHO 1986; Turunen et al. 2017). A whole school approach to health education, where daily school practices reflect school policy, promote a sense of belonging and creates possibilities for positive educational experiences. Improved learning, increased emotional well-being and reduced health risk behaviours are examples of the benefits (St Leger et al. 2009). Data shows that schools are most effective at promoting students' health when students themselves, but also staff, families and community members are actively engaged (WHO 1998). Partnerships with schools are needed to achieve and improve academic and health outcomes, but existing challenges, such as lack of teacher training, have to be recognized and addressed (Hayman 2016).

Although the home–school relationship and parents' role in children's learning processes, in general, have been studied internationally (e.g. Meirieu and Hameline 2000; Bæck 2010; Mackiewicz 2010; Goldking and Farmer 2013; Vuorinen et al. 2014; Mayo and Siraj 2015; Reynolds et al. 2015; Hajisoteriou and Angelides 2016; Mereoiu, Abercrombie, and Murray 2016), relatively little research has focused on health-related collaboration. In addition, a preliminary study (Jourdan 2012, 2013; Pommier, Guével, and Jourdan 2010) showed there are two preconditions for a school to contribute to reducing the health divide. Alongside a 'long term approach', building stronger links between schools and families is important to reduce the gradient of health inequities.

The aim of the present study was to explore the factors having an influence on the home–school relationship in general and in the field of health. The analysis is focused on the socio-economic factors.

Methods

General collaboration and interaction with the school and the child's classroom teacher, respective roles of school and family in relationship to health matters, and the consideration of health at school and at home were investigated via a questionnaire. Socio-economic factors having an influence on these views were also identified and analysed. The methods section presents the context of the study, the sampling, data collection and data analysis processes, and the ethical framework.

Context

The French educational system is highly centralized. Schooling is mandatory from age 6, the first year of elementary school, but almost all children go to school at age 3 (nursery school).

There are two kinds of primary schools: elementary schools (age 6 to 11) and comprehensive schools (nursery school and elementary school from age 3 to 11). France has specific health personnel (nurses and doctors) in schools. Health education is not taught as a separate subject but as a part of citizenship education (FME (French Ministry of Education) 2016). It does not require specialist teachers but is part of the daily activity of all school staff. It is focused on developing students' ability to make enlightened and responsible decisions. The French Ministry of Education (1998, 2574) writes:

> Unlike conditioning, health education aims to help young people gradually build personal capacity in terms of making decisions, adopting responsible behaviour, for themselves and with respect to other people and the environment, it also makes it possible to prepare young people for playing a responsible role in society where health matters are of major concern. (2574)

The current 'official' view of health education in the French education system is that it is integral to the education of the person and the citizen. The school is seen as well placed to contribute to health promotion. Nevertheless, studies have shown that in practice, French schools set a low priority on health education (Do and Alluin 2003).

In France, teachers are trained for three years at different departments of the university to earn a bachelor's degree, followed by a further two years in specific teacher training institutes within the universities. Health and citizenship education are compulsory in the pre-service training programmes, but there are no requirements related to the length of the module, which leads to a wide diversity of situations at the national level in France.

Sample

The study was performed in 2015, in the Auvergne-Rhône-Alpes region in France. The participating schools were randomly selected using cluster randomization on three criteria: socio-economic status (SES), location (urban or rural) and size (small or big). The school database was made available by the regional education authority, and the SES was assessed via the database of the French National Institute of Statistics and Economic Studies (FNISES). The schools were selected randomly in the different clusters except for 'small and urban' and 'big and rural', for which all schools were included (five and six schools, respectively). Schools were then contacted in order to determine whether they agreed to be included. When school staff did not agree to be included (four schools), another school in the same cluster was randomly selected. In total, 37 schools were selected. The researchers were not allowed to access the school databases, so the school principals were requested to ensure that enough parents of fourth- and fifth-grade students (age 9 to 11 years) filled in the questionnaire to have a sufficient sample for the analysis (300 respondents, 10% of the population). The data collection process was stopped after reaching 300 questionnaires. In addition, it is not authorized to keep the data about the SES of the parents in schools' databases in France, so the principals were requested to make sure the diversity of the parents was represented in the sample. Prior to data collection, the investigators met the school staff and provided information about the research.

Instrument and data collection

The 62-item questionnaire was adapted from Sormunen, Tossavainen, and Turunen (2013). It was piloted and used in a school health intervention in 2008–2010, in Finland. For this

data collection, it was translated into French and adapted to the French context, and then it was back-translated by a bilingual teacher living and working in Finland. After a pilot study with 215 French parents, minor modifications were made to ensure that all questions would be correctly understood. Additionally, two district-level inspectors and two school principals reviewed the questionnaire for content relevance.

The questionnaire was aimed at investigating parents' opinions about and experiences with schools and their health education as well as their assessment of schools' health-related practices. It included five main themes: (1) general collaboration and interaction with the school and the child's classroom teacher, (2) health guidance and family routines, (3) learning about health at school and at home, (4) health education at school and (5) health education responsibilities. Two modalities were offered to the parents to fill the questionnaire: online or paper. Demographic data (age, gender) and the parents' occupations were included in the questionnaire.

Data analysis

The data were analysed by the SAS statistical programme (version 9.4) and SPSS 23. Parents' occupations were re-categorized from eight FNISES (2003) categories to three categories – privileged, medium and underprivileged positions. Schools were categorized in three groups based on the total number of classes: small schools (three classes or less), medium (four to seven classes) and large (eight classes or more).

Demographic and social characteristics, and views on the home–school relationship and on health education were obtained using descriptive statistics: means and standard deviations for continuous variables and frequencies for categorical variables. A five-point Likert scale (completely agree – completely disagree) was used for questions related to parents' views, and a visual analogue scale (VAS) was used for describing parents' interest in school health education (from 0, corresponding to no interest, to 10, corresponding to maximal interest) and in describing teachers competence in health issues (from 0, corresponding to no competence, to 10, corresponding to maximal competence). A principal components analysis (PCA) was used to study the relationship between and define scale dimensions. Bivariate analysis, including inferential statistics, was conducted at the .05 level of significance. The multivariate analysis included regressions, which were conducted in attempts to understand and model the relationships between the dependent variables (satisfaction with the home–school relationship and satisfaction with school guidance in health-related matters) and independent variables (social and school-related variables) and to explore what might be causing the variation in the dependent variables.

Ethics

Ethical approval was sought and granted by the ACTé Research Group (EA 4281) for the study in France, and an ethical statement (19/2014) was obtained from the Committee on Research Ethics of the University of Eastern Finland for the whole study. Inspectors at the district level authorized the study, and parents and school staff were informed about the study prior to data collection. Ethical considerations were taken into account in guaranteeing the anonymity of the participants, and they provided verbal consent for participating in the study.

Results

Two hundred and ninety-six questionnaires were included in the analysis, which corresponds to 10.5% of the total population of parents of fourth- and fifth-graders at the 37 schools (n = 2810).

Parents' view on home–school collaboration

At the *school level,* a majority of parents were satisfied with their relationships with their child's school (67%), but 22% did not agree with this item. While, 61% of the parents considered the school to have a policy aiming at improving the home–school relationship, 30% of them considered this not to be the case. A majority of parents (88%) considered that it is easy to contact the school in case of problems or questions (Table 1).

At the *teacher level,* 13% of parents considered that it was not easy to talk to the teacher. Most parents (88%) said that the teacher had welcomed them into the school at other times besides parents' evenings. Over half of the parents (59%) considered the school to organize enough meetings between parents and teachers. According to 23% of parents, the teacher did not tell them about schoolwork-related issues in an understandable way (Table 1).

Parents' satisfaction with their relationship with the school and the teacher was linked to their family's SES. The lower the family's SES, the higher their satisfaction was. Their satisfaction was also linked to the kind of school (it was higher in comprehensive schools than in elementary schools) and the size of the school (the satisfaction was higher when the schools were small) (Table 2).

Parents' view of health education at home and at school

Almost all parents (96%) talked with their child about issues related to health and well-being. Most parents were satisfied with their own home health guidance (only 4% were not) and considered themselves to have enough knowledge concerning health and healthy-lifestyle-related issues (84%). Regarding health education in schools, parents' interest, measured in VAS (0–10 in interest), was 7.09 (±2.37) at mean. The majority of parents (88%) indicated that health education is an integral part of school, but only 34% of them considered it to be one of the school's missions, and only 24% considered it to be a subject as important as maths and language. Less than half (43%) of parents responded that they had talked to the teacher about issues related to their child's health. One-third of parents indicated that the school informed them about health issues that their child was being taught about at school, and 43% were satisfied with the school's health guidance (if the school provided any). Nevertheless, from the parents' point of view, school staff competency regarding health education (VAS 0–10 in competency) achieved a mean score of 5.07 (±2.38). A minority of parents (23%) were considered to be qualified persons among the school staff who could be called upon in the health area. Conversely, 71% agreed that it is interesting for the children when external professionals gave them information about health issues (Table 1).

Contextual variables were correlated with parents' views of health education (Table 3). Parents' interest in and views of staff competency regarding health education were significantly correlated with school satisfaction (in general and in the field of health) and school size and type. The higher the interest and rating of staff competency, the more satisfied the parents were towards the school's action in relationship to health.

Table 1. Description of parents' views on interaction with the school and education about health at school and at home.

		Totally agree	Partly agree	Cannot say	Party disagree	Totally disagree
The school has a policy aiming at improving the home–school relationship	%	25	36	9	22	8
	n	72	105	27	62	22
Parents are encouraged to take an active role in the school community	%	41	36	5	10	7
	n	118	104	15	30	21
I gladly participate in the school's events	%	38	38	11	8	5
	n	108	110	31	24	15
It is easy to contact the school in case of problems or questions	%	55	33	3	8	1
	n	158	94	9	24	4
I am satisfied with my relationship with the school	%	29	38	10	13	9
	n	84	109	30	38	25
School offers meetings about parents' role	%	5	12	18	30	35
	n	13	35	51	87	102
I am regularly in contact with the teacher	%	26	33	6	23	12
	n	74	96	16	67	35
There are enough meetings between parents and teachers	%	17	42	8	22	10
	n	50	121	24	63	30
It is easy to talk to the teacher	%	48	34	5	10	3
	n	138	96	15	29	8
The teacher tells about schoolwork-related issues in an understandable way	%	34	36	9	15	8
	n	97	103	25	42	22
The teacher welcomes me into the school at other times than just parents' evenings if necessary	%	52	36	7	3	2
	n	149	103	21	10	6
Teacher contacts us in various ways	%	31	34	9	20	6
	n	88	97	27	58	18
School informs me of the health issues my child is being taught about at school	%	8	25	17	31	18
	n	24	72	49	88	52
I am satisfied with the school's health guidance (if the school provides any)	%	15	28	49	4	5
	n	42	80	138	10	13
I talk with the teacher about the health and well-being of my child	%	18	25	15	24	18
	n	53	71	43	69	52
I am satisfied with our home health guidance	%	45	44	6	3	1
	n	130	128	17	10	4
I consider I have enough knowledge concerning health and healthy-lifestyle-related issues	%	47	37	7	7	2
	n	135	108	19	19	7
In our family, I talk with my child about health and well-being-related issues	%	55	41	3	0	1
	n	158	118	9	1	2

Table 2. Bivariate analysis on parents' views and contextual variables.

				School's staff competency in relationship to health matters[a]	Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]		Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
Total		Mean/%	7.09	5.07	54%	29%	17%	44%	56%	53%	24%	23%	18%	32%	51%	61%	39%
		SD/*n*	2.37	2.38	131	71	40	127	162	154	69	66	51	91	147	175	141
The school has a policy aiming at improving the home–school relationship	Mean	3.50	0.2	0.45	3.45	3.38	3.50	3.64	3.39	3.58	3.46	3.35	3.80	3.58	3.34	3.31	3.78
	p	(288)	**0.0392**	**<0.0001**		0.0900		0.1231			0.3906			0.0562		**0.0021**	
School encourages me to take an active role in the school community	Mean	3.93	0.10	0.36	3.92	3.79	4.13	4.19	3.73	4.12	3.84	3.58	3.92	3.95	3.92	3.71	4.27
	p	(288)	0.1035	**<0.0001**		0.4928		**0.0003**			**0.0020**			0.9536		**<0.0001**	
I gladly participate in the school's events	Mean	3.94	0.09	0.34	4.05	3.83	3.95	4.06	3.86	3.95	4.01	3.85	4.12	3.82	3.96	3.84	4.11
	p	(288)	0.1296	**<0.0001**		0.4662		0.3276			0.6792			0.5094		0.1129	
It is easy to contact the school in case of problems or questions	Mean	4.31	0.17	0.44	4.28	4.17	4.52	4.41	4.23	4.36	4.43	4.06	4.55	4.40	4.17	4.22	4.45
	p	(289)	**0.0050**	**<0.0001**		0.2006		0.0519			**0.0489**			0.0875		**0.0145**	
I am satisfied with my relationship with the school	Mean	3.66	0.17	0.50	3.57	3.56	4.20	3.85	3.51	3.71	3.66	3.54	4.10	3.63	3.53	3.45	3.97
	p	(286)	**0.0039**	**<0.0001**		**0.0102**		**0.0343**			0.6318			**0.0143**		**0.0005**	

(*Continued*)

Table 2. (*Continued*).

					Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]	School's staff competency in relationship to health matters[a]	Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
The school offers actions around parents' role	Mean	2.20	0.13	0.40	2.05	2.17	2.70	2.35	2.09	2.24	2.10	2.21	2.41	2.16	2.15	1.99	2.53
	p	(288)	**0.0283**	**<0.0001**		**0.0154**		0.0669			0.6275			0.6316		**0.0004**	
The school informs me of the health issues my child is being taught about at school	Mean	2.75	0.16	0.50	2.74	2.54	3.26	2.87	2.65	2.87	2.62	2.58	2.78	2.87	2.66	2.59	2.98
	p	(285)	**0.0086**	**<0.0001**		**0.0188**		0.1009			0.1831			0.4710		**0.0076**	
I am satisfied with the school's health guidance (if the school provides any)	Mean	3.45	0.200	0.540	3.40	3.44	3.51	3.58	3.35	3.48	3.43	3.40	3.33	3.40	3.52	3.30	3.68
	p	(283)	**0.0012**	**<0.0001**		0.6011		**0.0290**			0.9433			0.6483		**0.0008**	
I am regularly in contact with the teacher	Mean	3.37	0.13	0.39	3.24	3.41	3.82	3.46	3.30	3.38	3.36	3.36	3.61	3.41	3.27	3.20	3.64
	p	(288)	**0.0356**	**<0.0001**		**0.0478**		0.3603			0.9771			0.2725		**0.0078**	
There are enough meetings between parents and teachers	Mean	3.34	0.11	0.39	3.35	3.14	3.62	3.55	3.18	3.49	3.29	3.05	3.78	3.29	3.22	3.18	3.59
	p	(288)	0.0656	**<0.0001**		0.1791		**0.0218**			0.0664			**0.0131**		**0.0068**	

It is easy to talk to the teacher	Mean	4.14	0.10	0.35	4.03	4.09	4.63	4.22	4.08	4.17	4.26	3.95	4.39	4.20	4.02	4.04	4.30
	p	(286)	0.1025	**<0.0001**		**0.0090**		0.5390			0.1080			0.0944		**0.0422**	
The teacher tells me about school-work-related issues in an understandable way	Mean	3.73	0.17	0.41	3.65	3.52	4.27	3.87	3.62	3.78	3.65	3.70	3.90	3.75	3.66	3.55	4.00
	p	(289)	**0.0044**	**<0.0001**		**0.0156**		0.1917			0.8015			0.5179		**0.0101**	
The teacher welcomes me into the school at other times than just parents' evenings if necessary	Mean	4.31	0.13	0.28	4.28	4.31	4.55	4.39	4.25	4.34	4.29	4.27	4.49	4.32	4.24	4.23	4.44
	p	(289)	**0.0269**	**<0.0001**		0.3542		0.1713			0.5725			0.3920		**0.0323**	
The teacher contacts us in various ways	Mean	3.62	0.06	0.37	3.50	3.50	4.30	3.82	3.47	3.68	3.47	3.65	3.63	3.62	3.62	3.38	3.99
	p	(288)	0.3099	**<0.0001**		**0.0008**		**0.0360**			0.4827			0.9314		**<0.0001**	
I talk with the teacher about the health and well-being of my child	Mean	3.01	0.16	0.46	2.93	2.96	3.63	3.25	2.83	3.03	2.91	3.08	3.14	3.04	2.95	2.76	3.40
	p	(288)	**0.0096**	**<0.0001**		**0.0164**		**0.0116**			0.7637			0.6878		**0.0001**	
I am satisfied with our own home health guidance	Mean	4.28	0.08	0.20	4.29	4.18	4.50	4.38	4.20	4.35	4.30	4.09	4.35	4.27	4.26	4.20	4.40
	p	(289)	0.1970	**0.0010**		0.2585		0.0664			0.4795			0.6711		0.0672	

(*Continued*)

Table 2. (*Continued*).

					Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]	School's staff competency in relationship to health matters[a]	Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
I consider I have enough knowledge concerning health and healthy-life-style-related issues	Mean	4.20	0.10	0.17	4.34	3.96	4.33	4.31	4.11	4.27	4.17	4.06	4.31	4.19	4.16	4.12	4.32
	p	(288)	0.1012	**0.0037**		0.1611		0.1465			0.4495			0.6439		0.1012	
In our family, I talk with my child about health and well-being-related issues	Mean	4.49	0.19	0.06	4.47	4.56	4.58	4.47	4.51	4.52	4.51	4.40	4.68	4.47	4.44	4.50	4.47
	p	(288)	**0.0018**	0.3339		0.6932		0.9260			0.4372			0.0577		0.7378	

[a]Scale from 0 to 10 for these variables the means are replaced by Spearman correlation coefficients.
[b]Elementary schools from grade 1 to 5 (age 5 to 11) and comprehensive schools (nursery school and elementary school from age 3 to 11).
The bold values are significant at $p < .05$.

Table 3. Bivariate analysis on parents' views of health education and contextual variables.

					Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]	School's staff competency in relationship to health matters[a]	Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
Health education is one of the school's missions	% of yes	88%	4.18/7.54	2.97/5.37	87%	87%	92%	88%	88%	87%	87%	92%	90%	88%	87%	88%	87%
	p	(273)	**<0.0001**	**<0.0001**		0.6531		0.8532			0.5137			0.9174		0.7197	
The school must implement the national health recommendations	% of yes	60%	7.33/7.69	5.30/5.40	54%	61%	72%	66%	55%	30%	14%	19%	60%	54%	63%	60%	59%
	p	(234)	0.0924	0.7946		0.1545		0.0978			0.2283			0.4097		0.8091	
Health education is a theme as important as French or mathematics	% of yes	24%	7.20/8.55	5.30/5.52	22%	26%	25%	24%	24%	36%	33%	30%	21%	14%	31%	23%	26%
	p	(234)	**<0.0001**	0.4018		0.8257		0.9139			0.0528			**0.0263**		0.5851	

(*Continued*)

Table 3. (*Continued*).

				School's staff competency in relationship to health matters[a]	Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]		Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
Health education is important for children	% of yes	67%	6.96/7.83	4.86/5.60	69%	55%	86%	69%	66%	70%	65%	61%	71%	56%	72%	65%	70%
	p	(234)	**0.0012**	**0.0251**		**0.0054**		0.6316		0.4931				0.0742		0.4935	
There are qualified persons among the school staff who can be called upon in the health area	% of yes	23%	7.41/7.90	5.12/6.17	22%	19%	36%	25%	21%	22%	22%	25%	21%	18%	26%	23%	23%
	p	(234)	0.1259	**0.0007**		0.1406		0.4007		0.9244				0.4499		0.9837	

(*Continued*)

Table 3. (*Continued*).

					Parent's SES			Area		School context			School size			School type	
		Total	Interest on health education[a]	School's staff competency in relationship to health matters[a]	Privileged	Medium	Underprivileged	Rural	Urban	Privileged	Medium	Underprivileged	Small	Medium	Large	Elementary[b]	Comprehensive[b]
It is interesting for my child that external professionals intervene on specific health topics	% of yes	71% (234)	7.31/7.64	5.49/5.30	72%	66%	75%	71%	72%	76%	67%	65%	76%	69%	71%	70%	73%
	p		0.2061	0.6019		0.5973		0.8451			0.2658			0.7104		0.6666	

[a]Scale from 0 to 10 for these variables the percentage of 'Yes' answers was replaced by means of interest and competency for those who answered Yes vs. those who answered No.
[b]Elementary schools from grades 1 to 5 (age 5 to 11) and comprehensive schools (nursery school and elementary school from age 3 to 11).
The bold values are significant at $p < .05$.

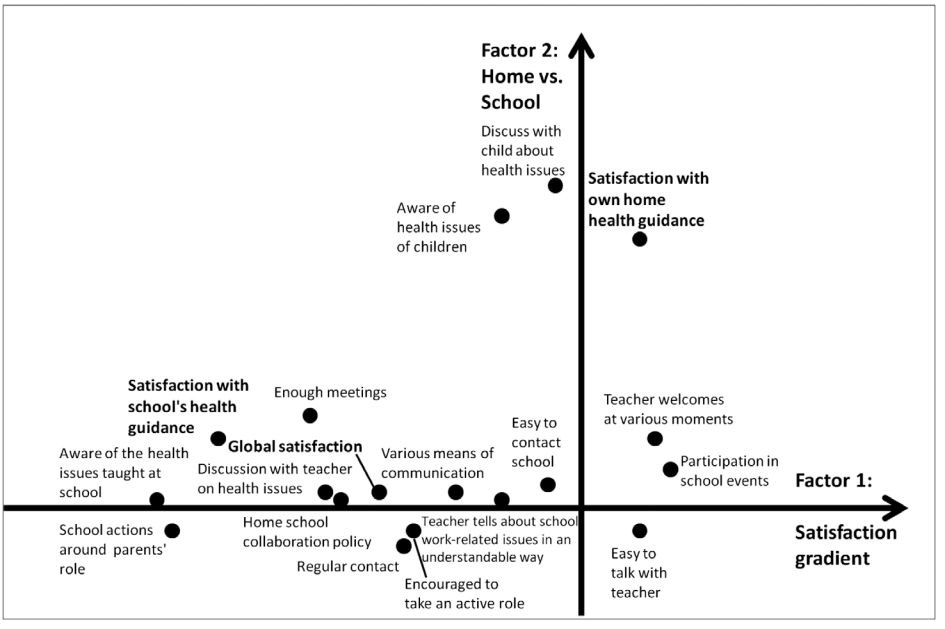

Figure 1. Principal component analysis.

Principal component analysis in Figure 1 represents the associations between the variables in a two-dimensional space. The first factor is related to the degree of satisfaction with lower levels of satisfaction shown on the left and higher levels on the right. Variables describing the relationship in the field of health education are on the left, showing that between 17 and 43% of parents were satisfied. Variables describing the home–school relationship in general are on the right, showing that between 59 and 88% of parents were satisfied. The second factor distinguishes items associated to school from those associated to home. Variables linked to health education at home are not related to those linked to health education in schools. In addition, these variables are mostly located in the part of the diagram corresponding to the highest level of satisfaction.

Multivariate analysis, namely a regression on satisfaction with the collaboration between home and school ($R^2 = 0.42$), yielded four factors that emerged as the most important determinants of parents' satisfaction: (1) school staff's competency in relation to health matters, (2) parents' SES, (3) school size and (4) school type. A regression on satisfaction with the school's health guidance ($R^2 = 0.22$) was also conducted (Table 4). Two factors emerged as the most important determinants of parents' satisfaction: (1) school staff's competency in relation to health matters and (2) school type.

Discussion

The aim of this study was to identify and understand the factors having an influence on the home–school relationship in general and in the field of health. In particular, the socio-economic factors in this relationship were examined. Two main findings emerged from the data: (1) parents' views on the home–school relationship were generally positive, but a group of parents did not find themselves connected with their child's school optimally, and the lower

Table 4. Multivariate regressions on parents' satisfaction with the home–school collaboration and the school's health guidance.

	'I am satisfied with the collaboration between home and school' ($R^2 = 0.42$)			'I am satisfied with the school's health guidance' ($R^2 = 0.22$)		
	OR	95% CI	*p*-value	OR	95% CI	*p*-value
School competency on health education[a]	1.762	(1.553–2.000)	<0.0001	1.451	(1.304–1.615)	<0.0001
Parent's socio-professional category						
Underprivileged vs. Privileged	3.318	(1.565–7.036)	0.0018			
Underprivileged vs. Medium	2.645	(1.185–5.905)	0.0176			
Size of school						
Small vs. Medium	3.342	(4.556–7.178)	0.002			
Small vs. Large	3.982	(1.947–8.143)	0.0002			
School type						
Comprehensive vs. Primary[b]	2.338	(1.405–3.890)	0.0011	2.03	(1.262–3.265)	0.0035

[a]Scale from 0 to 10 OR is for a one-unit increase in the scale.
[b]Elementary schools from grades 1 to 5 (age 5 to 11) and comprehensive schools (nursery school and elementary school from age 3 to 11).

the family's SES, the higher their satisfaction was, and (2) parents regarded health education to belong at school, but did not indicate it to be an important school subject. Additionally, they rated the perceived competence of school staff in health education as low.

These findings partially reflect previous international research illustrating that parents' views on the home–school relationship varied according to their SES. Parents with lower SES felt it was easier to talk with their child's teacher than parents with higher SES, perceived the teacher to tell them about schoolwork-related issues in an understandable way more than parents with higher SES did, and were generally more satisfied with their relationship with their child's school than parents with higher SES were. When looking at the phenomenon of the home–school relationship in general, parents in this study had mixed opinions, which is coherent with the literature (Meirieu and Hameline 2000).

Examining parental satisfaction with the home–school collaboration from the viewpoint of *school context*, the school size and school type appear to have an influence. Parents' satisfaction with their relationship with the school increased when the school was smaller. This finding is supported in the literature (e.g. Goldking and Farmer 2013). Parents' satisfaction was higher in schools that enrolled children aged 3–11 (comprehensive school) compared to elementary schools that enrolled children aged 6–11. The advantages of comprehensive schools were observed in several variables, such as school's encouragement for parents to take an active role in the school community or how easy parents found it to contact the school with problems or questions. This interesting finding can be at least partially explained by the longer and more intensive relationship between comprehensive school teachers and family, as well as the familiar environment (Mackiewicz 2010). This is confirmed in a previous study showing that at the preschool level, the teachers focus on parents as individuals, which might increase their ability to collaborate with diverse parents and to develop good relationships with all parents, regardless of their background (Vuorinen et al. 2014).

Moving to the theme of health, the key finding was that the parents perceived the competence of their child's school to be low regarding teaching of health issues (see Hayman 2016). Moreover, while the majority of parents considered that health education belongs in school, less than one-fourth indicated it as a theme as important as mathematics and language. Since health education is implemented differently in various countries (Aira et al. 2014) – either as an independent school subject that has its own status or from a broader perspective as part of citizenship education, like in France – parents may consider it less important compared to other subjects. Most parents in this study regarded external professionals as suitable health instructors for their children instead of their teachers, reflecting the importance of, for example, school nurses and other health professionals, but also clearly narrowing the competence of teachers. The importance of health education at schools, however, needs to be emphasised, and parents' conceptions about teachers' lack of competence requires deeper investigation.

When correlating parents' perceptions on health issues with their SES, the findings suggest that parents in the lower SES group spoke with teacher about their child's health and well-being more than parents with higher SES. Children from lower income families have been found to be academically less achieving than their peers from more wealthy homes (e.g. Mayo and Siraj 2015), and therefore, teachers may have more regular contact with low-SES parents, as this study also brings out. In addition, problems can also occur related to such children's health and well-being, since the home environment may not be optimal for their development; in the study of Tandon et al. (2012) lower SES home environments were found to have a passive effect on children. Teachers, therefore, may bring up these issues in discussion with parents, particularly if the consequences are observable at school in the form of physical or mental symptoms, such as tiredness, obesity or bullying behaviours. SES-related disparities in the home–school relationship have been supported by previous findings; for example, Bæck (2010) concludes in her study that highly educated middle-class parents may be a threat to teachers' professionalism and cause challenges in teachers' daily work. When interacting with less educated families, teachers may feel as though they have more academic authority.

Possible limitations to this study include the sampling method and the response rate. The schools were randomly selected, but the parents in the schools were not. This is linked to the fact that by law (which separates the public and private domains), French schools cannot have information about families' SES in their databases. This is why principals were associated with the selection process for the respondents, since they have the best knowledge of the diversity in parents' SES at the school level. The dropout rate is close to what is generally observed in similar studies in France (e.g. Grisay et al. 1990), since it is not possible to compel parents to fill out questionnaires, and there is a real mistrust about the surveys and the use of the data, even if there is a solid ethical framework. Additionally, many parents consider it a risk to criticize a teacher or the school in a questionnaire. The results are strong, and the relevance of the data is high, since this is the first of its kind in France but its representativeness is limited by the legal and social context.

Conclusion

The current study adds to the evidence regarding the settings for children's health promotion. The findings suggest that the parents' views on the home–school relationship were generally

positive. However, a group of parents did not find themselves to be optimally connected with their child's school, which is of particular importance for teachers and administrators, since it highlights the active role of schools in reaching out to parents in various ways. According to the results, lower SES positively related to satisfaction towards the school as well as parents' confidence in discussing their child's health and well-being issues with the teacher, indicating that these families experienced encounters with schools in a positive way. This is an extremely important sign in terms of decreasing health disparities and can be used to confirm the influential role of schools from a larger perspective.

The parents in this study did not see health education as an important school subject, which most likely implies the lacking status of health education as an independent school subject in French curricula (in comparison to other European countries where it is a subject, e.g. in Finland). In that light, this finding is understandable and also reflects the perceived lack of competence among school staff in health education.

To facilitate settings in which the health of children is a common priority, a partnership ideology with ample reciprocal communication and participation has to be implemented and pursuit. In this aim, staff training remains a critical issue. Further studies are needed to investigate the parents' views on health-related collaboration and to identify the efforts of schools to engage parents in a reciprocal relationship.

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