

CHAPTER 2

THE ESSENCE OF HEALTHY SCHOOL ENVIRONMENTS

2.1. INTRODUCTION

This chapter addresses the literature that informed the study as a whole. The chapter also, highlights the building blocks that support the creation of healthy school environments which are: health policies, health education, community involvement, nutrition, educator and learner involvement, and prevention of communicable diseases. Health programmes, health committees, leadership, and management and school culture are examined and discussed. The exploration of these crucial building blocks helped in understanding the rationale behind the creation of healthy school environments.

Scherz (2006: 28) purports that the creation of healthy school environments can be viewed as collective awareness of the factors that influence both the internal and external environments. This awareness is used towards an active pursuit of improvement in areas identified and agreed upon by the collective membership of the constituents within that system. For schools to be on top of the situation as far as the creation of healthy school environment is concerned, there is a need to understand the concept of healthy school environments.

2.2. HEALTHY SCHOOL ENVIRONMENTS

California Department of Education (2003: 3) and Garrett (2001: 64) define a healthy school as a place where teachers can teach and learners can learn in a welcoming environment. It is an educational setting where the climate promotes a spirit of acceptance and care for every child, where behaviour expectations are clearly communicated, consistently enforced, and fairly applied. A healthy school according to Hampshire Country Council (2009: 1), promotes physical and emotional health by providing accessible and relevant information and equips learners with the understanding, skills and attitudes to make informed decisions. It is a school that

understands the importance of investing in health to help learners do their best, raise levels of achievement and improve standards. The term 'health promoting schools' according to the World Health Organisation (2006) was developed to recognise educational institutions that constantly strengthen their capacities as healthy setting for living, learning and working.

Denman, Moon, Parsons and Stears (2002: 37) state that such physical aspects as ventilation, lighting and heating, state of buildings, sanitation facilities including clean toilets, smoking and nutrition policies and practice, access to clean and fresh drinking water throughout the day all contribute to the health and well-being of all those in schools. The United Nations Children's Fund (2009: 5) concurs with the above explanation adding that child-friendly schools and learning spaces mitigate the health problems by creating a healthy school environment that provides proper hygiene and by implementing life skills-based health and environmental education and by providing health and nutrition services as an integral part of schooling.

Barnekow, Branca, Collins, Izaki, Micko, Robertson and Veerbeek, (2006: 48) argue that it is schools' responsibility to provide a highly effective and efficient environmental setting for establishing healthy attitudes. California Department of Education (2003: 62) adds that the primary focus of environmental health is to make learners aware of how environmental issues affect their personal health. The school has to focus on specific steps that learners can take as individuals and citizens to protect and improve the environment. A number of health conditions are either caused or exacerbated by environmental factors.

Schools provide an ideal setting to improve health and nutritional knowledge and boost the ability of children to make informed choices. The school context offers a great possibility to reach large numbers of the population, including youth and staff members at school as well as families and community members. Hence, health messages learnt in school can be maintained and pursued by children at home and in their surroundings (World Health Organisation, 2000b: 3).

Healthy school environments are essential for learning, and all environmental problems should be dealt with to allow learning to continue unhindered. A school that minimizes health risks potentially minimizes the number of sick days for learners and staff members, putting that school in a better position to become a high performing facility (Grevatt, 2011: 30).

The United Nations Children's Fund (2009: 5) maintains that retaining a culture of clean, healthy environments means that school principals and educators should be committed to programmes that involve children in maintaining sanitary hand washing and drinking-water facilities and toilets. Mokhobo (2007: 9), when talking about the negative impact of poverty on the health of schools, indicates that filthy conditions, malnutrition, and diseases are rife in black areas, with school-going and other children being the most vulnerable. He further argues that, life in informal settlements is horrible and appalling, with lack of sanitation, sewerage and drinkable water. It is estimated that 76% of inhabitants of these settlements are striving to lead healthy lifestyles (Baumann, 2004: 7). Overcrowding in schools, a lack of infrastructural facilities is a severe threat and it impacts negatively on the well-being and wellness of the whole school population.

The World Health Organisation (1995: 4) advocates the Whole School Approach to health promotion at schools. The strategies used in the Whole School Approach are discussed below.

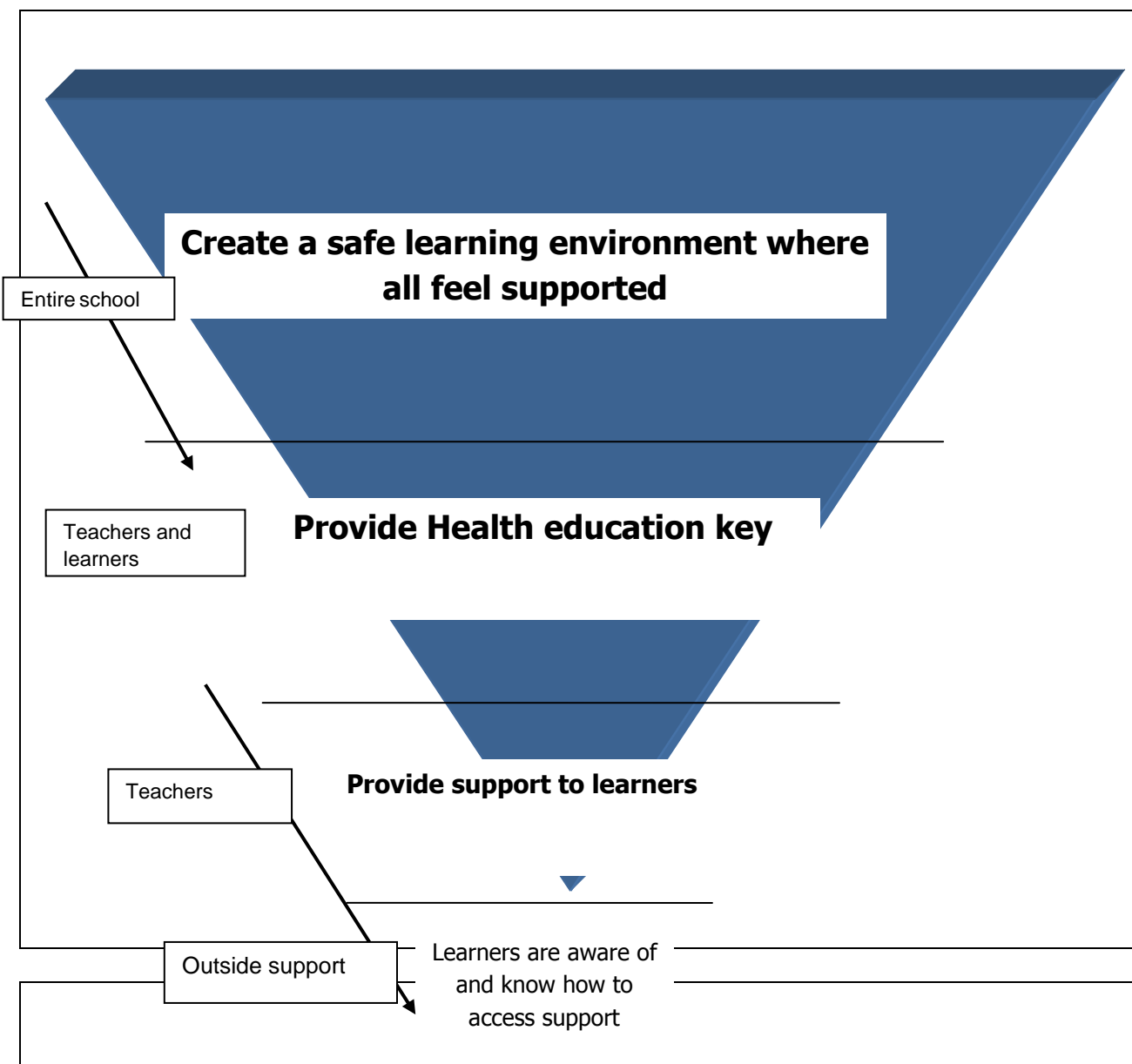
2.3. THE WHOLE SCHOOL APPROACH TO THE CREATION OF HEALTHY ENVIRONMENTS

The National Healthy Schools Programme (2007: 4) indicates that the whole school approach provides a model to support change and development involving learners, school staff and parents. It also provides a solid foundation from which developments and improvements are embedded in a systematic way throughout the school and effectively contribute to the physical and emotional health and well-being of all members of the community. The National Healthy Schools Programme (2007: 10) further states that at the heart of the Whole School Approach is a process which identifies needs,

develops actions and implements changes, ensuring that they are relevant and grounded in the ethos of the school and the needs of the local community.

Figure 2.1 below shows an adaptation of the World Health Organisation model. The four levels of the World Health Organisation model represent the multi-levels that encompass a Whole School Approach to the creation and maintenance of healthy environments in schools.

Figure 2.1: Whole School Approach model



Source: Adapted from the World Health Organization (1995)

The top level of the triangle puts emphasis, not only on the creation of a healthy school environment that is conducive to learning, but also on the involvement of the wider community. Partnership with the community in an effort to maintain healthy environments is discussed in detail in section 2.4.3.

The second level of the triangle emphasizes the need to educate all learners about health and well-being. It must be noted that the knowledge that learners gain should influence behaviour change. Efforts to integrate health into the school curriculum have been attempted in South Africa. Health education at schools includes the formal curriculum whereby learners experience learning opportunities which help them gain knowledge and skills to support others. Both educators and learners are actively involved (World Health Organisation, 2006: 22). The importance of Health Education in the development of Healthy school environments is discussed in detail in section 2.4.2.

The third level of the triangle points to the need for interventions and programmes to support learners with high health and well-being needs. There are two types of interventions according to Wyn, Cahill, Holdsworth, Rowling and Carson (2000: 595): those that are selective and those that are indicated. The selective programmes target learners who are the most in need and who are at risk, for example, those who are abused, traumatized, sick, neglected and vulnerable. The National School Nutrition Programme is a selective programme in that it targets learners who are from poverty stricken areas. Indicated programmes focus on learners who have early or mild signs of a disorder but have not yet presented at clinical levels. The initiatives targeted to assist learners may include peer support groups, counselling and guidance, and drug and alcohol programmes (Wyn *et al.*, 2000: 595). National interventions and programmes are discussed in detail in section 2.5.

The last level of the triangle indicates the need for professional support that is more individually focused. This kind of support may involve school counselling services or referral to community health centers and medical professionals (Wyn *et al.*, 2000: 596).

According to Young (2008), evidence shows that a whole-school approach, where there is coherence between school policy and practice, promotes social inclusion and commitment to education and actually facilitates improved learning outcomes, increases emotional well-being and reduces health risk behaviours. The creation of a healthy school environment is a multi-pronged, multi-layered and multi-strategy undertaking. The strategies used at schools to promote healthy environments are discussed in the section below.

2.4 STRATEGIES IN PROMOTING HEALTHY SCHOOL ENVIRONMENTS

The strategies that are addressed in this section include the development of policies (*cf.* 2.4.1) to guide the implementation of strategies, health education (*cf.* 2.4.2), community engagement (*cf.* 2.4.3), school nutrition (*cf.* 2.4.4), staff and learner involvement (*cf.* 2.4.5; 2.4.6), prevention of communicable diseases (*cf.* 2.4.7) and physical activity (*cf.* 2.4.8). The figure below summarises the determinants of health promotion.

Figure 2.2: Determinants of health promotion



The diagram indicates that these strategies are intertwined to such an extent that one strategy relies on all others to be effective. This could mean that educators depend on the availability of programmes such as school nutrition and the support of the

community and learners to work efficiently. Thus, health promotion at schools depends on the social model of health promotion emphasizing the needs of the individual at the centre of the entire organization and creating a supportive setting which helps in influencing the perceptions and actions of all involved (European Network of Health Promoting Schools, 2006).

2.4.1 Legislative framework

The situation in South African Schools is that the quest for a healthy school environment is propelled by way of directives and guidelines, emanating from the supreme law of the country, the constitution. The constitution of the Republic of South Africa, in the Bill of Rights, gives a clear guidance on the rights citizens have in relation to their environment. The constitution of the Republic of South Africa (SA, 1996a) says that everyone has the right to an environment that is not harmful to their health or well-being. This indicates that citizens, including learners, have a constitutional right to a healthy environment. It is therefore, the child's constitutional right to learn in an environment that will enhance their health and well-being. The constitution (SA, 1996a) further states that every child has a right, not to be required or permitted to perform work or provide services that place at risk the child's well-being, education, physical or mental health or spiritual, moral or social development. The learner therefore has a right not to be placed in any physical or mental health risk of any kind. Everything that is done at school should take into consideration that the well-being of the learner comes first. The constitution (SA, 1996a) indicates that a child's best interest is of paramount importance in every matter concerning the child. Taking into account that children spend most of the time at school, this presupposes that they should be kept in healthy environments that ensure their well-being and the cultivation of their maximum potential.

In the quest of creating a healthy school environment the National Policy on HIV/AIDS (SA, 1996b) provides a policy on HIV/AIDS, which must be implemented to keep the school environment healthy and eliminate infections. HIV/AIDS is one of the major challenges in South Africa. The national prevalence according to a study conducted by

the Department of Health in 2010 (Department of Health, 2010) was at 30 per cent while in the Mpumalanga province where this study was conducted was at 35.1 per cent. The National Policy on HIV/AIDS (SA, 1996b) therefore, seeks to contribute towards promoting effective prevention and care within the context of the public education system. The policy further states that the Governing Body of a school may develop and adopt its own implementation plan to give an operational effect to the national policy.

Another policy initiative aimed at addressing children's health needs is the National School Health Policy (SA, 2003). Specific objectives of this policy are outlined as follows: support the school community to create a Health Promoting School; address health barriers to learning; provide preventative and promotive services that address the health needs of school going children; and support educators in their school health activities in the classroom and the in the curriculum.

According to policy guidelines for youth and adolescent health (SA, 2001: 5), the two strands that weave through these policy guidelines include preventing and responding to specific health problems in adolescents and youth, and promoting the healthy development of all adolescents and youth. Healthy development includes the development of capacities, attributes and opportunities that promote the health of young people.

Aspects that can be used as a checklist in ensuring a consultative and inclusive process in the development of school policy are discussed below.

2.4.1.1 Policy development process

The National Healthy Schools Programme (2007: 18) argues that developing a health policy sets the strategic direction of the school in relation to health promotion. The rationale for the development of policies is to raise the profile of a school and to provide the philosophy and principles which underpin the way things are to be done. The process of developing or reviewing a policy is as important as producing the final document to ensure it does not become a paper exercise carried out in isolation of the

school community. This means trying to ensure that the process is inclusive (including all stakeholders, educators, learners, parents, school managers and the community members) and is developed in a way that enhances the emotional wellbeing of all those involved in its development (Crouch & Mabogoane,1998).

According to Scherz (2006: 66), policies and procedures are important determinants for organizational culture in that the rules and guidelines influence the attitudes and behaviour of the staff members and learners. An organization may be described as employee friendly when policies and procedures are not rigid or stifling. When the policies support the mission of the school and have been well thought through, there is greater clarity for the intentions of the school. Garrett (2001: 69) supports this, when he says, policies on health not only must be clearly communicated to learners and their parents but also enforced fairly through disciplinary action consistently and equally applied. The California Department of Education (2003: 3) indicates that, an organized set of policies, procedures, and activities developed and implemented through a collaborative effort that includes parents, the school, and the community is needed. The system is designed to protect and promote the health and well-being of learners and staff members.

The California Department of Education (2003: 39) further states that, a clearly stated policy that defines the coordinated school health system and expresses support for this system can greatly facilitate effective implementation. Specific district policies on a variety of health-related issues can be reviewed for their consistency with the coordinated school health system and incorporated into the school policy. Addressing all health issues in one broad policy helps ensure consistency and facilitates review and revision when necessary. Denman *et al.* (2002: ix) purport that education operates synergistically with policy development. Without the supportive environment provided by health policies, education may achieve relatively little.

The European Network of Health Promoting Schools (2006: 41) argue that policy acquaints the public with the position of the school and encourages citizen involvement in educational affairs. The authors indicate various reasons for the implementation of

policies, these include that: the policy provides a reasonable guarantee that there will be consistency and continuity in the decisions that are made under it; it informs the principal what s/he may expect from the governing body and what the body may expect from him/her; it creates the need for developing a detailed programme in order to be implemented; the policy provides a legal reason for the allocation of funds and facilities in order to make policy work; and it establishes an essential division between policy making and policy administration.

According to Van Deventer and Kruger (2010: 92), a policy should be printed, with copies available for all members of the staff and for all stakeholders. Van Deventer and Kruger (2010: 92) say that policy consists of a series of plans, for instance, general statements or interpretations that guide the thinking of the management team when making decisions. Since policy guides decision making, it follows that some discretion must be granted to those who will implement the policy. If this is not granted, the policy would simply have been formulated as rules.

Procedures are plans that establish a method for handling future activities that are repetitive by nature. They are guides to action, rather than to thinking, and they detail the exact manner in which certain activities must be accomplished. Rules spell out exactly what should be done, allowing discretion. They are usually the simplest type of plan. Rules should be regarded as specific instructions or fixed decisions which cannot be ignored. Rules and procedures, by their very nature, are designed to repress thinking; they should only be used when people in a school cannot use their own discretion (Honig, 2006).

Policy making is never a once off planning action. The education environment is dynamic and changing and planning therefore, is a continuous management task. Policy making creates broad general guidelines which implies planning and is related to aims, and based on values. Policy making influences the management task of the educational leader and manager, has long term validity, involves utilization of resources and is also a dynamic and social action. Policy, procedures and rules are formulated to address

problems and decisions which occur repeatedly in organizations (Van der Vegt, Smyth & Vandenberghe, 2001: 10).

The National Healthy Schools Programme (2007: 19) indicates the following as imperative in the process of policy development, and in ensuring that stakeholders play a meaningful role in:

- ensuring that the policy reflects the ethos of the school;
- involving all learners, including those who are less vocal and visible;
- involve all staff members and ensure that there is a cross representation of roles;
- involving parents and the wider community;
- discussing and defining the roles and responsibilities of the whole school community so that everyone can be clear about the relevance of the policy area for them;
- ensuring that the policy is available for all to refer;
- ensuring that monitoring procedures are in place to monitor and evaluate the process and amend the policy where necessary; and
- determine when the policy is to be reviewed.

The Grant Makers for Education (2011: 3) say that organizations encounter problems in following policies down to the ground. Van Deventer and Kruger (2010: 91) state that in the school situation a policy usually means some general plan or action that is designed to achieve a particular aim of the school. It may contain guidelines as to how persons should exercise their powers and make decisions. A policy also reflects the values that will be taken into account in making decisions. A school policy therefore serves as a guide for making management, functional and administrative decisions, and it reflects the school's value system. Kraak and Young (2002) further state that a distinction needs to be made between the policy making functions of the governing body and those of the professional management team of a school. The management team in a school is responsible for policy making regarding professional tasks such as day to day administration and organization of teaching and learning in the school, assessment, the

intra mural curriculum, activities that assist teaching and learning during school hours, which textbooks and educational equipment to buy, and determining the timetable. The policy making functions of the governance of a school, on the other hand, lies with the school governing body and includes the admission policy, language policy, rules about religious observances, a code of conduct for learners, and the rights and responsibilities of stakeholders (Sayed & Jansen, 2001).

There are challenges in the implementation of health policies at schools. A study conducted by Jayasundar (2010: 42) indicated challenges such as lack of parental involvement in school health matters; ideological differences amongst actors/stakeholders regarding the value of school health services; and the lack of a dedicated budget for school health services. A study conducted by Múkoma and Flisher (2004) concur with the last challenge in Jayasundar's (2010: 42) study indicating issues such as funding as barriers to implementing and sustaining the interventions and questions around teachers' commitment. Furthermore, continuity of the health promoting schools' initiatives were raised in studies conducted by Samdal (1999), Turunen *et al.* (1999) and Jamison *et al.* (1998).

2.4.2 Health Education

The California Department Education (2003: 3) indicates that one component of a coordinated school health system includes the development, delivery, and evaluation of a planned, sequential curriculum for students in lower grades through grade twelve and for parents and school staff. It is also designed to influence positively people's knowledge, attitudes, skills, and behaviours related to health. Greenberg (2001: 67) argues that when a well-designed curriculum and a supporting structure are available, the goal of health education for all learners is realistic and achievable.

In addition, Hochhauser (2003: 23) says, health education is integral to a coordinated school health system. A well-designed health curriculum for learners in lower grades through grade twelve offers abundant opportunities for engaging learners and involving them in meaningful learning experiences. The curriculum should provide learners with

opportunities to explore concepts in depth, analyze and solve real-life problems, and work cooperatively on tasks that develop and enhance their conceptual understanding. It also provides learners with the knowledge and skills that can lead to lifelong positive attitudes and behaviours related to health. According to Greenberg (2001: 67), not all learners learn in the same way, nor are they motivated by the same factors. Therefore, a variety of teaching strategies, both teacher-directed and learner-centred, should be used in health education. Activities should provide learners with a common experiential base. The National Health Schools Programme (2007: 20) says, curriculum planning and resourcing, including work with outside agencies enables schools to consider how the values, policies and practice that enhance physical and emotional health and well-being are planned and implemented through the school curriculum, both formal and informal.

Schools have a significant influence on children's health behaviour (American Academy of Pediatrics, 2000). Effective school health education teaches children what healthy and unhealthy behaviours are and the consequences of these behaviours (Lightfoot & Bines, 2000). Moreover schools are the usual setting for extra-familial interventions designed to modify children's health attitudes and behaviours. Schools are attractive for several reasons including their inclusivity (the majority of children in South Africa attend school in the early grades) and the young ages at which children begin school. The young age of school children is important; their health habits must be affected early, before mal-adaptive health behaviour becomes ingrained (Tinsely, 2003: 78). School based health education can help children avoid developing unhealthy habits when they are most vulnerable, and help them acquire health protective behaviours that become a habitual aspect of their beliefs and lifestyle (Tinsely, 2003: 78).

In South Africa the school curriculum in the General Education and Training band, and the Further Education and Training band, include the teaching of Life Orientation as one of the pillars of learning and teaching. Life Orientation plays a vital role in that it teaches learners life skills, ranging from eating healthy diets, creating awareness of communicable diseases, to physical exercise. Physical Development and Movement as

a learning outcome plays a role in learners' physical development. The Department of Education (2002a: 14) says, physical and motor development is integral to the holistic development of learners. It makes a significant contribution to learners' social, personal and emotional development. Play, movement, games and sport contribute to developing positive attitudes and values. This area focuses on perceptual motor development, games and sport, physical growth and development, and recreation and play. The other learning outcome that plays a role in the development of a healthy environment is, Health Promotion. The Department of Education (2002a: 13) indicates that, many social and personal problems are associated with lifestyle choices and high-risk behaviours. Sound health practices, and an understanding of the relationship between health and environment, can improve the quality of life and well-being of learners. The Life Orientation Learning Area Statement addresses issues relating to nutrition, diseases including HIV/AIDS and STDs, safety, violence, abuse and environmental health.

Time allocation in the Life Orientation curriculum is two hours per week in the Further Education and Training band, whilst in the General Education and Training band, it is four and six hours in the Intermediate and Foundation phases respectively. Before the advent of Curriculum Assessment and Policy Statement, Physical Education in the Further Education Training band was allocated a period per week. The subject assessment guideline for the Department of Education (2008: 6) states that, Learning Outcome 3 in Life Orientation comprises the Physical Education component of the curriculum. During engagement in this component learners develop motor skills and participate in physical activities. Learners, exposed to physical activity on a weekly basis, will directly experience the benefits of such participation and be better placed to make decisions about pursuing a physically active lifestyle. The same policy further states that, in Grades 10 and 11 sixteen hours a year should be spent on activities related to Learning Outcome 1 (responsible decision-making) and 60 minutes per week (36 hours in total, i.e. 50% of contact time) should be spent on Learning Outcome 3 (Physical Education). The remaining 20 hours should be split between Learning Outcomes 2 and 4. In Grade 12 sixty minutes per week (30 hours in total, i.e. 50% of contact time) should be dedicated to Learning Outcome 3 (Physical Education). The

remaining 30 hours should be split among Learning Outcomes 1, 2 and 4. The status quo is maintained when comparing what was initially the case and what Curriculum Assessment and Policy Statement espouses. Curriculum Assessment and Policy Statement Life Orientation Grades 7-9, Department of Education (2011a: 7) two hours per week is allocated to Life Orientation in the National Curriculum Statement. One hour per week will be spent on Physical Education and the remaining hour will be split among the other four topics. This means that there are 72 hours available for the teaching of Life Orientation. This excludes internal examination periods. The content is grouped in section 3 of this document and is paced across the 40 weeks (80 hours) of the school year to ensure coverage of the curriculum. A fixed period must be dedicated to Physical Education per week and this period will be labelled Physical Education in the school timetable.

According to the World Health Organization (2010: 10), school health education aims to help students develop the knowledge and skills which are needed to make informed decisions, practice healthy behaviours and create conditions that are conducive to health. School health education can be delivered in a number of different ways, depending on a country's needs and available resources. It can be taught as a specific subject, as part of other subjects such as Science, home Economics, Mathematics and Agriculture, or ideally as a combination of both. Curriculum plays a vital role in the creation of a healthy environment, because it speaks to what learners are taught at school. According to Garrett (2001: 93), the curriculum should include active listening, effective communications, cooperative problem solving, identifying solutions, and discussing and reaching agreements. Garrett (2001: 95) further indicates that, the high school curriculum emphasizes the need for students to apply learned processes to real world situations and problems. Fox and Wong (2002: 249) indicate that, it must be ensured that a formal curriculum is designed to provide adequate learning opportunities for students to develop knowledge, attitudes and skills for adopting healthy behaviours; and that teachers devote sufficient time to teaching all of the healthy eating expectations in the curriculum. The purpose of including Life Orientation in the curriculum according to the Department of Education (2002a: 4) is to empower learners

to use their talents to achieve their full physical, intellectual, personal, emotional and social potential. Learners will develop the skills to relate positively and make a contribution to family, community and society, while practicing the values embedded in the Constitution. The Life Orientation Subject will enable learners to make informed, morally responsible and accountable decisions about their health and the environment. Learners will be encouraged to acquire and practice life skills that will assist them to respond to challenges and to play an active and responsible role in the economy and in society.

Not only learners should be trained in understanding the importance of healthy nutrition, but the entire school community, including teachers and parents. Fox and Wong (2002: 249) encourage and support opportunities for teachers to be trained in nutrition education. He further adds that parents and the wider community must be educated about nutrition, and involve them in activities that promote the practice of healthy eating.

The inclusion of Life Orientation as a subject in the school curriculum plays a crucial role in developing the learners' sense of healthy life styles. Learning Outcome one that speaks about health promotion has a particular role in creating awareness about the importance of caring for our environments.

The Department of Education (2002a: 37) indicates that, the learner will be able to make informed decisions regarding personal, community and environmental health. The learner is exposed to a wider range of risky situations. The health and safety issues encountered are still affected by the physical and socio-economic environment. The learner should acquire the skills to make informed choices. The learner needs to develop a healthy lifestyle, informed by environmental awareness and by other health aspects. Lifestyle choices related to sexuality are crucial at this early age and should be dealt with sensitively.

The curriculum should be designed in a manner that it will be of value in the learner's practical life, if education does not incorporate important life skills to equip the learner for adult life, then that learner is bound to experience challenges later in life. Life

Orientation as a subject plays that important role. The Department of Education (2002a: 5) says many social and personal problems are associated with lifestyle choices and high-risk behaviours. Sound health practices, and an understanding of the relationship between health and environment, can improve the quality of life and well-being of learners. The Life Orientation Subject Statement addresses issues relating to nutrition, diseases including HIV/AIDS and Sexually Transmitted Diseases, safety, violence, abuse and environmental health.

2.4.3 Strengthening Community Engagement and Partnerships

Schools are institutions of learning, and in their nature they accommodate many learners at one time, therefore creation and maintenance of a healthy school environment should be the responsibility of all stakeholders, including government (Barnard, 2004: 39). Schools are always surrounded by social partners who always play a meaningful role in the life and success of the schools. The fact that schools do not exist in isolation of the societies in which they operate, in itself is an indication of how important their relationships with the community members are in achieving their mandate (Barton & Drake, 2002). Marx, Wooley and Northrop (1998: 11) argue that effective school change involves learners and their families. It requires mobilizing of both school and community resources to make children's education and health a community priority.

The community approach to health promotion emphasizes schools as one component of broader based health policy programmes. With local involvement, communities become a valuable resource for schools and contribute significantly to the sustainability of health promotion interventions. Van der Westhuizen (2010: 25) further states that, education systems which succeed generally have a strong community, parental and learner's identification with the school objectives and school processes. The school needs to embody the community's aspirations for the future, so that both parents and learners see the school as instrumental in the achievement of their life goal. Mokhobo (2007: 14), argues that schools can only be developed into health promoting schools if all stakeholders collaborate actively in the education of children. Burke and Picus (2001:

68) also say that the institutional level connects the school with its environment. Schools need legitimacy and support in the community. Both administrators and teachers need backing if they are to perform their respective functions in a harmonious fashion without undue pressure from individuals and groups from outside the school. Community involvement enhances the effectiveness of programmes by stimulating awareness about health (Perez-Rodrigo & Aranceta, 2001).

According to the Missouri Coordinated School Health Coalition (2008: 3) and Garrett (2001: 126), impacting long-term health risks is not a simple task relegated exclusively to schools. Therefore, there is a need for schools and community to work in a concerted team effort in planning for healthier schools. Planning and implementing activities directed toward learners' health needs, as well as school staff members, require that many people be involved. Collaborative efforts among family, community, and schools are the most effective approaches for both prevention and intervention. Schools that have managed to build strong social partnerships with their stakeholders and in communities in which they exist, usually become sustainable, and they are able to create a healthy learning environment for learners (Epstein, 2001).

The Ministry of Health Promotion (2010: 19) says that the development of positive working relationships with all school stakeholders such as learners, parents, school staff, administrators, and community partners is fundamental to all healthy school's work and critical for success. These relationships should be established and maintained at all levels. Strong relationships are needed to proceed with creating health-supporting environments, developing healthy policies, curriculum resources, or any other aspect of health promotion work.

The school community includes a network of agencies that provide services essential for a healthy school. Van der Westhuizen (2010: 24) says that the total social context of a country can be considered as made up of several overlapping sectors such as the economy, the ideology (religious, political, and social) and the political structure. Organized bodies such as parent associations and parent teacher organizations also exemplify social structures that are involved in education. The different social structures

have a different impact on education and they reflect the diverse range of needs. The relationship between the social structures and the education system differs from community to community. The education system organizes social interaction between educators and learners, educators and parents/community, and relationships between the school and social structures with an interest in education such as state, church and parents (Hornby, 2000). The education system interacts with different social structures, which retain their own identities and do not lose their character and freedom. Social structures with an interest in education cooperate in an organized way with the education system for the sake of, and to the benefit of, effective education (Rugh & Bossert, 1998).

The involvement and the contributions of civil society in this venture cannot be overemphasized, according to Barknow *et al.* (2006: 13). The school community plays a vital role in supporting the concept of healthy schools and the development of sustainable food and nutrition policy. To improve children's nutritional behaviour patterns and knowledge, the community has to be involved in health promotion through collaboration with different sectors and stakeholders. Barknow *et al.* (2006: 13) further state that the importance of involvement of local farmers as being very crucial, because collaboration between farmers and schools has multiple benefits, from the provision of nutritious, seasonal and regional produce for school children to field trips that allow pupils to learn more about food production, sustainability and ecological issues. Farmers can benefit by stimulating new market opportunities and also help children to understand the role of agriculture in society.

Parents and the community are involved in a variety of roles in the school, ranging from occasional volunteering to active, meaningful leadership on school committees. Parent and community involvement, health promotion for staff, and a healthy school environment all contribute to developing a school wide commitment to health. Each of these components should be developed and supported as a necessary part of the coordinated school health system. Together, the components of a coordinated school health system empower learners to develop and apply knowledge and skills leading to

healthy choices and lifelong good health (Epstein, 2001). Marx *et al*, (1998: 79) say that partnerships that help learners maintain their health, achieve academically, and become productive citizens involve multiple players with a range of interests and expertise. The effort to involve families in school health programme will be most successful if all members of the school community participate.

Garrett (2001: 63) states that, to ensure that safe plans are successful, it is essential that partnerships are developed and priorities and interests prioritized. Guthrie and Schuermann (2010: 361) argue that schools typically have the luxury of being surrounded by an abundance of community partners with whom relationships can be formed. However, not all community members are compatible with schools. It is important for principals to consider thoughtfully which community members are strategically aligned with a school's plans, goals or objectives. The success of a school-community partnership hinges on the ability of school management to effectively recruit and partner with appropriate community members.

The California Department of Education (2003: 188) says that involving families and the community in the coordinated school health system is essential to encouraging positive health behaviours in children. Family values and community norms help shape the health decisions of young people. It follows, then, that if schools are to promote children's health understanding, they must reach out to key influence groups in the community. Working together, the school, the family, and the community can tailor the coordinated school health system to meet the school's specific needs. Although the school receives support from family members in many different ways, it must uphold the role of the parent or guardian as the child's primary caretaker (Epstein, 2001). To do so includes understanding and respecting the different ways in which families and cultural and ethnic groups may view health-related issues. It also includes recognition that the law provides parents with basic rights regarding the review of certain health-related instructional materials and the option of removing their children from those parts of instructional programmes dealing with health, family life education, or sex education that conflict with the parents' religious training or beliefs (Hornby, 2000).

Denman *et al.* (2002: 35) say that the development of partnerships, both within schools, for example between education and health, and externally between the school and its local community, is also important to the operational success and local credibility of health promotion. Denman *et al.* (2002: 35), further argue that it has long been recognized that schools are more likely to be effective if good relationships are fostered with parents, and there is active co-operation and involvement.

The California Department of Education (2003: 193) also says that a high degree of parent and community involvement is essential to unifying and strengthening the components of a coordinated school health system. Parent and community involvement should be encouraged from the earliest stages of programme planning and conceptualization and should be cultivated as programmes continue and expand. Parents, other family members, and representatives of the community, including representatives of community agencies and organizations that provide health-related services, can be linked to the coordinated school health system in a variety of ways.

The United Nations Children's Fund (2009: 32) indicates that all stakeholders are needed to support and sustain a protective healthy environment. The relationship between the school and the community is reciprocal. For instance, a healthy school brings lessons of daily care and health, hygiene and environmental education to their families and communities. Families and communities in turn provide financial and other support to maintain and repair the school facilities. In healthy schools, families and community members participate in school activities, after-school programmes and curricula preparation. Marx *et al.* (1998: 74) also indicate that, school-community partnerships contribute to the success of coordinated school health programmes. Communities expect schools and families to prepare learners to become healthy and productive citizens. Communities in turn have a responsibility to join with schools and families in support of efforts, such as coordinated school health programmes, that can help achieve this goal.

Barknow *et al.* (2006: 13) state that generating publicity for school food and nutrition initiatives encourages involvement of the local community in school activities. In

addition, it is crucial to keep parents informed regarding the actions and changes taking place within the school in order to maintain their support.

2.4.4 School Nutrition

Barnekow *et al.* (2006: 4) say that childhood and adolescence are critical periods for health and development, as the physiological need for nutrients increases and the consumption of a diet of high nutritional quality is particularly important. Eating habits, lifestyle and behaviour patterns are established during this period that may persist throughout adulthood. Patterns of eating have a significant influence on health and well-being. A healthy diet during childhood and adolescence reduces the risk of immediate nutrition related health problems of primary concern to school children, namely obesity and malnutrition. In addition, young people whose healthy eating habits developed early in life are more likely to maintain them and thus be at reduced risk of chronic ailments such as cardiovascular diseases, cancer, type II diabetes and osteoporosis in adulthood. Food and Agriculture Organization (2005: 23) claims that a good diet is essential for education. Children who do not eat well do not grow and learn. They are often sick, miss lessons and may drop out of school early.

Barnekow *et al.* (2006: 5) say that the fundamental issues behind public health concerns for young people are the changes in food habits that have developed as a result of the globalization of food. Over the past few decades significant changes have taken place in eating habits and home environments. The increase in families, with two working parents and time limitations, has led to the 'convenience revolution' with pre-packed processed products forming the basis of the majority of meals prepared in the home. The opportunity for children to learn and develop basic food skills at home are declining, at the same time as cooking skills are being removed from the school curriculum, due to increasing time and cost factors (Evergreen, 2001). Many children and adolescents grow up without learning the basic skills of how to provide for a healthy diet. Eating out may be the only option for feeding themselves with which they are familiar, encouraging the consumption of large portions of meals and snacks with unknown calorific and nutrient content (Coffey, 2001).

2.4.4.1 Nutrition and learner performance

Valleau, Almeida, Deane, Muskoka, Froats-Emond, Henderson, Dufferin, Prange and Wai (2004: 5) indicate that adequate nutrition is essential for the optimal growth and development of both children and youth, and for avoiding nutrient deficiencies. Research (Kingdon & Monk, 2010; Nduku, 2007) shows that there is a clear link between good nutrition and school performance. Negative consequences on learners' ability to learn can occur if learners do not eat well, because under-nourishment has impacts on children's behaviour, school performance and their ability to concentrate and perform complex tasks (World Health Organisation, 2006). Children's brain function is diminished by short-term or periodic hunger or malnutrition caused by missing or skipping meals. It is well-documented that students who eat a nutritious breakfast daily are better prepared to participate in the day's learning activities than those who do not eat breakfast (Brownell & Yach, 2006).

Marx *et al.* (1998: 16) contend that learners who are hungry, sick, or depressed cannot function well in the classroom, no matter how well the school. Schools must improve academic performance through fostering health and fitness of young adolescents, by providing a health coordinator in every middle school, providing access to health care and counselling services, and providing a health promoting school environment. The United Nations Children's Fund (2009: 3) state that good health and proper nutrition are prerequisites for effective learning. Healthy, well-nourished children learn better, and school health and nutrition programming is recognized as a means of improving children's nutritional status, learning achievement and general well-being. According to Valleau *et al.* (2004: 1), nutrition is important to people of all ages, but it is particularly important to the well-being of children and adolescents.

Even short-term hunger can adversely affect a child's ability to learn. Deficiencies of iodine or iron have been shown to reduce children's cognitive and motor skills and even their Intelligence Quotient (IQ). Marx *et al.* (1998: 210) say that schools as well as national, state, and local organizations, can take steps to implement school nutrition

services that promote healthy eating. Inadequate nutrition can have a detrimental effect on children's learning ability as well as on their physical development. In addition, they promote nutrition education for students, with instruction on cooking methods, menu preparation, use of local foods and balanced diets. This not only provides children with good nutrition in the short term, but also helps them develop the attitudes, knowledge and values they need to make appropriate dietary decisions throughout their lives.

World Health Organisation (1997: 17) contends that policies are needed at school level (integrated with national food and nutrition policies) to support and provide resources for programmes to supplement nutrition, rectify micronutrient deficiencies, and ensure that appropriate food safety practices are followed. Dobbins-Harper and Fickel (2006: 12) say that children need to be equipped with skills and information to build healthy and nutritious eating habits. In this way they will learn real-life strategies for evaluating food options and making healthy choices. Dobbins-Harper and Fickel (2006: 15) also contend that parents are key partners in the fight to prevent childhood obesity. The pervasiveness of contradictory and confusing information on proper diet and exercise has made it critical to re-educate parents about the importance of good nutrition and physical activity, particularly since they often serve as the primary role models for their children.

Nutrition and physical activity are always intertwined, for palpable results it is imperative to implement one with the other. The energy and nutrients lost during exercise must be restored with a nutritious diet. Barnekow *et al.* (2006: 7) say that healthy nutrition during childhood and adolescence lays a foundation for healthy adulthood. Therefore the multiple benefits of healthy food and nutrition in childhood and adolescence reinforce the need for these issues to be a high priority on school agendas.

2.4.4.2 National School Nutrition Programme

The National School Nutrition Programme, as is currently running in schools, plays a crucial role in addressing poverty and malnutrition. The learning process in school tends to be negatively influenced by factors such as malnutrition and hunger and it was for

this reason that the South African government established the Primary School Nutrition Programme (PSNP) in schools in 1994, which was later renamed the National School Nutrition Programme (NSNP). The overall purpose of the National School Nutrition Programme is to improve the health and nutritional status of South African primary school children, to improve levels of school attendance and to improve the learning capacity of children (Wildeman & Mbebetho, 2005). There is high poverty prevalence in communities across South Africa and especially in Mpumalanga.

The Public Service Commission (2008: 4) says that the Primary School Nutrition Programme was introduced in 1994. At its inception, the programme was called the Primary School Nutrition Programme and its aims were:

- 1 to improve education outcomes by enhancing active learning capacity, school attendance and punctuality by providing an early morning snack;
- 2 to enhance broader development initiatives especially in the area of combating poverty;
- 3 to link the PSNP to other Reconstruction and Development Programme; and
- 4 to integrate the PSNP into a broader Integrated Nutrition Programme.

At that time the programme was coordinated by the Department of Health, because the programme was mainly regarded as health promotion initiative. The Department of Health (2010: 15) indicates that in October 2008, the then Minister of Finance, announced that the National School Nutrition Programme would be extended to secondary schools in the country's poorest communities. Funds were allocated to the provincial education departments towards procurement of meals, equipment and utensils in preparation for the expansion. The National School Nutrition Programme is currently in operation in schools, with the intention of ensuring that learners have something to eat even as they deal with their educational programmes.

The results of an evaluation conducted by the Public Service Commission (2008: 8) in the Eastern Cape and Limpopo provinces indicated challenges in the implementation of the programme. The following problems were highlighted:

- **Role players have varying levels of awareness regarding roles and responsibilities** - Various stakeholders such as school principals, members of school governing bodies (SGBs), teacher coordinators, and food handlers were at different levels of awareness of the roles and responsibilities that they were expected to play in the implementation of the programme. While there are stakeholders who are aware and carrying out the roles and the responsibilities they are expected to do in the programme, there were some who did not know what was expected from them, especially in Limpopo.
- **There are varied levels of compliance with the Guidelines of NSNP-** Compliance with the Guidelines for the implementation of the programme varies from one province to the other. In the Eastern Cape, the provision of food to learners was not done every day of the week as prescribed by the Guidelines. In Limpopo, the provision was done everyday of the week. In all instances, learners are provided with food during break time which ensures that the nutrition programme does not interfere with the teaching and learning at the respective schools.
- **Infrastructure for the NSNP is not adequate-** The majority of the schools do not have adequate infrastructure to support the effective implementation of the NSNP. The schools do not have infrastructure such as storage facilities for food supplied, refrigerators to store perishable food, kitchen and cooking equipment. The lack of these facilities poses a problem because meals are prepared in the school premises.

The Department of Education (2009: 5) indicates that the overall performance of the programme nationally was exceptionally good. It provided meals to an additional 943 699 quintile (Q) 1 secondary school learners for the first time, thus increasing the total number of learners reached, to 7 125 273. Learners were provided with meals for an average of 191 days, a significant increase from the 187 days in the 2008/09 financial year. The programme also improved in providing learners with five cooked meals in six provinces as compared to 2008 where only three provinces provided cooked meals on all five days of the week. Only three provinces out of nine still reported to serving

uncooked meals at least once a week. This improvement was made possible by the increase in the average cost per meal per primary school learner from R 1, 40 (2008/09) to R 1, 85 (2009/10). The Department of Education (2010: 4) claims that the National School Nutrition Programme provides meals to more than six million learners every day. In Mpumalanga 73.3 per cent in 2009 and 76.6 per cent of learners in 2010 benefited from the NSNP according to Statistics South Africa (2010).

According to the Public Service Commission (2008:8) the NSNP is perceived to have impacted positively on the learners, contributing in addressing hunger and poverty among the learners and families and communities in which participating schools are located. There has been an increase in the school attendance, concentration levels, and social and physical participation by learners in school related activities. The level of absenteeism by learners has dropped among the schools participating in the programme in the Limpopo and Eastern Cape provinces. There is also active community involvement in the programme which is ensured through active participation of parents on the school governing bodies (SGBs) which appoint local community members as food handlers and where possible, as food suppliers.

The majority of beneficiaries come from poor backgrounds most staying with relatives and not their biological parents. The biological parents of these learners have either passed away or do not have the capacity to take care of them. Some of the learners also come from child-headed households (Public Service Commission, 2008: 8). These are vulnerable learners who are exposed to a myriad of societal ills ranging from poverty to diseases, affecting them or their families directly. These conditions if left unattended have ripple effect on their learning. Mokhobo (2007: 21) says that squalid conditions, malnutrition and diseases are rife in black areas, with school-going and other children being the most vulnerable. He further argues that life in informal settlements is horrible and appalling, with a lack of sanitation, sewerage and drinkable water.

Mokhobo (2007: 21) further argues to say, poverty is an obstacle which prevents people from leading healthy lifestyles. Because of little income, unemployment and other forms

of economic burdens, scores of families cannot survive. Additional economic burdens are imposed on families through loss of income by those who have to give up working and looking after people living with AIDS. Where the bread-winner has died, extended families may also face costs of supporting dependents. The continuous absence from work by the bread-winner due to ill-health has economic effects on the family, as what little money they have is spent on medication. In the event of death, permanent loss of income may result, which in turn may result in a child-headed family. More distressing is that, affected children are often obliged to take on parental responsibilities, such as feeding and clothing. Due to the psychological and emotional strains of these responsibilities, these children's performance usually declines at school.

The Department of Education (2010: 13) says that children on the National School Nutrition Programme count among the neediest individuals in the country. The Department of Education (2010: 6) further says that a meal served early in the day is able to provide learners with the necessary nutrients in order to remain alert and to concentrate in class. This is particularly important when learners go without breakfast before they come to school or if they have to walk long distances to get to school. The energy levels of these learners and their ability to concentrate would be improved by receiving a meal early in the day.

Garden projects play an essential role by providing vegetables to the Nutrition Scheme, and help in the provision of healthy diets. The Department of Education (2010: 24) claims that the extra food from the gardens has meant that there are often leftovers from the daily meals. With this surplus some needy learners are able to take meals home for other family members. The school now provides the needy learners with vegetables and fruit to take home to their families. The United Nations Children's Fund (2009: 5) also says that child-friendly schools and learning spaces typically address malnutrition through 'food for education', providing in-school meals or snacks and take-home rations for vulnerable children, orphans and girls. These strategies encourage parents to send children to school regularly, and they may also encourage communities to prepare and serve meals and support school garden projects.

Ebersöhn and Eloff (2006: 458) identify the following groups of children as being vulnerable: children with disabilities; children with chronic illnesses; children infected and affected by HIV/AIDS; children without care-givers; children living in poverty-stricken conditions; children who have been abandoned; children who work; children working as sex-workers; children living on the streets; children who are being neglected; children who are being/have been abused; children who are refugees and illegal immigrants; and children used as soldiers. Vulnerable children are a reality in South Africa. Educators will increasingly need to deal with this diversity in their classrooms. These challenges are evident in the description of who the vulnerable learner is, as well as in the types of challenges faced by these learners, their educators, schools and families. Ebersöhn and Eloff (2006: 464) further say that social development services, health services and NGOs would have an entry point via schools to vulnerable children, their families and communities at large. Ideally this would mean an in-house (school) nurse (maybe even a clinic), social worker, feeding programmes, and access to government grants. UNAIDS (2005: 64) conclude by saying that the infrastructure of the schools could also be utilised after hours. Classrooms can serve as bedrooms for children on the streets; adult learners can attend literacy classes in the afternoons or evenings. Schools, as such, can form clusters to share resources and mutually benefit from collaborative efforts. In this regard it would be prudent to team a good-practice school with other schools currently struggling to support vulnerable children. These are just some suggestions of how schools could utilise the asset-based approach to support vulnerable children in partnership with communities.

2.4.5 Staff involvement

The California Department of Education (2003: 2) argues that individuals must understand the role they must play in protecting, maintaining, and promoting their health and the health of others through healthy behaviours and choices. Denman *et al.* (2002: 34) say that the role of teachers and school management is central both to the implementation and sustainability of health promotion. They are best placed professionally to initiate and develop the concept. The degree of teacher involvement

and commitment, however, is dependent on their knowledge and understanding of health promotion. Denman *et al.* (2002: 34) further argue that the lack of teacher training in health related issues has affected their readiness to make a meaningful contribution.

The California Department of Education (2003: 187) maintains that part of the value of a staff health-promotion programme lies in the numerous personal benefits it can offer staff members. Consistent with the growing number of health and fitness programmes supported by private industry, schools should view health promotion for staff as part of an overall approach to disease prevention and sound health policy. In addition, adults must view themselves as role models for healthy behaviour if they are serious about helping young people achieve health literacy. School-based health and fitness programmes for staff members and other adults can take many forms, including work-site health promotion programmes; health-risk appraisals; personal goal-setting sessions; support groups; employee assistance programmes; classes in aerobics, stress management, weight control, and smoking cessation. Many factors govern the ways in which school health policies are developed. These according to Jourdan, McNamara, Simar, Geary and Pommier (2010: 520) and Han and Weiss (2005) include:

- the political will to develop an HE policy allowing sustainable commitment on the part of institutions and communities;
- a favourable environment such as the support and facilitation of principals, existing teaching practices and the importance given to the well-being of the students;
- beliefs of staff and perception of their role in Health Education, their perception of effectiveness and acceptability of Health Education programmes and belief in their own effectiveness; and
- factors linked to the policy itself such as training and assistance given to staff.

Therefore, staff commitment in the health promotion programmes plays a crucial role. The success of the widespread implementation of Health Education in schools will

largely depend on their view of their contribution and their capacity to implement it (Lee, St Leger & Cheng, 2007: 317).

2.4.6 Learner involvement

Denman *et al.* (2002: 58) say that the involvement of learners in the development of health promoting schools is a key issue and one that should rank among the main objectives in the realization of the concept in schools. Denman *et al.* (2002: 58) further argues that, giving learners an opportunity to be involved in and consulted about personal, social and health needs is as important as becoming a healthy school. Marx *et al.* (1998: 45) say that the intent of comprehensive school health education is to motivate learners to maintain and improve their health, prevent diseases, and avoid or reduce health-related risk behaviours. The school health programme also provides learners with the knowledge and skills they need to be healthy for a lifetime. The importance of local healthy schools programmes involving learners at school level cannot be overemphasized.

The Ministry of Health Promotion (2010: 27) claims that learners have valuable perspectives and should be engaged to offer input to ensure school health programmes and services are meaningful. They should be viewed not only as recipients of health promotion efforts, but as partners, with valid views and the ability to make and carry out decisions. Guthrie and Schuermann (2010: 348) maintain that learners are an integral part of a school, family, and community partnership. They have a direct effect on the alignment of the spheres by serving as an intermediary between the school and their family. Students serve in this capacity as teachers frequently depend on them to effectively transmit important messages to their families. Students are more likely to cooperate in these situations if they are motivated and engaged in their education. A heightened level of commitment to educational excellence can occur when students believe that their school, family, and community genuinely care about their personal and academic well-being.

Learner participation is of crucial importance, and therefore cannot be taken lightly. The learner comes from the community, and in reverse what he learns at school is put into practice in the community, therefore this relationship should always be encouraged and nurtured.

2.4.7 Prevention of communicable diseases

According to the National Policy on HIV/AIDS (1996b: 15) the Member of the Executive Council is mandated to make provision for all schools and institutions to implement universal precautions to eliminate the risk of transmission of all blood-borne pathogens, including HIV, effectively in the school or institution environment. Universal precautions include the following: the basis for advocating the consistent application of universal precautions lies in the assumption that in situations of potential exposure to HIV, all persons are potentially infected and all blood should be treated as such.

2.4.7.1 Injuries and medical emergencies

Accidents and injuries do not happen according to schedule, but happen anytime, anywhere and when least expected. This is the reason why first aid kits must be kept, especially at schools where many learners gather at one specific time. Medical emergencies and injuries can happen anywhere unexpectedly, therefore, institutions like schools, businesses and workplaces should always be ready to deal with any medical eventuality should it present itself. In South Africa, according to the National Education Policy Act (SA, 1996), it is a legal requirement that all schools should keep first aid kits, and teachers and learners should be equally empowered on how to manage them.

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The National Education Policy Act (1996: 1-31) further states that, a fully equipped first aid kit should be available at all school or institution events, outings and tours, and should be kept on vehicles for the transport of learners to such events. The importance of keeping a fully equipped and properly managed first aid kit cannot be

overemphasized. The Republic of South Africa Government Gazette (2005: 7) indicates that, an employer shall take all reasonable steps to ensure that persons at work receive prompt first aid treatment in the case of injury or emergency. Where more than five employees are employed at a workplace, the employer of such employees shall provide a first aid box or boxes at or near the workplace which shall be readily available and accessible for the treatment of injured persons at that workplace, taking into account the type of injuries that are likely to occur.

The National Education Policy Act (1996: 1-31) says that all schools and institutions should train learners, students, educators and staff in first aid, and have available and maintain at least two first aid kits. Each of which should contain the following: two large and two medium pairs of disposal latex gloves; two large and two medium pairs of household rubber gloves for handling blood soaked material in specific instances (for example when broken glass makes the use of latex gloves inappropriate); absorbent material, waterproof plasters, disinfectant (such as hypochlorite), scissors, cotton wool, gauze tape, tissues, containers for water and a resuscitation mouth piece or similar device with which mouth-to-mouth resuscitation could be applied without any contact being made with blood or other body fluids; protective eye wear; and a protective face mask to cover nose and mouth.

2.4.7.3 Training and empowerment

It is the responsibility of the Department of Education as an employer to educators, to ensure that the school environment is healthy, and that the educators are relevantly trained and supervised on how to maintain a healthy school environment. The Occupational Health and Safety Act (1993: 8) says that providing such information, instructions, training and supervision may be necessary to ensure, as far as is reasonably practical, the health of the employees. In dealing with wounds and injuries, precautionary measures should be taken in disposing of any medical waste and used material. The National Healthy Schools Programme (2007: 30) argues that the physical and emotional health and well-being of all adults within the school community as well as children and young people should be addressed. The Whole School Approach

encompasses the professional development needs, health and welfare of all adults working in the school, including teachers, administrative staff and general workers.

In training the educators, the Department of Education would be making a massive contribution because they would in turn be the ones who would be driving the creation of a healthy school environment project, and it would be easy for them if they are well empowered.

2.4.7.4 Communicable diseases

The California Department Education (2003: 65) states that the most important message to convey in this content area is that students have a considerable measure of control over their health and that chances of contracting most illnesses can be greatly influenced by students' health-related choices and decisions. Such communicable diseases as sexually transmitted diseases (STDs), including HIV/AIDS and hepatitis B, dramatically illustrate the point. Chances of contracting these diseases are greatly reduced when young people abstain from sexual activity and intravenous drug use and use universal precautions when dealing with other people's body fluids. The Department of Labour (2005: 5) indicates that care should be taken especially in treating all blood and other body fluids as potentially infectious; taking all reasonable steps to ensure such blood and other bodily fluids are suitably cleaned up in a manner to prevent biological agent disease transmission; taking all reasonable steps to ensure that the disposal of such blood and other bodily fluids contaminated materials are suitably disposed of. The California Department of Education (2003: 66) further says that communicable and chronic diseases are too often the consequences of short-sighted or uninformed choices.

2.4.8 Physical Activity

It is essential for learners to be involved in extracurricular activities for their own physical development, whether competitive or noncompetitive. Heppell (2005: 3) says that primary school-aged boys from previously disadvantaged communities rarely have

the opportunity to participate in structured physical activity and competitive sport. The Department of Education (2011a: 8) indicates that all learners shall participate in teams and competitions involving learners of similar developmental levels. It further states that, each school shall have a structured programme for recreational school sport. Relevant games and activities that promote mass participation shall be identified, prioritized and implemented. All learners shall participate in these activities on an on-going basis.

Recreational school sport activities involving learners from different schools may be organized by school governing bodies of the schools concerned. All school sport programmes must aim to enrich the curriculum at both General Education and Training, and Further Education Training Phases. Heppell (2005: 3) further argues that, activities in childhood development must include both the motor and health aspects of physical fitness, because children need a reasonable level of motor skill development to take part in exercise and sport activities which will provide them with endurance, power and strength.

Children also need reasonable levels of fitness to engage in exercise and sport activities which will provide them with physical activity as adults. Heppell (2005: 4) also contends that, academic performance can also be enhanced by physical activity. Gelbard (2009: 2) further indicates that, physical activity improves academic performance and decreases behaviour problems. Schools that offer physical activity have higher reading, writing, and mathematics performance even when physical activity leaves less time for academic instruction. It is therefore imperative that children engage in physical activity even in school, because this has a positive contribution to the school environment and to how they learn.

Physical activity is very important for children's growth and well-being, Gelbard (2009: iv) says that people's health is intimately linked to the foods they eat and to their physical activity. Regular participation in physical activity contributes to the social and mental well-being of children and to their academic success. In today's society, where obesity in children is on the rise, physical activity is an essential component of children's lives. The World Health Organization (2008: 10) says that increasing the number of

physical education classes and/or sports classes is one of the most direct policies to increase students' physical activity.

Based on the above, schools cannot afford not to incorporate physical activity in their programmes, because this has a direct impact on the performance of the school and also the health of children. Marx *et al.* (1998: 117) state that schools are uniquely positioned to teach children and youth the benefits of lifetime physical activity because they serve nearly all children and have facilities and equipment as well as staff with the expertise to provide instruction and supervision. Moreover, there is evidence that quality school-based physical education can contribute to the health of children and the adults they will become. The draft policy on school sport highlights the importance of learner participation in sport; it also emphasizes participation by all learners in different sporting codes.

According to Gelbard (2009: 1), regular physical activity has a positive impact on both academic success and health and when combined with good nutrition, it can play an important role in reducing the obesity epidemic. Overweight children are at greater risk of developing chronic health problems, including type 2 diabetes, high blood pressure, asthma, and heart disease, and they face serious health consequences as they grow into adulthood. Physical activity helps counteract overweight and obesity. Barnekow *et al.* (2006: 5) say that the World Health Organization Global Strategy on Diet, Physical Activity and Health recognizes physical inactivity as one of the main risk factors for non-communicable diseases and consequently the burden of overweight and obesity. Particular attention is given to concerns regarding the unhealthy diet, lack of physical activity and energy imbalances in children and adolescents.

Physical activity is believed to be an important factor determining the weight of children. Activity levels among children and adolescents are low (St-Onge, Keller & Heymsfield, 2003). Sedentary behaviours, such as playing electronic games, are the general norm and are believed to be directly associated with obesity. In addition, inactive children and adolescents who consume small amounts of food may compromise the range of nutrients they consume and fail to meet requirements. To maintain a healthy weight,

children and adolescents need to balance energy intake and expenditure (The Food Commission, 2001).

The benefits of physical activity are not only temporal but life long, the impact is not only physical but also emotional. Gelbard (2009: 3) contends that, physical activity also positively affects learners' mental health and emotional well-being. Research shows that participating in physical activity increases adolescent girls' self-esteem and feelings of self-worth. Research also shows that when adolescent boys and girls increase their physical activity, they feel more confident in their academic, athletic, and social abilities. The reverse is true as well, that when adolescents decrease the amount of physical activity in which they participate, they feel less confident in their academic, athletic, and social abilities. The Missouri Coordinated School Health Coalition (2008: 3) contends that, a healthy, physically active child is more likely to be academically motivated, alert, and successful in school, and is more likely to establish habits that will foster good health throughout life. With access to our state's children and a strong community link, the school is the most effective setting to increase knowledge, form attitudes, and develop behaviours that affect the health and safety of young people and help them establish lifelong healthy behavior patterns. Physical activity should not be misconstrued to mean army long hours' army like training sessions, but 30 to 60 minutes of daily physical activity (Gelbard, 2009: 3).

The California Department of Education (2003: 185) also says that physical education should provide all students with opportunities to participate in a comprehensive, sequentially planned physical education programmes. Through movement, physical education advances the physical, mental, emotional, and social well-being of every person in the pursuit of lifelong health. Students should have opportunities to develop and enhance their movement skills and their understanding of how their body moves and should participate in a variety of activities leading to lifelong enjoyment of physical activity. Physical education for children in kindergarten through grade twelve is the subject of another framework.

Dobbins-Harper and Fickel (2006: 8) state that today's children rarely ride bicycles or walk to school, often because schools are located on the periphery of the community or require crossing busy streets or navigating unsafe neighbourhoods. Children aged 8 to 18 spend an average of 4.5 hours per day watching television and movies or playing video games. Study by Dobbins-Harper and Fickel (2006: 8) found that each additional hour of television watching increased a child's risk of obesity by 2 percent, due largely to the consumption of high-fat, sugary snacks while watching television. Barnekow *et al.* (2006: 33) further indicate that children practice progressively less physical activity as they grow older. Between the ages of 12 and 18, the average amount of regular physical activity decreases by 50%; however, boys are consistently more active and fit than girls. In all countries and across age groups 11, 13 and 15-year-old boys report being physically active for at least an hour a day more often than girls: 4.1 days and 3.5 days, respectively. The gender difference varies, however. Gender differentials widen with age, with female activity declining as puberty approaches. Physical activity also shows wide geographical variation. Measured by reporting the number of days per week that young people are active for an hour or more, levels range from 3.4 days in Belgium to 4.9 in Ireland for boys, and from 2.7 days in France to 4.1 in Canada for girls (Lissau, 2002). Despite differences between age groups, some countries and regions are consistently in the top quartile: Belgium, France, Italy and Portugal. In South Africa physical activity levels and opportunities for physical activity opportunities distribute differentially across socio-economic strata. For example in a study conducted by McVeigh, Norris and de Wet (2004:984) indicate that children from birth to twenty years from more affluent homes reported higher levels of physical activity, less television viewing time, and had a higher lean mass than their more disadvantaged counterparts.

Active children and adolescents have increased metabolism and subsequently, better appetites. It should be noted that children are strongly influenced by the behaviour of parents and care-givers; active parents usually have active children. In addition, active children are more likely to be active adults, thereby reducing the risk of degenerative illness and chronic disease in later life (Stettler, Signer & Suter, 2004). Schools should be encouraged to incorporate physical activity frameworks into the whole school

approach to health. Children's ability to practice physical activity is related to their development. Therefore, the type and intensity of activity should match age and ability. Younger children are not aware of the possible dangers during exercise and safety should always be maintained (World Health Organisation, 2004). Physical activities (for example, running, jumping, cycling, climbing and throwing, catching or hitting a ball) and simple games (for example, chase or tag) are appropriate for young children. These activities should be play-based to be more attractive for children. They can also participate in developmentally appropriate organized play or activities (for example, tumbling, tag, gymnastics, dancing). Children under six years old do not have the motor skills or mental and emotional capabilities to participate in organized sports. Some types of suitable activities include:

- endurance activities that strengthen the heart and lungs such as play-based running, jumping and swimming; and
- flexibility activities such as gymnastics and dancing that require bending, stretching and reaching; and muscle-building and bone strengthening activities, such as climbing (Carter, 2002).

Increased physical activity should be promoted to children and adolescents of all ages. Healthy eating and regular physical activity contribute to a healthy body (Carter, 2002).

According to the Draft School Sport Policy for Public Schools in South Africa (SA, 2009:10), the principal's responsibility regarding physical activity is to: ensure that the school sport policy for the school is in place; report to the SGB on school sport matters; ensure that the school sport plan is implemented; ensure that educators are supported in offering school sport activities; and participate in the compilation of the school sport policy and the school sport plan.

The lack of physical activity has far reaching implications in children's health, and this indirectly has bad consequences for the rest of the community. Behaviours that put learners' lives at risk of death, disability or potentially reduce their quality of life including their life expectancy should be eradicated.

2.5 NATIONAL HEALTH SCHOOL PROGRAMMES

Three national programmes including The Environmental Conservation (Eco) Schools Programme, Soul Buddies and the garden project were identified by the researcher as programmes that are currently running at schools. This section also deals with how programmes are coordinated. The Eco school programme in which most schools in the Mpumalanga province are part of is presented below.

2.5.1 Environmental Conservation School Programme

The Environmental Conservation (Eco) Schools Programme is an international programme that South Africa adopted in 2003. The programme focuses on themes such as: local and global issues; nature and biodiversity; community and heritage; resource use; and healthy living. The themes are integrated into the schools' curriculum. The participating schools are also required to develop lesson plans that address topics related to the environment (Wildlife and Environmental Society of South Africa, 2012: 1).

The Eco programme is run by the Wildlife and Environmental Society of South Africa (WESSA) in partnership with the World Wildlife Fund. Various other organizations support Eco-Schools. Wildlife and Environmental Society of South Africa (2012: 1) indicates that the Eco Schools programme operates in over 51 countries worldwide. Over 1000 schools in South Africa joined in 2011 with Mpumalanga contributing an estimated figure of 100 schools in total.

At schools, groups of teachers, learners, community members and/or partner organizations get together and undertake a project to improve some aspect of environmental management at their school. This usually ranges from saving electricity to starting a garden. Teachers draw on these practical projects to strengthen environmental learning at the school. Each year they strive to improve on their efforts, thereby qualifying for an internationally recognized symbol of excellence, the Eco-Schools Flag (Wildlife and Environmental Society of South Africa, 2012: 1).

The portfolio of evidence is submitted at the end of each year. This is how participating schools are assessed. The portfolio must include a record of all the activities that took place at school. This is a portfolio of evidence that shows that the school has taken all the required steps, that is: formed a committee, written a code, conducted two whole school reviews and two theme audits, took action to improve, and taught at least three related lessons. The Portfolio must include evidence of all these, as well as examples of learners involvement and curriculum-related work (Wildlife and Environmental Society of South Africa, 2012: 11).

2.5.2 Soul Buddies

The Soul Buddies clubs form part of a project that was established in schools with the intention of teaching learners leadership skills, and also to address health related problems. Clacherty and Associates (2006: 1) maintain that the Soul Buddies is a multi media edutainment vehicle created for 8 to 12 year olds by the Soul City Institute. It consists of a television drama, radio drama and print materials. The first television drama series was aired on SABC 1 during 2001. Since then two further series have been screened and Soul Buddies has become an important part of life for many South African children.

The Soul Buddies clubs programme which now operates in schools, is intended to help schools to support learners affected and infected with HIV/AIDS, thus rendering them as nodes of care (Soul City Institute, 2012). Buddies are friends who spend time together. Clacherty and Associates (2006: 4) maintain that the Soul Buddies clubs programme is a media vehicle that educates while it entertains, which also takes into consideration the real problems and issues that concern young people.

One of the aims of the programme according to the Soul City Institute (2001: 164), is that children must know their rights in a concrete way and become empowered to demand those rights, both as children and then as adults later in life. The Soul City Institute (2001: 165) further states that independent evaluations have shown the effectiveness of the Soul City project to impact on a variety of health issues by

conveying information, increasing debate and interpersonal interaction, and changing attitudes, practices and social norms. The Department of Education (2010: 10) argues that learners who are part of Soul Buddies clubs programme become inspiring role models to their peers by showing the spirit of volunteerism and helping each other. They also instill good values and good hygiene practices.

2.5.3 Garden Project

Food gardening was initiated by the Department of Education to create a source of food so as to supplement the diet of learners (Castle & Bialobrzeska, 2009: 9). The Food and Agriculture Organization of the United Nations (2010: 12) adds that school gardens should be primarily for educational purposes. The garden should be linked to good nutrition, putting education first. The long-term goals are food security and healthier lives for children and society. School gardens can also be used as a training ground for learners to develop life-long skills where they can put to practice what they have learned in their homes.

Food gardening is relevant for schools in Mpumalanga. According to the Mpumalanga Provincial Government Draft Report (2011), Mpumalanga can be broadly defined as an agriculture household. At least 25,5% of Mpumalanga households are involved in Home Production for Home Consumption (HPHC), more than the national average. These are households that earn income from either formal employment in the agricultural industry or as skilled workers, or from sales or consumption of home produce or livestock.

The Department of Education (2010: 24) indicates that all members of the community, teachers, learners and their parents participate in ensuring the garden blooms and blossoms, even during school holidays. The Food and Agriculture Organization (2010: 4) says that school gardens cannot single handedly raise the level of children's health or substitute for school meals; but they can contribute to them. Above all, they must be an educational instrument targeting not only children, but also their families, the community, and the school itself.

The Food and Agriculture Organization (2005: 2) maintains that running a school garden requires not only horticultural knowledge but also people skills and common sense. Other useful qualities are enthusiasm, organizational capacity and a flair for publicity. One needs to plan and manage, find resources, get help and support, keep in touch with those involved, organize garden work and lessons, motivate people, and publicize garden achievements. However, garden leaders do not have to do all this themselves. Good garden management means building up the school's capacity until the garden can almost run itself.

According to the Food and Agriculture Organization (2005: 3) the size of the garden will depend on the amount of land available, and the demand for vegetables. Small gardens cannot feed the whole school but it can make a difference by contributing essential health-preserving fruit and vegetables, and sometimes poultry, meat or fish, to basic rations of cereals, legumes and oil (Food and Agriculture Organization, 2010: 8).

According to the Food and Agriculture Organization (2005: 4), it is vital for the school staff to be trained in the development and maintenance of the garden project. Training depends on what knowledge and experience the school already has in this regard. A training course can be organized in basic garden management, nutrition, organic gardening methods and project based learning across the curriculum. Training can be provided by people with expertise from the agricultural services, a parent, a Non Governmental Organization or the education department. Whoever receives training should pass it on to others, for example, in informal meetings. Feedback on training reinforces the training, spreads the knowledge and protects the garden programme from losing its only expert (Marneweck, Bialobrzaska, Mhlanga & Mphisa, 2008).

The Food and Agriculture Organization (2005: 12) further says that the school gardens are very visible and attract local interest. They therefore do best when they have support from families and the local community. Parents may act as volunteers, helping with garden work. Organization for Economic Cooperation and Development (2008: 60) indicates that the school educators, in the most successful school gardens, are interested and lend a hand. Both teaching and non-teaching staff can contribute.

2.6 HOW SCHOOL HEALTH PROGRAMMES ARE COORDINATED

Marx *et al.* (1998: 17) say that although most schools have some elements of a coordinated school health programme, few have a health programme that includes all components at a fully functioning level, and fewer still effectively coordinate all. Marx *et al.* (1998: 17) further states that successful implementation of an innovation depends on several factors, including characteristics of the innovation itself. Booth and Samdal (1998:365) state that the following characteristics contribute to successful implementation: underlying purpose and potential outcomes; perceived value in addressing identified needs; clarity of purpose; adaptability; replicability; consistency with the school's mission and vision; ease of implementation (for example, requirements for additional training and resources); credibility with school staff and the community; capacity for broadening the knowledge base of students or staff; potential to enhance, supplement, or support existing programmes.

Dryfoos (2000) identifies five characteristics, critical to successful adoption or implementation of programmes:

Relative advantage: If school communities perceive coordinated school health programmes as more effective than the existing fragmented programmes, they are more likely to implement such programmes. To determine the perception of relative advantage, a school community could ask the following critical questions: what are the benefits and costs of implementing a coordinated school health programme? Do the perceived benefits to the physical, mental, social, and emotional health of students, their families, and school staff outweigh those that exist? How will implementing a coordinated school health programme affect teaching and learning at the school?

Compatibility: If schools and communities view coordinated school health programmes as consistent with existing values, responsive to student, family, and staff needs, and supportive of school plans, they are more likely to support programmes. Questions that can help determine compatibility include: are coordinated school health programmes consistent with the philosophy and values of the school community? Does this model

address identified needs, concerns, and interests of students, their families, school staff, and the community? Do coordinated school health programmes support the mission, goals, objectives, and priorities of the school? How successful were past attempts to implement elements of a school health programmes? What facilitated and what impeded past efforts? How much change in existing programmes and structures will this model require?

Complexity: If school administrators and staff believe that implementation of coordinated school health programmes is easy, they are more likely to move forward with implementation plans. Some questions to answer about complexity are: does staff understand coordinated school health programmes and how such programs support educational achievements? Do key implementers understand the breadth and depth of each component of a coordinated school health programme? How many school staff will be involved in implementation? How much professional development will staff need to implement a coordinated school health programme? How much time, effort, and energy will implementation require? Are adequate human and fiscal resources available to support implementation?

Trialability: If a school can pilot some or all components of a coordinated school health programme and in effect try out the concept, it is more likely to begin implementation. Questions about trialability might include: can schools initially implement only one or a few components of a coordinated school health programme? Can school communities implement the model in stages? How adaptable is the model?

Observability: if school administrators can document successful implementation of coordinated school health programmes, they are more likely to facilitate their implementation. Questions that might help to verify the benefits of a coordinated school health programme include: are there examples of schools that have partially or fully implemented coordinated school health programmes? Can the school community see some successes? Have staff, parents and other caregivers, and others confirmed the relative advantage of using this model?

2.7 HEALTH COMMITTEES

The National policy on HIV/AIDS (SA, 1996b: 25) indicates the importance of the establishment of the Health Advisory Committee for the purposes of advising on issues of health including issues pertaining to HIV/AIDS. The Health Advisory Committee (1996: 26) indicates that the structure should consist of educators and other staff, representatives of the parents of learners at the school or students at the institution, representatives of the learners or students, representatives from the medical or health care professions. The structure should also elect the chairperson who is knowledgeable within the field of health care.

The California Department of Education (2003: 195) says that an approach that has proven successful is that of establishing a local school health council, sometimes called a school health advisory council. Primarily advisory in nature, school health councils are groups of persons who represent diverse segments of the community and who collectively advise the local school system on health-related issues, activities, and programmes. Representatives might be community-based health professionals and volunteers, school nurses, health educators, school administrators, physical education teachers, parents, students, and others interested in and concerned about school health.

The Missouri Coordinated School Health Coalition (2008: 4) indicates that, a School Health Advisory Council (SHAC) is an on-going advisory group composed primarily of individuals selected from segments of the community. The group acts collectively in providing advice to the school district about aspects of the school health programme. Generally, the members of a School Health Advisory Council are appointed by the school district to advise the school district. Most often, School Health Advisory Councils are advisory to an entire school district, but a SHAC may also be useful for an individual school desiring their own advisory council.

According to the National policy on HIV/AIDS (SA, 1996b: 26), the main duties of the committee entail, advising the Governing Body or Council on all health matters including

HIV/Aids, be responsible for developing and promoting the school or institution plan of implementation of HIV/Aids and review the plan from time to time. The consultation of the committee will be crucial relating to the prevention of HIV transmission in the Code of Conduct.

The Missouri Coordinated School Health Coalition (2008: 4) says that a School Health Advisory Council can assist a school district in the promotion and protection of student and employee health. Involving parents and other community members on a School Health Advisory Council enables the school to use valuable community resources. According to the Missouri Coordinated School Health Coalition (2008: 5), it is important to emphasize that advisory councils are formed to provide advice. These groups do not become part of the administrative structure of the schools, nor do they have any legal responsibilities within the school district.

The formation and establishment of the Health Advisory Councils, should be understood in the context of being sub-committees of School Governing Bodies or Councils, so they operate under the command and jurisdiction of the SGBs. On their own they do not have any legal standing. Their formation will take different shapes depending on the environment of their establishment and operation. Determination of membership into this committee according to the Missouri Coordinated School Health Coalition (2008: 6) should first of all be commitment to quality school health programmes for the children of their community, and the following undergirding criteria may be used:

- demonstrated interest in youth issues,
- awareness of the community,
- professional ability,
- willingness to devote time,
- representative of the population, and
- credibility of individuals.

The California Department of Education (2003: 6) urges schools to establish a school health committee and appoint a school health coordinator or chairperson to oversee the school health programme.

The credibility and dedication of the members will, as indicated above, be a tonic for the successful implementation of health programmes at schools, and if the committee is sufficiently efficient the impact will also be felt in neighbouring communities outside the school parameters. The attainment of a healthy school environment does not only rely on the availability and presence of relevant health committees at school, but the most crucial fact is how effective and functional those committees are in performing duties and responsibilities they intend to achieve. These aspects are serious determinants of the effectiveness and functionality of the structures, the committee should be steadfast in the implementation of these aspects to ensure its success.

2.8 LEADERSHIP AND MANAGEMENT

Mashoko (2007: 32) say that, the School Management Team is the structure that is responsible for the day-to-day management of the school and the implementation of the school's policies which have been determined by the School Governing Body. The principal holds ultimate responsibility for making sure that the work is done and he can choose how to share that responsibility with other SMT members. Mokhobo (2007: 27) argues that, a school policy serves as a guide to ensure that management carries out duties collectively in planning or operation of school programmes. Marx *et al.* (1998: 15) indicate that, within local schools, adoption, implementation, and coordination of the components of a coordinated school health programme remain a challenge. Mokhobo (2007: 51) also says that leadership in the school situation is about guiding people to achieve the school's objectives. For management to organize, coordinate and plan, it is important for leadership to be democratic. Mashoko (2007: 17) says that the School Management Team is a structure which is responsible for day-to-day administration and organization of teaching and learning and all the activities which support its obligations. The principal and heads of departments, are therefore accountable to the National Department of Education and the SGB for results. It means that the success of the

school needs not depend on the principal alone. Marx *et al.* (1998: 53) say that strong leadership is especially important in today's school environment. Mashoko (2007: 18) also says that the SMT has the responsibility to make sure that the health and well-being of the school is promoted among educators and learners within the school as well as in the community. The World Health Organization (2008: 33) says that monitoring and evaluation are systematic processes to assess the progress of ongoing activities, identify constraints that need corrective action, and to measure effectiveness and efficiency of the outcome of the programme.

Van Deventer and Kruger (2010: 68), when commenting on leadership and management say that the terms leadership and management are distinguishable, but more often than not they are used interchangeably. Leadership is frequently seen as an aspect of management, with born leaders being characteristics individual with visionary flair and the ability to motivate and inspire others, even if they lack the managerial skills to plan, organize effectively or control resources. The difference between leadership and management is that leadership relates to mission, direction and inspiration, whilst management involves designing and carrying out plans, getting things done and working effectively with people. A school principal has to be both leader and manager.

2.8.1 Management of programmes

Management is defined as the administration of business, including the organizing and controlling of the affairs of a business or a sector of business (Encarta Online Dictionary, 2009). This includes successful handling and controlling of health matters. Meier and Marais (2007: 3) define management as the process of working with and through individuals and groups and other resources, to fulfill organizational goals.

Effectiveness according to Gewertz (2003: 7) refers to undertaking the right activities, doing right things and striving to reach the set objectives while at the same time serving the right market in an appropriate manner, thus, acting in the best interest of the community as a whole. This includes encouraging all stakeholders (educators, learners and parents) to be committed, allowing them to produce outcomes, explaining what and

why things could be done in a certain way, sharing information regarding health and facilitating networks (Mogonediwa, 2008: 10).

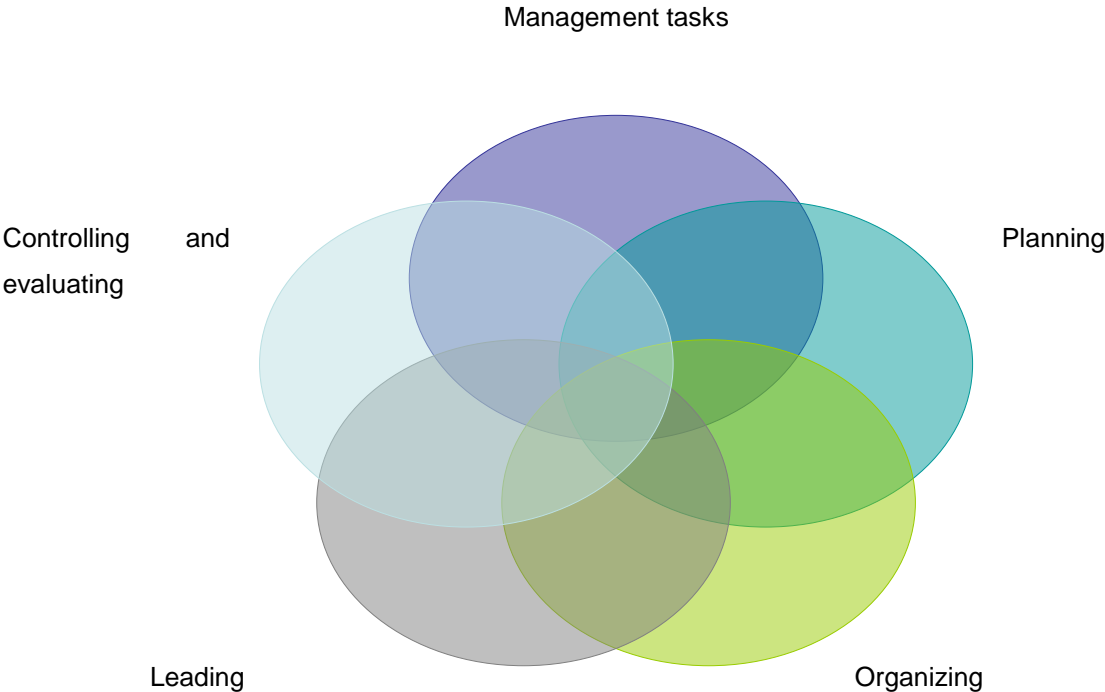
Accountability means that persons in positions of responsibility can be held liable for their actions. All stakeholders bear the responsibility of ensuring a healthy school environment. The School Management Team (SMT) is responsible for the meaningful management of school affairs and taking care of the young lives entrusted to them. The future of many children is in their hands. The school community therefore, demands an open and honest account (Steyn, De Klerk & Du Plessis, 2008: 119) of the way healthy school environments are managed.

One of the tasks that the management entails is planning. Van Deventer and Kruger (2010: 79) indicate that plans have two basic components which can be considered during the course of planning. The plans include future aims which are based on the identified needs, which are broad statements of intent. Aims are operationalized, put into practice, thus becoming a reality, by breaking them down into specific and reachable outcomes. Plans also include a plan of action which is a specific course of action to ensure that the necessary things are done to achieve the aims and outcomes that have been planned. Van Deventer and Kruger (2010: 84) further state that determining a plan of action involves developing various courses of action for reaching the desired aims and outcomes, evaluating these alternatives, and choosing from among them the most suitable alternative for reaching the outcomes. In this step, decisions about future actions are made and it is here where the guidelines for effective problem solving, decision making and delegating are most relevant.

The California Department of Education (2003: 5) concur with the importance of formally planning activities adding that the quality of services should be continuously monitored as an integral part of the community public health and primary care systems. The training and use of competent, properly prepared personnel should be expanded to implement quality coordinated school health programmes.

Van Deventer and Kruger (2010: 75) mention the management tasks as planning, organizing, leading and controlling. Thus the work a manager does is that of planning, organizing, leading and control in relation to the people, outcomes and resources available at a specific school, in order to fulfil the primary need of education in South Africa. They explain the tasks as follows:

Figure 2.3: Management tasks



Source: Van Deventer and Kruger (2010)

Marx *et al.* (1998: 53) say that without the strong commitment to school health on the part of school management teams and student families, successful implementation is unlikely. A study conducted by Inchley *et al.* (2006: 68) concur with strong management involvement, in this study senior management leadership helped to embed the Health Promoting School concept in the life of the school through school development planning, as well as providing benefits in terms of resourcing, delegating responsibilities to key members of staff and liaising with external agencies. Where senior management did take the lead, it gave the project status and their involvement was considered crucial to effective implementation even if they were not participating at an operational level.

Van Deventer and Kruger (2010: 88) recommend the use of the following principles when planning: planning should always take place within the limits of the school's policy where all aspects of policy should be related; planning must be in line with the plans of other health programmes and the school as a unit; planning should be flexible.

The California Department of Education (2003: 11) adds that for health education to be made meaningful, systems that support effective health education and make health an important priority in the school must be in place. The school's approach must be well planned, must be coherent, must be implemented consistently, and must be supported by all adults in the school. All the components of the school's programme must be mutually supportive and consistent with the overall goal of promoting and enhancing learner's health.

The California Department of Education (2003: 21) argues that, school health programmes are evaluated because schools and communities need data to guide their programme, decision making and development, to obtain programme support and funding, and to demonstrate progress in meeting their programme goals. Schools are required increasingly to collect data that objectively assess student achievement and behaviour. Schools also are encouraged to set concrete and measurable goals for making improvement.

2.8.2 Monitoring and evaluation

Monitoring and evaluations of these programmes is of extreme importance in ensuring sustenance, productivity and growth. Middlewood and Lumby (1998: 164) argue that monitoring is about making judgements to the plan, both small and large, during the implementation process. Monitoring may thus be seen as a continuous process, which may or may not involve the collection of data. It involves looking and checking without necessarily making value judgments or taking any action. In the same breadth when talking about evaluation, Middlewood and Lumby (1998: 164) maintain that, evaluation may draw on information gathered through monitoring, or assembled at the point of evaluation. Although it does not have to, it normally takes place at the end of a cycle in order to see if the educational organization is achieving what it set out to achieve and if not, why not, as part of a feedback loop to compare strategy formulation and implementation with results. Where intention and results do not match, corrective action can take place. Middlewood and Lumby (1998: 165) emphasize that evaluation is needed to check on progress and correct mistakes. But evaluation also serves other purposes. It helps managers take account of changes and their effects on the organization's progress. Van Deventer and Kruger (2010: 86) say that monitoring and controlling plans, are the most difficult part of planning, because at this stage one must rely on the one resource that can and very often will let one down namely, people. Emergencies and unexpected meetings, as well as issues that are irrelevant to the plan that must be carried out, often interrupt the effective execution of the plan. If the planning process is used as an effective management tool, it will help to maintain momentum.

The school that does not evaluate its processes ignores an aspect that has potential to propel the school into a positive direction, and a state of management prowess. Middlewood and Lumby (1998: 166) say that the same rigour that is brought to any research process may build confidence in the reliability of the information gathered, though, of course, time constraints may be a limiting factor. This implies that evidence is collected systematically and not on an adhoc basis. All these elements can be

integrated within an evaluation plan, which may well be part of the school development plan. Relevant resource will have to be allocated in every programme the school undertakes, this including the evaluation process. Middlewood and Lumby (1998: 167) allude to say this leads to questions of resources. Evaluation does require resources, the main one being time.

Typically, school principals and teachers work together with learners to prepare and carry out a plan for monitoring and keeping up the facilities and helping learners stay clean and healthy (United Nations Children's Fund, 2009). Communication plays an important role in this situation and cannot be underestimated. Lazarus, Donald and Lolwana (2002: 148) say that four important aspects of structures and procedures which need to be understood and developed are structural arrangements, information flow or communication, decision-making, and accountability. Guthrie and Schuermann (2010: 63) argue that if an organization does not possess on its staff the previously listed range of technical skills, then there is little recourse but to engage the services of outsiders. However, when the decision is made to utilize outside planners to obtain technical competence, gain outside legitimacy, stimulate change, or all three, then the bona fides of those involved is critical.

2.9 SCHOOL CULTURE AND ENVIRONMENT

The National Healthy Schools Programme (2007: 24) says that the culture of a school is defined by the social processes, values and norms that shape its character. The physical and emotional environment shapes the way children, young people, staff, parents feel and behave. At its most basic, it is essential for children and young people to feel safe, both physically and emotionally at school. This will have a significant influence on their ability to learn effectively. The California Department of Education (2003: 4) argues that the period prior to high school is the most crucial for shaping attitudes and behaviours. By the time students reach high school, many are already engaging in risky behaviours or may at least have formed accepting attitudes toward these behaviours. Also that, all teachers should receive substantive preparation in health education content and methodology during their training. The California

Department of Education (2003: 39) further says, non-teaching staff at the school, such as secretaries, school maintenance personnel, and classroom assistants, interact with and influence young people. The entire staff should be offered training in the philosophy of the coordinated school health system and their roles in helping students develop lifelong healthy behaviours. In addition, opportunities for cross-training with school-linked health and human-services providers will greatly strengthen the coordinated school health system.

2.10 CONCLUSION

The focus of this chapter was to address the literature relevant and foundational to the study. Applicable policies and legislative framework were identified and discussed in relation to the study. This chapter discussed the strategies that play a vital role in the promotion of a healthy school environment, and amongst others, community participation is flagged in this regard. The indication being, the creation of a healthy school environment is not a lone venture, but a collaborative process requiring the involvement and participation of everyone. Prevention of communicable diseases and the management of the first aid kit are also pointed out. The role and impact of national programmes in the form of Eco Schools and the Soul Buddies project were also looked at, and an understanding was given of how they operate. The role of management teams in supporting and monitoring the activities of the committees is very crucial in ensuring successful implementation of programmes. The literature as quoted in this chapter will be the bedrock, support base and a referral point of the whole study.

The next chapter deals with the research methodology employed in this study.