

**THE ROLE OF SCHOOL MANAGEMENT IN PROMOTING HEALTHY LEARNING
ENVIRONMENTS FOR GRADE R LEARNERS**

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JPTD (SEBOKENG COLLEGE OF EDUCATION), ACE (NWU), Bed HONS (NWU)

A dissertation submission in the fulfilment of the requirements for the degree

MAGISTER EDUCATIONIS

In

Education Management

At

NORTH-WEST UNIVERSITY

(VAAL-TRIANGLE CAMPUS)

Supervisor: Dr S.J. Kwatubana

Vanderbijlpark

2014



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DECLARATION

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THE ROLE OF SCHOOL MANAGERS IN PROMOTING HEALTHY LEARNING ENVIRONMENTS FOR GRADE R LEARNERS

DEGREE: MASTER OF EDUCATION (MED)


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29 April 2014

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MAMOTSEKUA G. KOLOKOTO

MAY 2014

ACKNOWLEDGEMENTS

I would like to thank God for giving me strength, I wouldn't have managed on my own. He covered me with his love, mercy and favour. I also want to thank the following people for their support and patience throughout the sleepless nights.

- My supervisor Dr Siphokazi Kwatubana for her supervision, motivation, guidance and patience. I don't have enough words to thank her, may the Almighty God bless her on my behalf by granting her and her family the desires of their hearts
- Dr R. Krugel for her assistance with the language editing of this document.
- All the library personnel of NWU for supporting me with relevant sources needed for this research study.
- My children, Moiloa, Tshediso, Lerato and Neo for their encouragement, and support especially Neo who needed me most to assist with homework, but could not get my help.
- Mpho, Thabang, Itumeleleng and Nthabiseng and all my friends for their support.
- Tshepo Tau who assisted with one of the resources that enabled me to complete my work and all my friends for their support and encouragement.
- All the participants in the Sedibeng West District who sacrificed their time to make this research study a success.
- The Sedibeng West District for granting me permission to conduct research in schools.
- My church for understanding when I could not perform my duties as expected.

DEDICATION

I dedicate this work to my late mother Agnes Mtjilebe, my husband Michael Kolokoto and my brother Edward Papi Mtjilebe. May their souls rest in peace.

ABSTRACT

Key words: role of SMT; promotion of healthy school environments; healthy school environments for Grade R learners; learning environments; management of healthy environments; Reception year

The main aim of this study was to investigate the role of school management in promoting healthy school environments for Grade R learners in the Sedibeng West District. A literature review revealed that there are two types of health programmes: those that support the curriculum and those that are part of the curriculum. School managers have to focus on both in their efforts to promote health in schools. South African schools adapted a Whole School Approach in creating and sustaining healthy environments. Whole School Approach includes the development of health policies, health education, community, learner, teacher involvement, nutrition and prevention of communicable diseases.

A qualitative research approach was used and data was generated by means of interviews, documents, photographs and narratives. Four research sites were purposefully selected and four principals, three Heads of Departments for Foundation Phase, four health coordinators and four Grade R practitioners participated in this research. Only one of the research sites had a School Based Health Centre.

The study revealed that curriculum-based health programmes including physical education, physical activities and health education were effectively implemented although they were not effectively monitored and evaluated. Health programmes supporting the curriculum include nutrition, first aid and health services. Both health services and nutrition were effectively implemented and monitored whilst there were serious problems with first aid. Practitioners were not trained for first aid, in the three schools where first aid kits were available were not checked therefore not replenished. In one school there was no first aid kit, thus, there was not much focus on precautionary measures in the participating school. There was therefore, no

strategies in place for the management of health programmes that support the curriculum.

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CHAPTER 1

OVERVIEW OF THE STUDY

1.1 INTRODUCTION AND RATIONALE

Growing children require healthy learning environments not only to develop holistically (Meier & Marais, 2007: 204) but also to learn effectively (Berry, 2002:2). Research studies by Berry (2002:1) and Morrison (2012:255) repeatedly show that children who are reared, cared for, and taught in healthy environments, are healthier, happier and more achievement oriented than children who are not raised in environments that underpin efforts to safeguard their health. Thus the environment has an effect on the development of growing children and their well-being (Gordon & Browne, 2008:282).

A healthy learning environment is defined as an environment that affords for learners' physical and psychological health (Morrison, 2012:9) by providing relevant information, thereby equipping children with skills to make informed choices about their health. A healthy learning environment is a place that provides for facilities and resources that is conducive to the promotion of health (Denman, Moon, Parsons & Stears, 2002:25; Jerome, 2008:52). In an effort to enhance such environments, schools create health programmes that look at a number of contentious areas such as, active health committees, school health policies, healthy nutrition, physical activity and health education (Jones & Furner, 1998:8; World Health Organization, 2003:19-26; Morrison, 2012: 255). The promotion of such programmes requires school managers' commitment and recognition of the need to offer health-enhancing environments. The question that arises is whether school managers play their role in such a way that Grade R learners benefit from these multipronged initiatives.

A Grade R class is a reception class, that learners aged four and a half (4 ½) turning five (5) by 30 June in the year of admission, have to attend as part of the compulsory 10 years of education from Grade R to 9 (SA, 2005:2; United Nations Children's fund, 2007:2; Zill & Ziv, 2007:3). Learners doing Grade R are in the pre-operational stage (2-7yrs) according to Erikson (1950) and it is important for such children's

health habits to be affected, before maladaptive health behavior becomes deep-rooted (Tailor, 1999). There is a growing need to deal with health issues in young children, according to a research by the Medical Research Council (MRC) (2000) child health has deteriorated due to pediatric AIDS. UNICEF (2007) states that one tenth of children in South Africa are malnourished because of poor quality of food and fifty per cent of these children are in pre-school. Children are vulnerable, reasons highlighted in the literature for the vulnerability include: high poverty rates (fifteen per cent of children) (UNICEF, 2007) caused by food insecurity, and orphan hood due to HIV, and other related matters (14 million orphans in 2008) (Statistics South Africa, 2008).

The role of school management in the creation of a healthy school environment is to enhance health promoting programmes, assist in the development and implementation of policies, support learners and educators in their endeavors to ensure health promotion in schools (SA, 2002:10) and to develop partnerships between the school and its local community (Denman, *et al.*, 2002:35). According to the Department of Health and Wellness (2008:2), there is a need to address health issues through a coordinated approach that ensures compliance with comprehensive policies. The School Management Team's (SMT) role therefore would include frequent monitoring of the school premises to ensure that healthy environments are promoted. Fourie (2005:35) and Thurlow, Bush and Coleman (2003:35) define management as the organization and coordination of activities using available resources efficiently and effectively. Management therefore, requires a collective decision making to adopt policies, and make commitments to pursue specific plans for health risk reduction.

A survey of related literature indicates that studies conducted regarding healthy school environments exist, but:

- **internationally**, these studies focus on Whole School Approach to the creation of healthy school environments (World Health Organization, 2006:1-7; St Leger, Young, Blanchard & Perry, 2010:6); the process of creating healthy school environments (Inchley, Muldood & Currie, 2006:66); evaluation of health promoting schools (Inchley, *et al.*, 2006:65-66); and

- **nationally** there is not much research that is conducted as the creation of healthy school environments is relatively new. Two studies can be mentioned: one that evaluated the process of promoting healthy school environments in nine provinces in South Africa (SA, 2008:7; Mukoma & Flisher, 2004:68); and another one which evaluated the implementation of the National School Nutrition Program (SA, 2008:11).

There are therefore, no studies conducted on the role of management in enhancing healthy learning environments.

1.2 BACKGROUND OF THE STUDY

The rationale behind this section was to provide a setting giving an outline of where the study was conducted.

This study was undertaken in the Sedibeng West District of Education in the Gauteng Province. The Sedibeng West District falls under the Sedibeng District Municipality (SDM), the poorest municipality in the Gauteng Province. The unemployment rate according to SDM (2009) was at 95.3%, poverty at 43% in 2005 and at 38% in 2010, HIV/AIDS prevalence at 31.8% in 2008 and 28.9% in 2009. The leading causes of death in SDM are influenza and pneumonia followed by Tuberculosis. Both these illnesses are HIV/AIDS opportunistic diseases and most of the deaths could be HIV related. The SDM used to be an economic hub in the 1990s but because of economic melt-down things took a nose dive, most companies closed down and others moved to better areas.

Thus, the only hope for a healthy community in this area therefore lies with the promotion of healthy environments in schools. CSIR (2002: 38) explains poverty as generally being characterized by the inability of individuals, households, or entire communities, to command sufficient resources to satisfy a socially acceptable minimum standard of living. Poor families create poor communities, and it is these poor communities that ultimately raise children who are vulnerable.

There are still big companies that are fully operational such as MITTAL and Cape Gate to mention a few. SASOL firm is close to SDM situated in the Fezile Dabi District. The two districts are just separated by the Vaal River. The presence of these industries in this area, do not only come with benefits but there are also some snares

they are coupled with. The major negative environmental impacts caused by these industries include air pollution and water pollution. Although measures have been taken to regulate the air pollution in these firms, the negative impact of the activities is still experienced by the communities.

Council for Scientific and Industrial Research (CSIR) (2002: 11) indicates that South African coal produces smoke when burned, and most of this coal is concentrated in areas like South Highveld coal fields in areas like Secunda, and Eastern Highveld coalfields, in areas like Ermelo and Volksrust. These are also areas where the same kind of pollution takes place. This presupposes that as a result these areas will be highly polluted, because of the gas emissions and smoke from industries and mines, taking into account that due to their operations, SASOL and Eskom release smoke.

CSIR (2002: 39) says that worldwide an estimated three million people in developing countries die every year from water-related diseases caused by exposure to microbiological pathogens resulting from inadequate sanitation and waste disposal.

What should be noted in this regard is that there are a number of primary and secondary schools in this area that enroll thousands of learners, who can be directly affected by water and air pollution if the situation is not properly managed. This is what prompted this study, and in this area in particular, to determine how schools, through their management teams, are managing the situation.

1.3 STATEMENT OF THE PROBLEM

As indicated earlier on, the main health problems for children in South Africa are poor nutrition, poverty, environmental factors including loco-motor dysfunction impacting negatively on the overall development of young children. The prevalence of poverty in communities across South Africa causes learners to face the risk of ill health and severe learning difficulties (SA, 2008:2). Malnutrition in early life is associated with reduced capacity to learn and physical development resulting in stunted growth. Undernutrition primarily affects young children especially those whose parents have a low education status, low or no income, and live under poor environmental conditions (Iverson, Du Plessis, Marais, Morseth, Adolfsen-Hoisætger & Herselman, 2010:72).

According to Midford and McBride (2001: 789), little effort has been made to teach children preventive health attitudes and behavior in pre-schools. This may be due to the assumption that children are not cognitively ready for this type of instruction. Although there is a focus on specific health issues such as substance use, abuse and more recently AIDS (Sussman, 2001: 195; Jones, 2002-2003:10) other health issues are neglected. It is imperative for children to learn in their early school years that preventative health is important (Mellanby, Rees &Tripp, 2000: 534).

According to the DoBE Curriculum and Assessment Policy Statement (CAPS) (2012:11), the development of the learners' gross and fine motor skills are fundamental in the Foundation Phase. Unfortunately physical activity is not fully available to young children as it should be. Young children, according to Engler, Governer and Haveman, (2002:2) are not given the opportunity to participate in organized sports. According to Green, Smith and Thurston (2009:187) and Pryke (2006), there appears to be declining levels of physical activity among children and modern living generates less energy for daily activities (due to changes in transport, entertainment and environmental concerns). The sedentary lifestyle can lead to obesity and other health related problems. Thus, there is a need to find ways to actively boost exercise in order to avoid health problems.

To address these barriers the school health policy is required to strengthen and vertically facilitate the creation and maintenance of healthy school environments (Department of health, 2002:10-12).The problems highlighted above lead to the questions indicated in the heading that follows.

1.4 RESEARCH QUESTIONS

The primary research question guiding this study was:

What role does the school management play in promoting healthy learning environments?

Secondary questions that informed the main question are:

- What is the essence of healthy learning environments?

- What is the role of the SMT in health programmes that support the curriculum?
- What role does the SMT play in curriculum-based programmes that address health issues?
- What is the role of the SMT in promoting healthy physical environments?
- What is the role of the SMT in providing effective leadership and implementation of health policies to spearhead health programmes?
- What recommendations can be made to school managers to enable them to be more effective in the promotion of healthy learning environments for Grade R learners in the Sedibeng West district?

1.5 AIMS AND OBJECTIVES OF THE STUDY

The main aim of this study was to understand the role of school management in promoting healthy learning environments in the Sedibeng West District. This aim has been operationalised in the following objectives to:

- investigate the essence of healthy learning environments;
- investigate the role of the SMT in health programmes that support the curriculum;
- investigate the role the SMT play in curriculum-based programmes that address health issues;
- investigate the role of the SMT in promoting healthy physical environments;
- investigate the role of the SMT in providing effective leadership to spearhead health programmes; and
- to come up with recommendations that can be made to school managers to enable them to be more effective in the promotion of healthy learning.

1.6 RESEARCH METHODOLOGY

This study was conducted in two phases: a literature review and an empirical research. The literature review led to the understanding of the essence of healthy

school environments, their importance for Grade R learners and how they are managed to ensure that learners benefit from such initiatives. The literature review guided the development of an interview schedule used in the second phase, the empirical research. The modus operandi in each of the phases is indicated below:

1.6.1 Research paradigm

Paradigms are all encompassing systems of the interrelated practice and thinking that defines the nature of researcher enquiry along three dimensions: ontology, epistemology, and methodology or a perspective based upon sets of values and philosophical assumptions, which is a design for collecting and interpreting data. (Terre Blanche, Durrheim & Painter, 2006:6, Gray, 2009:579, de Vos, *et al.*, 2011:40). In this study a social constructivist paradigm was followed. According to Creswell (2009:8) the goal is to rely as much as possible on the participants' views of the situation being studied. My role was to make sense of the meanings the participants have about the role of SMTs in promoting healthy school environments.

1.6.2 Literature review

The conceptual framework below assisted in mapping out and writing a critical literature review. According to Creswell (2009:25) and Bless, Higson-Smith and Kagee (2006:24) the literature review "provides a framework for establishing the importance of the study as well as a benchmark for comparing the results with other findings" by reading relevant information regarding this research topic.

The review of national and international, primary and secondary literature sources was undertaken to collect relevant data on the role of management in ensuring healthy learning environments for Grade R learners. Leedy and Ormrod (2005:162-165) define primary sources as the original source texts which are also called archival data because they are kept in museums, archives, libraries and or private collections that are generally regarded as being closer to whatever is or was true while secondary sources are the work of other scholars writing about the issues being studied. Primary data was collected mainly via the empirical study which underpins this study. Secondary data was gathered by means of a literature review of journal articles, theses, dissertations and the department of education's policy records. To identify secondary data sources for the proposed research, I searched

EBSCOINFO, ERIC, EBSCO, NEXUS and SABINET for relevant studies using the variables stated below.

The following keywords were used:

Role of the SMT, promotion of healthy school environments, healthy school environments for Grade R learners, learning environments, management of healthy environments, reception year.

1.6.2.1 Conceptual framework

The central themes that guided this study are indicated in the table below:

Table 1.1 Summary of literature

Theme	Sub themes	Sources
Rationale		Atkins, Kimberly, Hoagwood, Kutash and Seidman (2010); Bullard (2003); Erasmus (2006); Grevatt (2011); Gordon and Browne (2008); Isabel (2008); Kwatubana (2014); Lackney (1996); Morrison (2012); National School Climate Centre (2007); Peltzer (2003); Strong Wilson and Ellis (2007); Tannant (2005); Telljohann, Symons, Pateman and Seabert (2012); UNICEF (2009); WHO (1998); WHO (2003)
Developmental stages of Grade R learners		Desai (2010); Newman and Newman (2006); Robbins <i>et al</i> (2006)
Health programmes that benefit Grade R learners	Whole school approach Policy development and	Adelman Gilligan and Lehrer (2008); Barnekow <i>et al</i> (2006); Buhl (2009); CAPS (2012); Carlifonia Department of Education (2003); Centres for Disease Control and Prevention (2006); Coe,

	<p>implementation</p> <p>The national Policy on HIV/AIDS (Act 27 of 1996)</p> <p>The Integrated School Health Policy</p> <p>Curriculum Assessment Policy Statement</p> <p>School Nutrition Policy</p>	<p>Pivarnik, Womack, Reeves and Malina (2006); Department of Education (2002); Department of Education (2009); Department of Basic Education (2013); Department of Environment and Heritage (2005); Department of Health (2002); Department of Health (2005); Department of Health (2012); Deschenes <i>et al</i> (2003); Fox and Wong (2002); Global Child Nutrition Foundation (2010); Grantham-McGregor, Chang and Walker (1998); Greenberg (2001); Han and Weiss (2005); Hannon and Brown (2008); Health Protection Agency (2010); Heath, Brownson and Kruger (2006); Integrated School Health Policy (2012); Keeton, Soleimanpou and Brindis (2012); Kwatubana (2014); Lightfoot and Bines (2000); Motsoaledi (2011); Nathan and Moran (2008); National Association for Sports and Physical Education (2002); National School Health Programme (2007); National Policy on HIV/AIDS (1996); Pike and Colquhoun (2010); Rubin (2013); Scrimshaw and San Giovanni (1997); Sims (2012); Sorhaindo and Feinstein (2006); Statistics South Africa (2008/2009); Mason-Jones, Momberg and De Koker (2012); Timmons, Naylor and Pfeiffer (2007); Tinsley (2003); UNESCO (2010); UNICEF (2004); Van</p>
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		Stuijvenberg (2005); World Health Organization (1997); World Health Organization (2000); Wyn, Cahill, Holdsworth, Rowling and Carson (2000); Young (2008)
Role of school managers health promotion		Connecticut State Board of Education (2005); Department of Environment and Heritage (2005); Eriksson (2011); Jourdan, McNamara, Simar, Geary and Pommier (2010); Kwatubana (2014); Lang <i>et al</i> (2009); Meier and Marais (2012); Muldoon and Curie (2006); Nytrø <i>et al</i> (2000); Pearson (2007); RSA (2008); WHO (1998); Whysall, Haslam and Haslam (2006)
Challenges in maintaining healthy school environments	<p>Non compliance to policies</p> <p>Health committees that are dysfunctional</p> <p>Lack of collaboration and synergy</p>	California Department of Education (2003); Draxler (2008); Hornby (2011); Moore and Skinner (2010); Muldood and Curie (2007); Shallcross (2004); UNICEF (2009); WHO (2003)

1.7 RESEARCH DESIGN

According to Mouton (1999:107), Leedy and Ormrod (2005:85) and Mouton (2009: 107), a research design is defined as a set of guidelines, instructions and a general strategy to be followed in order to reach a goal. The research design enabled me to anticipate the appropriate research decisions regarding the structure and the features of my research.

A qualitative research design was employed in this study. Leedy and Ormrod (2005:133) and Creswell (2009: 4) define a qualitative design as a means for exploring and understanding the meaning individuals or a group ascribe to a social human problem, it focuses on phenomena that occur in natural settings. A research design is a “strategic framework for action that serves as a bridge between research questions and the execution and implementation of the research (Terre Blanche, *et al.*, 2006: 33).

One of the advantages of a qualitative research is its ability to produce more in-depth comprehensive information. Although the downside is that it limits scope, the intention was to gain understanding and not to generalise.

The qualitative research design was appropriate for this study because my aim was to explore and understand the meaning and experiences Grade R practitioners and SMT members ascribe to the role of school managers in the promotion of healthy environments for Grade R learners.

1.8 STRATEGY OF ENQUIRY

Strategies of enquiry are methods, designs or models that provide specific direction for procedures in a research design (Creswell, 2009:11). The phenomenological research strategy was chosen for the aim of this study. This strategy of enquiry focuses on the identification of the essence of human experiences about a certain phenomenon in order to interpret and understand their actions (Creswell, 2009:12; Gray, 2009:171).

This approach enabled me to have an opportunity to understand the role of SMTs in the promotion of healthy learning environments from the participants’ point of view.

1.9 POPULATION AND SAMPLING

A sample comprises elements or a subset of the target population considered for inclusion in the study or it can be viewed as a subset of measurement drawn from the population that researchers are interested in or the particular entities the researcher select (Leedy & Ormrod, 2005:144; de Vos, *et al.*, 2011:223). The population of this research were all SMT members in schools that had Grade R classes and Grade R practitioners.

The sampling in this research was done with a specific purpose that was, to get participants who were directly involved in the teaching and management of Grade R learners. Purposive sampling seeks to identify information rich cases which can then be studied in depth (Patton, 2002). The sample the participants who served the purpose of the study best (Terre Blanche, *et al.*, 2006:139; de Vos, *et al.*, 2011:393), and not selected based only on their availability and willingness to participate.

The disadvantage in the use of a purposive sampling is that it can be highly prone to researcher bias (de Vos *et al.*, 2011:393). Multiple sources of data (*cf.* 1.9) were used to avoid bias.

A stratified purposive sample included the principals, SMT members and grade R practitioners who were relevant to answer research questions that enabled me to determine the role of management in promoting healthy learning environments for grade R learners.

Schools in the Sedibeng West District were requested to participate in this research study. According to Leedy and Ormrod (2005:139), a typical sample size is from five to twenty five participants with direct experience with the phenomenon being studied. The sample comprised of fifteen participants (n=15) consisting of school managers (n=7), Grade R practitioners (n=4) and health and safety co-ordinators (n=4). Lists of schools with grade R classes were collected from the district office.

1.10 DATA COLLECTION

Data collection refers to all basic material used by researchers in the collection of information (Creswell, 2009:178). According to Leedy and Ormrod (2005:143), qualitative researchers often collect data from multiple sources. Data in this research was collected by means of interviews as the predominant mode of data collection in conjunction with photographs and narratives.

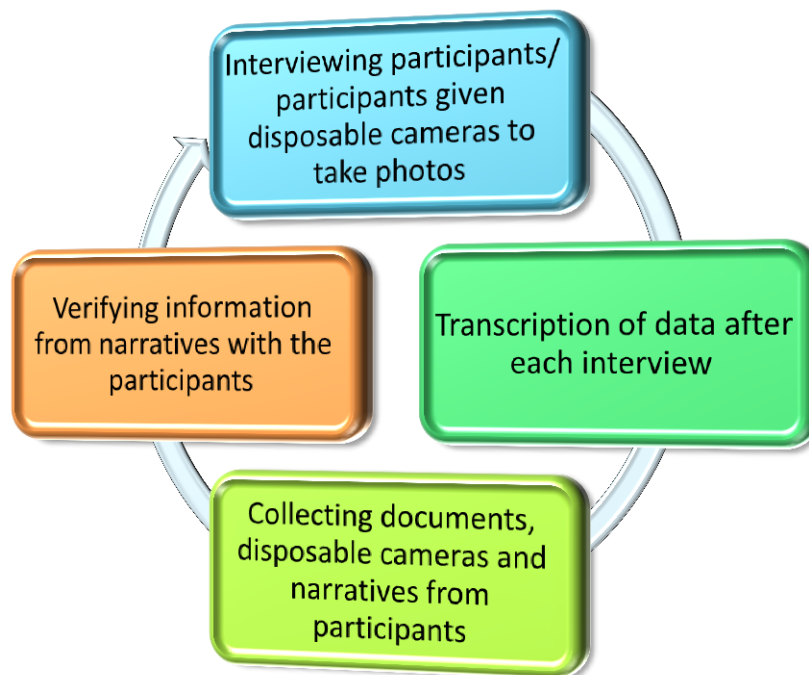
An interview is a two-way conversation in which the interviewer asks the participant questions to collect data and learns about the ideas, beliefs, views, opinions and behaviours of a participant (Terre Blanche, *et al.*, 2006:51; Nieuwenhuis, 2007:87; de Vos, *et al.*, 2011:342) in this research (*cf.* 1.9).

Semi-structured interviews were used to corroborate data emerging from photographs and narratives. The focus on semi-structured interviews led to the development of an interview schedule. A Semi-structured interview was preferred because it allowed me to probe in order to get more clarity from participants, while also providing a set of basic questions.

A tape-recorder was used to record interviews however; I obtained permission from participants prior to the recording. Recorded interviews were transcribed into a written text for the purpose of analysing data to help me understand the problem and the research question.

The photographs, assisted in comparing audio-taped data and visual data and the narratives as they were part of a collaborative interaction between the participants and myself. Disposable cameras were supplied to participants to take photos of playgrounds, toilets and classrooms used by Grade R learners. Participants were encouraged to write narratives to accompany and expand upon the photographic evidence to the concretization of the interviews (Flick, 2006). According to Gray (2009:186), photographs allow a detailed recording of facts and capture processes that are too rapid for the human eye. The use of photographs in qualitative research is discussed in Chapter 3 (*cf.* 3.5).

Figure 1.1 Data collection process



The data collection process in the figure above helped in the facilitation of the analysis of data while it was collected. I went back to the field several times for more data and clarification until I was satisfied that no new information was emerging.

1.10.1 Role of the researcher

I was the primary research instrument in this study. I collected data through documents, photographs and by interviewing participants. My role included the four crucial roles indicated by Creswell (2009: 177):

Figure 1.2 Roles of the researcher in data collection



Steps taken in each of these roles are elaborated in Chapter 3. Building a relationship with participants was of utmost importance to me as Mouton (2009:149) indicates that the researcher is often seen as a stranger, an outsider, or an intruder

in the research field. Other roles such as interviewing participants, capturing interview data, transcribing the data, collecting documents, disposable cameras and narratives were also embarked on. Chapter 3 elaborates on how these roles were played.

1.11 DATA ANALYSIS AND INTERPRETATION

The process of data analysis involved making sense of the text (interview responses and narratives) and image data (photographs). Data analysis involved preparing the data for analysis, and moving into deeper understanding of the transcribed and image data. I followed the procedure suggested by Leedy and Ormrod (2005:140), after transcribing the interviews I identified statements that related to the topic (coding), grouped statements into meaning and units (categories) and looked for divergent perspectives so as to construct a composite.

Triangulation of data collected by means of interviews, narratives, documents and photographs was necessary. Flick (2009: 445) indicates that triangulation refers to merging different sorts of data. Denscombe (2007:134) states that triangulation is the practice of presentation of data from more than one perspective. The rationale behind triangulation was to get a better understanding of what was investigated by viewing it from different positions. How this data was triangulated in this research is discussed in depth in Chapter 3.

1.12 ETHICAL ISSUES

According to Leedy and Ormrod (2005:101) and Terre Blanche, *et al.* (2006:61) “whenever human beings are the focus of investigation, one must look closely at the ethical implications of what one is proposing in order to respect the participants and the sites for research”. Crucial ethical measures taken into consideration in this research are discussed below:

Protection from harm - The researcher ensured physical and emotional protection of all participants. They were also given an opportunity to withdraw from the investigation if they were no longer willing to participate. Interviews were conducted at school after contact time. This ensured physical protection as all other educators were still at school. Participants were advised not to respond to questions they were not comfortable with; this was done to protect participants’ psychological well-being.

Voluntary participation- Participants were not forced or coerced in partaking in this research study. Participants were informed about the purpose of the research and how it was to be conducted. Only participants who voluntarily agreed to partake in the research study took part in the proceedings of this study. This was important for me as it was an indication of the interest participants had regarding the topic investigated. I assumed that they would be motivated and willing to fully participate in the research.

Informed consent form- A written informed consent form was distributed to schools where participants were informed of the nature of the study to be conducted. The duration of the participant's involvement and, procedures followed were also stated. A copy of a signed consent form is in Appendix (4)

Permission-I asked for permission from the ethics committee of NWU Vaal campus to conduct this research. After the permission was granted a research request form was sent to the Gauteng Department of Education. On the receipt of the approval from the Department of Education (Appendix 2), I then approached principals of targeted schools, showed them the approval from the Department of Education and also supplied them with a request (Appendix 3) to conduct interviews at their schools. I then explained the consent form to each volunteering participant of the targeted schools. After agreeing to take part they were requested to sign the consent form.

Confidentiality- Strict measures were taken to ensure the confidentiality of participant's records. Participants' responses were handled with confidentiality. Consideration was also given to the storage of data collected and the disposable cameras so that only my supervisor and I have access to it. No names or personal information was recorded; instead participants are referred to as Participant 1, 2 up to 15.

Actions and competencies of the researcher-I was honest in all my dealings with the participants. Reasons for the study were clarified and the manner, in which ethical guidelines were honoured, was also indicated. I used my skills to train participants on how to use the disposable cameras. I read few articles on how to conduct interviews and I was aware of the skills one has to possess in order to carry

out a fruitful interview. These skills included active listening, paraphrasing, probing and transcribing.

1.13 CHAPTER DIVISION

A preview of the chapters in this study was as follows;

CHAPTER 1: OVERVIEW OF THE STUDY

In this chapter information on the background, the aims and the research methodology of this study were provided

CHAPTER 2: THE FUNDAMENTAL NATURE AND THE ROLE OF MANAGEMENT ON EARLY CHILDHOOD DEVELOPMENT

The aim of this chapter was to explore the fundamental nature of the role of management in the promotion of healthy learning environments for Grade R learners

CHAPTER 3: RESEARCH METHODOLOGY

This chapter contains the research methods, data collection and sampling procedure employed in the research.

CHAPTER 4: PRESENTATION AND DISCUSSION OF RESULTS

Analysis of data generated through interviews photographs and documents is analyzed and interpreted in this chapter.

CHAPTER 5: SUMMARY, FINDINGS AND RECOMMENDATIONS

This chapter contains a summary of this whole study and reflects on the findings of the literature review and the empirical study. The findings and the recommendations are presented.

1.14 CONCLUSION

This chapter started by giving an introduction and the rationale of this study. The problem leading to investigation of the topic is stated. The approaches to the creation of healthy school environments were mentioned and are discussed in Chapter 2 (*cf.* 2.2). The research paradigm, method used and participant selection, data collection and data analysis, and interpretation were also explored in this chapter. It was necessary to familiarize myself with the ethical considerations and

values used in conducting research as I have to consider those aspects in every phase of this research. Finally the chapter layout shows how this study unfolded from the first chapter to the last one. This chapter formed the base of the whole study, thus, the succeeding chapters build up on what this chapter has started.

In the next chapter, the literature review is presented.

CHAPTER 2

THE ESSENCE OF HEALTHY LEARNING ENVIRONMENTS

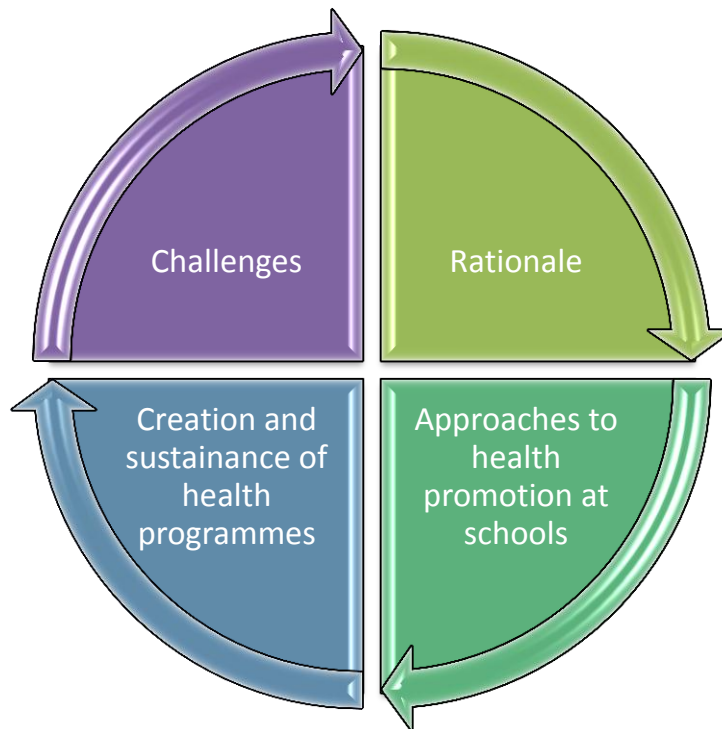
2.1. Introduction

The focus of this chapter is on the essence of healthy learning environments and the benefits to learners. The chapter starts off by elaborating on the rationale for the creation of healthy school environments, then a discussion about the approaches to creation and sustenance of healthy environments follows and lastly the challenges are explored.

Healthy learning environments are environments that provide and support a physical development and contribute to the health of learners (World Health Organisation, 2009:5). Healthy Environments according to Children Alliance (HECA) focus attention on the school environment as one of the key settings for promoting children's environmental health. According to Kwatubana (2014:256), if a learning environment is not healthy then learners will also be vulnerable to contracting illnesses and diseases. Environmental factors cause illnesses and diseases and disabilities including gross loco motor dysfunction and impaired vision and hearing. Healthy environments can lead to healthy learners that enjoy schooling. The most elements of a healthy school environment is related to the physical condition of the buildings, playgrounds, sport facilities and other school properties.

Garrett (2001: 64) and the California Department of Education (2003: 3) 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. The essence of healthy environments will be discussed based on the framework summarised in the figure below.

Figure 2.1 Summary of Chapter 2



2.2 THE RATIONALE

For many Grade R learners the school is their second environment they live in besides their home. They are used to an environment with just their family members; the school environment is totally different from this. Erasmus (2006:75) indicates that the reception year which is referred to as 'Grade R', is part of the Foundation Phase (Grade R to 3) in the General Education and Training Band of the National Qualifications Framework (NQF). Grade R focuses on learners in the ages between five and six years. At this level learners are being prepared for their schooling years.

As indicated in the introduction a healthy environment is an environment which does not expose children to health hazards or put them at risks of diseases and injuries. Psychological safety requires an even finer sensitivity on the part of the teaching staff (Gordon & Browne, 2008:383). A healthy environment setting is important for all children. A clean, well-maintained class with a positive atmosphere and social climate increases learner and staff self-esteem and learner achievement (Morisson, 2012:304).

Telljohann, Symns, Pateman and Seabert (2012:18) reveal that the environment in which a student spends a large part of each school day makes an impact on both their academic achievement and their health status. This impact will be discussed in the subsequent paragraphs.

Healthy school environments are essential for learning, and all environmental problems should be dealt with to allow learning to continue undisturbed. A health-promoting school (HPS) can only be realised when a school constantly strengthens its capacity as a healthy setting for living and learning. A clean and healthy environment improves learners' learning and is directly related to academic achievements and also boosts their confidence (National School Climate Centre NSCC, 2007:5). Results of a research conducted by Peltzer (2003:1) indicate that learners who have positive perceptions regarding their school environments were significantly more likely to engage in health promoting behaviours. Health promotion in schools is imperative in that health environments directly improve learners' health and also enable effective learning (Kwatubana, 2014:255).

Since children's experiences are limited by their surroundings, the environment that is provided for them has a crucial impact on the way their brain develop (Strong-Wilson & Ellis, 2007:43). Strong-Wilson and Ellis (2007:43) further state that development in children during early stages is faster than in adults, including the brain development, as a result the surroundings in which learners live will determine the pace in which the brain develops, faster in healthy environments and slower in an unhealthy environment. The positive impact of healthy environments on the child's brain plays a major role in the brain's ability. Children living in a healthy environment are more likely to maximise their thinking ability, intellectuality and the brain has a potential to grow to its full potential (Strong-Wilson & Ellis, 2007:43).

Isabel (2008:2) opines that the early environment where young children live will help determine the direction of their brain development. Isabel (2008:2) further states that children who have the opportunity to develop in a healthy environment are challenged to think and use materials in new ways. Appropriate experience during early years in logical thinking can have a positive impact on the child's current development, as well as brain connections that will last a lifetime.

An unhealthy environment can thus, have a negative impact on the brain development of young children. If a child lives in an unhealthy and threatening environment his/her brain will develop slower and it will lose the synapses that are not being used. It is during these early stages when one can form and mould a child's brain and if the surrounding is right, it will be far less difficult for one to do so (Bullard, 2003:1). In a study conducted by Bullard (2003:1) a tendency for traumatised children to be overly sensitive to cues of perceived environment threats, creating a 'quick trigger' for survival behaviours was found. As a result, these children have a predisposition to impulsive, aggressive behaviours or withdrawal and depression. A positive environment reduces the problem of mental disorders in children according to Tannant (2005:5).

Atkins, Kimberly, Hoagwood, Kutash and Seidman (2010:40) argue that the high prevalence of school-aged learners with mental health disorders challenge families, schools, and community resources to build an environment that will benefit such learners.

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 institution (Grevatt, 2011:30). While all children may be exposed to threats to well-being in and around school, children from poor communities are at particular risk (UNICEF 2009:10). It is the role of every school to reduce environmental health threats and risks so as to eliminate health hazards in the school surroundings (Kwatubana, 2014:255). A contaminated environment can cause health problems which cannot be recognised during schooling time but in later years. Health effects such as cancer and neurological disease may be delayed until much later in life (WHO, 1998:3).

Learners spend most of their time at school therefore the state of the learning environment will influence their health drastically. According to WHO (1998:3) and Greenman (2005:1) many children spend a large portion of their wakeful hours in early childhood group settings, this happens during their critical developmental stages. The environment where they spend most of their time will tell whether it is healthy or unhealthy by the health status of learners. Isabel (2008:1) indicates that this massive number of hours in one environment demands that the space be

carefully designed to create the best place possible for young children. It seems that the reason that the early childhood environment has such a strong role in children's development is due to the amount of time children spend in these environments.

According to Grevatt (2011:30), 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. Many childhood illnesses and deaths are greatly influenced by the environment (WHO, 2003:5).

A healthy learning environment has to be welcoming to learners and educators. If the school respects the rights of learners they will respect the environments in which they learn by creating the environment that will protect their health and make them feel loved and cared for. Teachers perceive that cleanliness, orderliness, and the general character of a school building influence learner behaviour (Lackney, 1996).

Research highlights the high-quality experiences in the early years as essential. It also indicates that the experiences provided by high-quality Early Care and Education (ECE) programmes can have a positive impact on children's cognitive and social development (Morrissey & Warner, 2014). The short-term participation in high-quality programmes results in increased child intelligence quotient and school achievement. Some of these benefits fade out over time, particularly gains in intelligence quotient, though this has been attributed to the poor- quality (foundation) and (intermediate) that early intervention participants typically attend (Morrissey & Warner, 2014). It is therefore essential that early health education and promotion should not be taken for granted by assuming that children are not yet ready to learn.

The foregoing paragraphs indicate that there is a relationship between clean, healthy environments and academic performance, brain development and well-being of learners. Time spent in unhealthy school environments put learners at risk of ill health and underdevelopment. It is therefore necessary to discuss children's developmental stages to understand how learners benefit from healthy environments. The stages of development such as that of Erickson and Piaget will be discussed in the section below:

2.3 DEVELOPMENTAL STAGE OF A GRADE R LERANER

The psychosocial stage according to Newman and Newman (2006) includes the early school years from the age of 5 to 12 years. The learner in the reception class is between 5 and 6 years of age. The psychosocial stage is dominated by imagination as the key element. Educational programmes in this stage are developed in such a way that learners are allowed room to express their sense of imagination, thereby developing their sense of purpose.

Robbins *et al.* (2006) indicate that Piaget proposed four causal factors that determine cognitive development: maturation; physical experience which includes action with the environment; social interaction involving interchange of ideas between people; and equilibrium including the internal self-regulating system that operates to reconcile the roles of maturation, experience and social interaction.

Learners in the psychosocial stage must be afforded opportunity to play with various natural, simple materials and role playing as the use of symbolic thought is apparent (Robbins *et al.*, 2006). Real life activities become imperative. Children can participate in activities that pertain to the creation of healthy environments. Participation in hygiene practices such as the washing of hands, cleaning of the classroom, picking up papers and others provide an opportunity to contribute productively to the environment in which they live (Robbins *et al.*, 2006).

According to Piaget (in Newman & Newman, 2006), learners in this stage are in the pre operational stage. Piaget distinguishes between two sub-periods: the pre-conceptual characterised by the development of language and imaginative play and the intuitive characterised by the emergence of skills in areas of numbers, classification and interrelationships (Desai, 2010:6). During the intuitive period, there is emergence of skills in the areas of numbers, classification and interrelationships. In addition, behaviour eventually becomes less egocentric and more social.

Physical development results from the interaction between individual factors of heredity and environmental forces. Abnormal growth patterns often reflect this interaction. A striking illustration of this effect is the failure to thrive syndrome in which children suffering from prolonged neglect or abuse simply stop growing (Robbins *et al.*, 2006). In these children, psychological stress produced by their

social environment causes the pituitary gland to stop secreting growth hormones. When the environmental stress is alleviated, and the child receives care, affection, and stimulation, growth resumes often at a rate that enables catch-up growth to occur. In body growth, brain growth, and all other aspects of physical and psychological development, genes and environment collaborate to produce normal development (Robbins *et al.*, 2006). Thus, physical developments are affected by the environment no less than psychological ones. A healthy environment is therefore, necessary for normal growth of the body, brain, and nervous system

2.4 BACKGROUND OF THE RECEPTION CLASS IN SOUTH AFRICA

Early Childhood Development as defined in the White Paper 5 (2001) refers to a comprehensive approach to policies and programmes for children from birth to nine years of age with active participation of their parents and caregivers. It further claims that its purpose is to protect the rights of children by developing their full cognitive, emotional, social and physical potential. According to the White Paper 5 (2001) the enrolment target was 1.7 million Grade R learners by 2010, the idea was to have all learners who enter Grade 1 to have participated in an accredited Reception Year Programme and form part of the Foundation Phase. The target was not met in 2010 and was extended to 2014. According to the Department of Basic Education (DoBE) (2011:4), there has been a steady increase in Grade R participation, in 1999 from 15% to 70% in 2010. The target is to increase the percentage by 80% in 2014 and by 100% in 2019. The need to meet these targets is aimed at making the Reception class compulsory. The Provincial Departments of Education in South Africa allows the school itself to report on its readiness for Grade R in terms of physical space, for Grade R classes, the assessment of the school's report is made by the department in order to accept or reject the application for a reception class (Department of Education, 2008:7).

In countries such as Australia, Canada, France, Germany and Hong Kong pre-schools are compulsory, whilst in other countries such as England, Sweden and South Africa pre-schools are still not compulsory. In White Paper 5 (2001) it is indicated that the goal in the medium policy is to realise the constitutional obligation to provide all learners with ten years of compulsory school education including the reception year.

Early learning does not only focus on education but combines it with care. The elements of quality child education and care according to the Canadian Council on Learning (2006:4) include:

- **A high adult-care ratio**

According to the Canadian Council on Learning (2006:4) a high-adult child ratio is associated with closer attachment between the child and the care giver and gives an ideal ratio of 1:8 for pre-schoolers. This high child-adult ratio is linked to children being more independent when they reach Grade 1 with better cognitive development, communication and social skills. Staff child ratio varies according to counties (Bertram & Pascal, 2002:25).

The ratio in developed countries such as, Japan 1:19; Canada 1:20; Hong Kong 1:20; Australia 1:25; France 1:26; Germany 1:30, Ireland 1:30; United Kingdom 1:30 and United States of America 1:30. In developing countries such as Botswana learner-teacher ratio is at 1:25; South Africa, 1:30 (Department of Basic Education, 2011), Ghana 1:33 (World Bank, 2012).

Literature indicates that a smaller class size is desirable especially in the lower grades as it facilitates better access of pupils to the teacher, and provides an opportunity for better achievement of learning objectives (UNESCO, 2000). Qualified practitioners are needed to lay the foundation in early learning.

- **Post Secondary Training/Education**

The Canadian Council on Learning (2006:4) argues that practitioners with diplomas or university degrees are more responsive to meet the needs of children they are taking care of. Such practitioners are therefore able to provide children in their care with activities that are both stimulating and appropriate to their levels of development.

Due to the diverse qualification pathways in Early Child Development (ECD) the Department of Basic Education (2011:6) considers the following qualifications: higher certificate in grade R practices (NQF level 5-120 credits), advanced certificate in

grade R practices (NQF level 6- 120 credits), and a diploma in grade R practices (NQF level 6, 360 credits).

The proposal by the Department of Higher Education and Training (2010:12) is a diploma in Grade R practices (NQF Level 6) as a minimum requirement for Grade R practitioners. The rationale is to develop practitioners who can demonstrate general principles, as well as focused knowledge and skills for Grade R practices. Research (National Development Agency (2012:30) indicates that there are still many practitioners that do not have the qualifications mentioned in the foregoing paragraph. Even those who have the qualification are not registered with the South African Council for Educators which is a professional regulatory body in South Africa. The Table below indicate the number of qualified practitioners.

Table 2.1 Qualifications statistics by NQF level (April 2005 – July 2006)

Qualification Title	Number Qualified
Basic Certificate: ECD (Level 1) no longer offered	71
National Certification: ECD (Level 4)	5375
Higher Certificate: ECD (Level 5)	161
National Diploma: ECD (Level 6)	27
Total	5634

Source: National Development Agency (2012:30)

The table above indicates that most practitioners have ECD (Level 4) qualification. If the proposal indicated above for Level 6 as a minimum qualification very few practitioners would qualify. A high qualification has often been used as an indicator of quality, however, there is a caution regarding this perception. According to Human Sciences Research Council (2010), qualification level was not always associated with higher quality outcomes such as quality of care and learning especially in classes with older children. Effective teaching requires a well-defined space that allows learner participation in activities.

- **Well defined space**

Children thrive in settings where there are clear boundaries between group space and activity areas, whether indoors or outside. Well-defined spaces are associated with positive interactions among children and between adults and children, and with more time spent exploring the environment (Canadian Council on learning, 2006:4).

The DoBE (2010) makes provision for healthy indoor and outdoor space for Grade R in its budget. The allocation and utilisations of funds in the implementation of Norms and Standards for funding for Grade R sites (DoBE, 2010:3) is as follows:

- 15% of the amount received by the school for Grade R is used for telephone, fax machine, photocopier, copier machines, equipment for connectivity within the school and the internet, small capital items and t cleaning equipment;
- 20% for the up-keep and maintenance of the Grade R facility, including minor repairs of the Grade R class and outdoor equipment ; and
- 65% is used for consumable and Learning and Teaching Support Material (LTSM) including stationery, cleaning materials for replenishing items in the First Aid Kit, teacher reference books, sandpit and sandpit toys, jungle gyms, equipment for human movement such as hoops, beanbags, balls, balance beams, and wheeled toys.

A breakdown of the Grade R budget indicated above can be presented as follows for a school under section 21:

For as school with 44 Grade R learners, a total amount of R55, 801.62 would be allocated by the department. This money is for the promotion and efficient and quality education of learners in Grade R. The distribution according to percentages above would be:

- R11 160, 32 for maintenance (15%).
- R8 370.24 for services (20%)
- R36 271, 05 for Learning and Teaching Support Material (65%)

According to the Department of Education (2008:7) a budget and expenditure for Grade R must be separated from other expenditure within the school.

Since Grade R is not yet fully compulsory and free the DoBE (2011:7) argues that the payment of fees by Grade R learners should provide resources which must benefit the learners in the Grade R classes and for the payment of practitioners. Funds should be deposited into the school account and be managed by the School Governing Body (SGB). There is also a need for a well-structured curriculum.

- **Well structured, well planned curricula**

Child care that is organised and offer age appropriate activities for children, enables children to achieve higher on cognitive tests and show greater levels of creativity. It is therefore essential that the curriculum in the reception class is age appropriate (Canadian Council on Learning, 2006:5)

Learning in the early years must be based on quality, developmentally-attuned interactions with primary caregivers and opportunities for play-based problem-solving with other children thus, stimulating brain development (Policy Brief; 2006:3). The CAPS (2012) document for Grade R focuses on Mathematics, Life Skills and Languages. For the purpose of this research only specific aims for Life Skills will be presented.

In Life Skills the specific aims of the curriculum are to:

- strengthen learners' physical, social, emotional cognitive development;
- promote creative and aesthetic skills and knowledge;
- promote knowledge of personal health and safety;.
- promote understanding of the relationship between people and the environment; and
- raise awareness regarding social relationships, technological processes and elementary science.

The Grade R curriculum for Life Skills consists of a range of factors such as personal development, social development, emotional development and health and safety to be implemented by the practitioner. A range of skills are also taught. The age of admission to Grade R differs according to country.

- **Ages of admission**

In Australia and the United States of America the age of admission has been at five and more often at six (Betram & Pascal, 2002:8).The White paper 5(2001)for public schools in South Africa regards learners aged 4 turning 5 by June in the year of admission to be ready for Grade R.

The section below deals with all health programmes that are available at schools for Grade R learners. These health programmes are part of ensuring health promotion in schools.

2.5 HEALTH PROGRAMMES THAT BENEFIT GRADE R LEARNERS

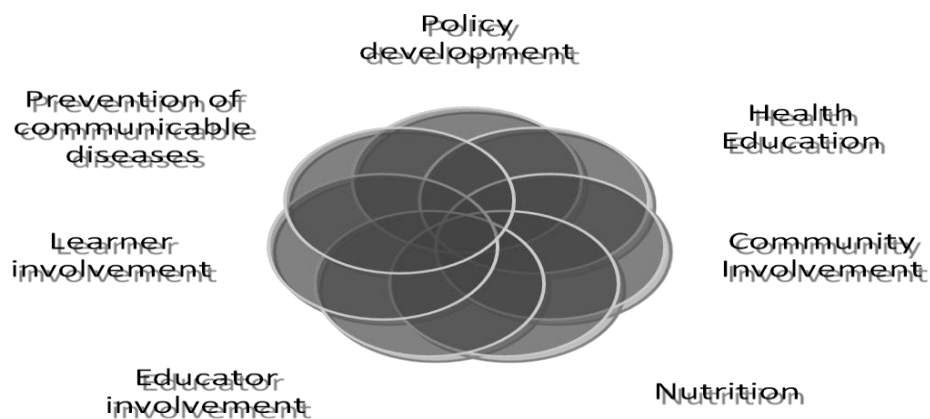
In this section I will elaborate on different programmes that schools implement in their effort to create healthy school environments. It is necessary to discuss the approach used in South African schools. It is in this approach that different health programmes and strategies are developed. Health programmes are planned activities such as physical activities, physical education, healthy environment and nutrition services intended to promote health and well-being of learners. Health programmes complement and promote human health (Wyn, Cahill, Holdsworth, Rowling & Carson, and 2000:595).

2.5.1 Whole School Approach

The World Health Organisation (1995: 4) advocates the Whole School Approach (WSA) to health promotion at schools. This means that the implementation of Whole School Approach is seen as a contributing factor that brings change as far as healthy environments are concerned. The adoption of a WSA to health promotion is not unique to South Africa; many countries all over the world adopted this approach (Kwatubana, 2014:255). Kwatubana (2014:255) further indicates that this approach includes stakeholders within the school and in communities. According to the Department of Environment and Heritage (2005:10), a WSA to a healthy environment emerges from the school's vision and is articulated in all facets of school life: that is, how the school is organized and operated; school design (within the limitation of existing structures); development and management of school grounds; reduction and minimisation of resource use by the school (water, energy,

products and materials); enhanced connections between the school, its community and other educational institutions; conservation and protection of biodiversity in the school and its grounds; and reorientation of the curriculum and the teaching and learning towards sustainability of such environments. According to the Department of Environment and Heritage (2005:12), schools implementing a WSA to healthy environments focus on the key points in the following diagram as their strategy:

Figure 2.2 Focus of the Whole School Approach



Source: Kwatubana (2014)

It becomes imperative to implement the strategies highlighted in the WSA effectively as Deschesnes *et al.* (2003) cautions that poor standards of implementation are

unlikely to yield positive results and can undermine the credibility of any approach. The WSA can be better implemented if school managers play their role effectively as discussed below.

2.5.2 ROLE OF SCHOOLMANAGERS IN HEALTH PROMOTION

School managers play a dual role in health promotion: that of managing health programmes to ensure effectiveness in implementation by providing support and that of providing leadership so as to give guidance and spearhead the operations, thus, becoming the driving force. Meier and Marais (2012:6) define education management as a process followed by a school manager to work with and through learners, staff members and resources according to policies and programmes to achieve the educational goal. The Department of Education (1996) defines management as the creation of conditions that enable the undertaking of activities associated with the desired organisational goal.

The role of school managers according to Ngcobo (2012:420) is to ensure appropriate resources for the organisation. The resources needed for health promotion as indicated in figure 2.2 include: people that are willing to form part of health promotion; equipment including the one used for prevention of communicable diseases and physical activity; facilities including sport and play and sport grounds; and funding to ensure sustainability of programmes. Optimum utilisation of funds becomes imperative where such resources are scarce. The lack of resources can be detrimental to effectiveness of health promotion in schools.

According to Kwatubana (2014:264), the principal, one member of the School Management Team (SMT) and one or few members of the School Governing Body (SGB) can form a committee that will be responsible for management and monitoring of the implementation of health promoting programmes in schools. The commitment and leadership of this committee will therefore bring a consistent support to all members including learners.

The SMT is central in enhancing productivity and enabling the development of health programmes and initiatives to meet the learners' health needs (Ngcobo, 2012:29). Since health promotion is a new initiative; SMT would consider organisational structural change in its curricula, teaching and learning methods to improve the

school's physical and social environment. Thus, the focus will not only be on academic achievement (Ngcobo, 2012:29). To adopt a comprehensive approach to health promotion is not easy according to Cristie (2010:30), especially given the current climate of over emphasis on public examination results. For an example, the gap between practice and what ought to be is greater for health education in that if the aim is to develop healthy habits what is assessed is just knowledge or theory and not practice.

According to Inchley, Muldoon and Curie (2006:68), the involvement of managers helps to embed the Health Promoting School (HPS) concept in the life of the school through school development planning, as well as providing benefits in terms of resourcing and delegating responsibilities to key members of staff. However, the lack of involvement by managers can lead to several factors that hinder and facilitate implementation of health programmes as identified by Whysall, Haslam, and Haslam (2006). Factors hindering health promotion include lack of management commitment, a negative attitude towards health promotion, insufficient resources and prioritisation of throughput and pass rates, neglecting health promotion.

Factors facilitating effective management for health promotion include:

- Managers who understand the importance of health interventions, who do not regard implementation of health programmes as an extra workload (Whysall *et al.*, 2006). Therefore, there is a need to develop managers' knowledge and attitudes in health related issues (Pearson *et al.*, 2007).
- Supportive managers who focus on health-promoting organizational culture and apply a participatory approach when developing and evaluating comprehensive health-promoting policies and programmes. A participatory approach allows the possibility of negotiating the design of the intervention, attention to conflicts of interests and unspoken behaviors that change and the ability to define roles and responsibilities for actions (Nytrø *et al.*, 2000) for all participants;
- Collaboration which is a common feature of health promotion. It is the role of the SMT to invite external experts on workplace health promotion to collaborate with different internal health promoters in the school. A study

conducted by Lang *et al.* (2009) report that institutions nominating a specific individual to liaise with external experts are more successful in building health promotion capacity. The role of the liaising officer is to solicit the help of external experts in the implementation of health programmes.

According to Kwatubana (2014:265), various social structures could impact differently on health promotion initiatives and could provide the school with a range of skills and resources. Therefore, the involvement of external stakeholder in health promotion could be beneficial to all staff members and learners within the school premises.

The educator is the key member of the school staff in maintaining and promoting healthy behaviours and choices. Educators have a significant influence on learners on the view they have on health promotion. Their involvement in everyday life activities such as teaching about health promoting issues, taking part in collective projects and facilitation of health promoting tendencies become imperative. Reduction of health risk behaviours are influenced by the commitment of an educator (Jourdan, McNamara, Simar, Geary & Pommier, 2010:519). Educators are encouraged to join children when they play at their physical level, for the opportunity to be involved in health programmes (South Africa, 2008:35). Educators and learners can thus be seen as partners in health promotion.

Effectiveness depends on educators' commitment especially, when they assist learners to build their personal capacity in terms of making decisions, adopting responsible behaviour for themselves and with respect to other people and the environment. The responsibilities of such educators with regards to health promotion need to be shared among a larger group of staff for change to be sustained (Department of Environment and Heritage, 2005:19).

For the effective involvement of educators, WHO (1998:28) encourages engagement in training to gain information to incorporate effective issues related to health in their subject area/s. It is urged that educators should be provided with information about basic relationships between the environment and health, and also be informed on how to generate a feeling of responsibility towards health promotion.

Learners should be given the opportunity to show their initiatives in the promotion of healthy schools. Learners' contribution to health promotion according to the Department of Environment and Heritage (2005:18) should be highly regarded and encouraged to help them to operate ideas that will improve health conditions for themselves and others. According to the Connecticut State Board of Education (2010:5) active participation of learners to create and sustain a healthy learning environment, serves as positive role models towards others in schools, at home and in the wider community.

Thus the role of management becomes critical in ensuring that educators and learners work hand in hand in promoting health and that both these stakeholders are committed and motivated to play their role. The support of the SMT becomes imperative, without this support the structure will collapse. The health programmes need to be evaluated. Eriksson (2011) defines evaluation as a systematic and careful judgement of a phenomenon after completion of an event, in order to follow up, systematise and judge ongoing or finished activities and their results. The result of the evaluation may be used to correct mistakes and reinforce successes.

The SMT has to play a role of providing guidance which is associated with leadership. According to Christie (2010: 696), leadership is the exercise of influence which can take place inside formal organizations, and can be exercised in most activities. It is a position of influence that is directed to formal or informal outcomes and often associated with vision and values. Leadership intends to exert influence over one person or group affect other people's attitudes and energising their participation in the activities associated with the organisational success (Msila, 2013:262).According to Hargreaves (2006), influence by leaders can last long and spread despite changing circumstances.

Followers can be influenced by leaders to believe that to cooperate is in their best interest (Brighouse & Woods, 2006), creating conditions that energise the carrying of the activities. Thus leaders must, according to Thurlow (2003), have leadership capacity to energise others to undertake tasks.

It is often a valorised concept associated with success rather than failure on the notion of effective leadership, and or lead people astray in the notion of bad

leadership (Christie, 2010:695). Thus, leaders influence, guide and motivate followers to take action by continuously articulating the vision of the school.

The implementation of health programmes can only be effective to the extent leadership is exercised. Health promotion starts with the development and implementation of health policies.

2.5.2.1 Policy development and implementation

According to the World Health Organization (2000), creating a healthy school environment means applying a new way of thinking, about health and the role of the school. The development of health policies help the school managers to think about the importance of healthy environments, develop a vision for the school and come up with strategies on how to implement the health programmes developed.

According to Young (2008), evidence shows that a WSA, where there is consistency between school policy and practice, promotes social inclusion and commitment to education and essentially facilitates improved learning outcomes, increases emotional well-being and reduces health risk behaviours.

Many factors govern the ways in which school health policies are developed (Han & Weiss, 2005; Barnekow *et al.* 2006), the factors are indicated below:

- the political will to develop a health policy allowing sustainable commitment on the part of institutions and communities;
- a favorable environment such as the support and facilitation of SMTs, existing teaching practices and the importance given to the well-being of learners;
- beliefs of staff and perception of their role in health promotion, their perception of effectiveness and acceptability of health programmes and belief in their own effectiveness; and
- factors linked to the policy itself such as training and assistance given to staff

The National health policies that apply to learners in Grade R include the National HIV/AIDS policy Act 27 of 1996 (South Africa, 1996), the Integrated School Health Policy(South Africa, 2002) and the Curriculum Assessment Policy Statement (2012).

- **The National Policy on HIV and AIDS (Act 27 of 1996)**

The National policy on HIV/AIDS (South Africa, 1996) intends to address the issues of HIV/AIDS in schools. The focus of this policy is among other things on Non-discrimination and equality with regard to learners and educators with HIV/AIDS, issues relating to HIV/AIDS testing and the admission of learners to a school, attendance at schools by learners with HIV/AIDS, disclosure of HIV/AIDS related information and confidentiality, a safe school environment and prevention of HIV/AIDS transmission during play or sport and education on HIV/AIDS. The prevention of communicable disease is essential in schools due to HIV/AIDS pandemic in South Africa (Kwatubana, 2014:257).

Therefore, the National Policy on HIV/AIDS (South Africa, 1996:15) mandates schools to implement universal precautionary measures in order to eliminate the risk of transmission of all borne-blood pathogens. The Department of Health (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 that 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.

Children are prone to injuries. Minor injuries may serve as sentries for major injuries although Kotch, Dufort, Stewart, Fieberg, McMurray, O'Brien, Ngui, and Brennan (1997:270) caution us by indicating that these injuries may not present health consequences. The results of a study conducted by Kotch *et al.* (1997:271) indicate that falls from heights need to be a focus for practitioners, particularly in schools where there is more and bigger playground equipment. Scrapes and cuts were the leading injury types according to Kotch *et al.* (1997:271) followed by swelling and bumps and bruises. Safety in childcare is an on-going concern and neglecting it may lead to unregulated safety hazards in school settings.

According to the National Policy on HIV/AIDS (South Africa, 1996), it is a legal requirement that educators and learners be trained on providing first aid. The policy does not indicate who should be responsible for making provision for such training. It can therefore be assumed that the SMT and the SGB can be responsible for such a

crucial undertaking. Training of practitioners according to Kotch *et al.* (1997:271) should emphasize playground safety and knowledge of peak times of injury. The training should be based on injury prevention, first aid and cardiopulmonary resuscitation in addition to these, making follow ups and keeping records of child care injuries are also important. Reliable childcare injury surveillance systems are needed at schools not only to track the extent of injuries but also to come up with strategies to deal with this issue (Kotch *et al.*, 1997:271).

The National policy on HIV/AIDS (South Africa, 1996) states that every school must have at least two first aid kits to deal with injuries that need immediate attention. All first aid kits in schools should contain necessary equipment needed for emergency health risks. According to the National policy on HIV/AIDS (1996:1) a fully equipped first aid kit should be available at all schools or institution events, outings and tours. Contents should be checked and replaced to avoid shortage of equipment when needed and also to refrain from using expired items.

- **The Integrated School Health Policy**

The Integrated School Health Policy (2001) provides guidelines for the development of a comprehensive school health service that operates within the framework of health promoting schools. The Integrated School Health Policy (2001) is a policy implemented to strengthen the school's capacity to address children's needs for healthy development (Department of Health, 2012:6). The school nurses conduct two assessments on site: individual learner assessment which is health screening and environmental assessment.

The individual learner assessment according to the Integrated School Health Programme (Department of Health, 2012:6), is to be conducted by qualified nurses. The screening is done on the following: nutritional assessment, physical assessment (Gross & fine motor), vision, oral health, hearing, speech, chronic illness (Long term health conditions), TB screen and psychosocial support in cases of mental health. The school nurses have to focus on deworming (including bilharzia and malaria control where appropriate), immunisation against tetanus and diphtheria, oral health (where available) and minor ailments.

According to the Department of Health (2012:14) it is the responsibility of the District Health Forum which is composed of members of the Department of Health, Department of Education including the District Based Support Teams (DBST) and the School Based Support Teams (SBST) to schedule visits to schools. All schools with new school entrants such as Grade Rs and Grade 1s should be visited as soon as possible in the school year (Department of Health, 2012:14). The main reason for this important visit is to conduct individual learner assessments and on-site services on all new entrants. The policy further suggests that the visits to schools with new comers in the lower grades should ideally be completed during the first quarter of each year before assessments of learners in other targeted grades can be undertaken. A finding in a study conducted by Kwatubana and Kheswa (2014) on the implementation of integrated health policies was that of few visits by nurses. According to these authors health nurses were overburdened because of many schools they were responsible for.

The Department of Health (2012) mandates that an environmental assessment conducted in all schools should focus on: first aid kit, sick bay, water and sanitation, cooking area, physical safety, access for disabled learners and ventilation (airborne infections). However, the policy states that the visits are annually. The policy is not clear on how all these assessments can be done in just one visit.

It is the responsibility of the SMT to ensure that its school has a designated person who can liaise with the school health nurse. This liaising officer can be the Life Orientation educator or a member of the SBST as delegated by the SMT. School managers have the responsibility to develop health policies and procedures and essentially changing the school culture to become greener and healthier (Sims, 2012).

According to the Integrated School Health Policy (2012:21), the joint National Task Team (Department of Health, Department of Basic Education and Social Development Department) must establish mechanisms for monitoring and evaluating the school health policy. Effective monitoring and evaluation will depend on active reporting, monitoring and evaluation of the programme to ensure learner coverage and identify gaps and barriers to implementation.

- **School-Based Health Centers (SBHC)**

The SBHCs were established due to a movement that led social activists in the United States to serve the need of young people living in disadvantaged communities by providing health and social services in schools. This movement started at the turn of the 20th century. These health services by SBHCs were offered voluntarily and could not be formally incorporated into the wider health system. The impulse to provide School-Based Health services emerged over the years from the realization that young people's health status and their educational achievement are closely related and from the need to provide an accessible consumer oriented service (Mason-Jones, Momberg & De Koker, 2012:2).

South Africa is currently embarking on the development of SBHC as part of its primary healthcare re-engineering programme (Motsoaledi, 2011). The establishment of SBHC is a way of delivering effective, comprehensive primary and preventative health services to young people, especially those that are normally underserved by health services (Mason-Jones, *et al.*, 2012:2). Unfortunately, there is no research conducted on the effectiveness of such centres in South Africa and records on the number of centres that have been established are not available. Thus, information provided below is based on the established SBHCs in international countries.

The SBHC provide access to healthcare in school premises from Monday to Friday during school hours. It provides essential primary care services, with the aim of overcoming barriers such as transport issues, limited community services, and inconvenient location or appointment systems. The SBHC can also act on the multiple determinants of health, including public health interventions and environmental change strategies. The provision of SBHC can vary from fully equipped and permanently staffed centres with medical nursing and auxiliary staff to clinic offering nursing services for only a few hours per week (Mason-Jones *et al.*, 2012:2). The SBHC could also serve as a valuable component of a medical home, providing increased access to health care for vulnerable youth, who are geographically isolated from other health care settings and for children whose parents cannot take time off work.

The advantages of school as a location for delivering healthcare services include the fact that schools are where most young people are, they are accessible to families,

can provide a comprehensive and non stigmatizing health services and can provide links between schools and communities (Mason-Jones, *et al.*, and 2012:2). According to Keeton, Soleimanpour and Brindis (2012:132) research has demonstrated the SBHC impact on delivering preventive care, such as immunizations; managing chronic illnesses, such as asthma, obesity, and mental health conditions; providing reproductive health services for adolescents; and even improving children's academic performance. To access care on school site also benefit both the learner and the school setting, where learner average daily attendance is not affected (Keeton *et al.*, 2012:137).

The SBHC present many opportunities for increasing outreach, prevention education, early screening and detection, and continuity of care for community members, families, and the school workforce. Health promotion trainings and activities on nutrition, exercise, stress reduction, and other topics can be provided to children within the SBHC (Keeton *et al.*, 2012:146).

Despite their proven success, SBHCs have consistently faced challenges in securing adequate funding for operations and developing effective financial systems (Keeton *et al.*, 2012). According to Mason-Jones *et al.* (2012:7) this could mean that SBHC may not be the main source of health care due to the limited coverage of schools, services offered or opening times (that is, closed at weekends and during holidays). A seamless provision of health services is thus important. The scope of SBHC services expands, beyond the provision of individual client health-related services to reach the broader school community. This would enable everyone to have access to enter school premises freely, even if it is not for health services. This free access to school premises can put learners and educators in danger if not checked (Keeton *et al.*, 2012:145).

For the success of this kind of collaboration, mutual respect and co-operation between school personnel and the SBHC staff is important in contributing to a more holistic and comprehensive approach to care (Keeton *et al.*, 2012:145).

It was necessary to discuss water and sanitation although there is no specific policy addressing these issues in the Department of Education. Water and sanitation are a major determinant of a healthy environment.

- **Sanitation**

A study conducted by the Department of Education, Department of Social Development and UNICEF (2011:14) in three provinces in South Africa reported that only about half of the participating schools had piped water inside the building. Around 50%–60% of facilities had flush toilets and pit latrines were found in 41% of public schools. Almost three-quarters of public schools complied with the standard of one toilet per 20 children. Many public schools did not have separate toilet facilities for Grade R learners.

According to the Department of Basic Education (2013), all schools must have sufficient basic water supply which complies with all relevant laws and with water available at all times for drinking, personal hygiene and food preparation.

The Department of Basic Education (2013) further states that all schools must have a sufficient number of sanitation facilities that are easily accessible to all learners. The ablution facilities must provide privacy and security and promote health and hygiene standards that comply with all relevant laws. A cleaning and maintenance routine of toilets must be in operation to ensure that clean and functioning toilets are available at all times (WHO, 2009:22).

Learners in schools that do not have sufficient number of ablution facilities are at risk of contracting diseases. According to the Health Protection Agency (2010:7) the risk of transmission of most communicable diseases can be reduced significantly by routine attention to basic hygiene. In January 2014 a Grade R learner in Limpopo province fell and died in a pit toilet in school (Nkosi, 2014). This incident highlights the plight of learners in schools that do not have toilets that are of standard. The article by Nkosi (2014) on the IOL news also highlights a similar dilemma in Eastern Cape schools where in about five schools there were no toilet facilities and learners relieving themselves in the veld. The Norms and Standards for funding for Grade R (Department of Education, 2010) does not say anything about toilets for Grade R learners.

- **Curriculum Assessment Policy Statement (CAPS)**

The DoBE CAPS document from Grade R-12 provides guidelines on curriculum and assessment in the schooling sector, the programmes that address health promotion are discussed below:

- **Health Education**

Schools have the responsibilities to educate their learners about health behaviours and first and foremost be promoters of health lifestyles since they form an essential part of the health promotion in schools (Kwatubana, 2014:255). The California Department of 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 learners in lower grades through grade twelve and for parents and school staff. The curriculum addressing health issues is 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.

The Foundation Phase learners according to the Department of Basic Education (2011:13) are taught about health issues through Life Skills. Life Skills intends to expose a range of knowledge, skills and values that strengthen their physical, social, personal, emotional and cognitive development; creative and aesthetic skills and knowledge through engaging in dance, music, drama and visual art activities; knowledge of personal health and safety; understanding of the relationship between people and the environment; and awareness of social relationships, technological processes and elementary science. The study areas for Grade R in Life Skills Education include Beginning Knowledge, Creative Arts, Physical Education and Personal and Social Well-being. Health education should focus on changing the health behaviour of an individual (Pike & Colquhoun, 2010).

According to Tinsely (2003:78), health education in schools 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. The Department of Education (2002: 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.

According to UNESCO (2010:5), education of learners on health and hygiene issues, should include information about cleanliness, personal hygiene, sanitation, healthy food (balanced diet) and clean drinking water, preventive information against various non-communicable and communicable diseases. Fox and Wong (2002:249) encourage and support opportunities for educators to be trained in nutrition education. Thus further add that parents and the wider community must be educated regarding nutrition, and involve them in activities that promote the practice of healthy eating. Effective school health education teaches children what healthy and unhealthy behaviours are and the consequences of these behaviours (Lightfoot & Bines, 2000). According to the World Health Organization (2010: 10), school health education aims to help learners to develop the knowledge and skills which are needed to make informed decisions, practice healthy behaviours and create conditions that are conducive to health.

Provision of the above information equips learners with knowledge that will enable them to take care and protect themselves against various health hazards and diseases and subsequently, live healthy.

- **Physical activity**

The years 5 to 6 are regarded as the golden age of motor development. The skills that are learnt during these years are building blocks for complicated movement in later years. There are three types of motor skills according to CAPS (2012):

- Loco motor which includes running, jumping and hopping;
- Object control which includes throwing, catching and kicking; and
- Stability and balance, including fine motor skills that help learners in: pencil grip activities, tongs, tweezers, puzzles, threading, weaving, dressing frames, and others, while developed gross motor skills help when climbing, swinging, balancing, and others.

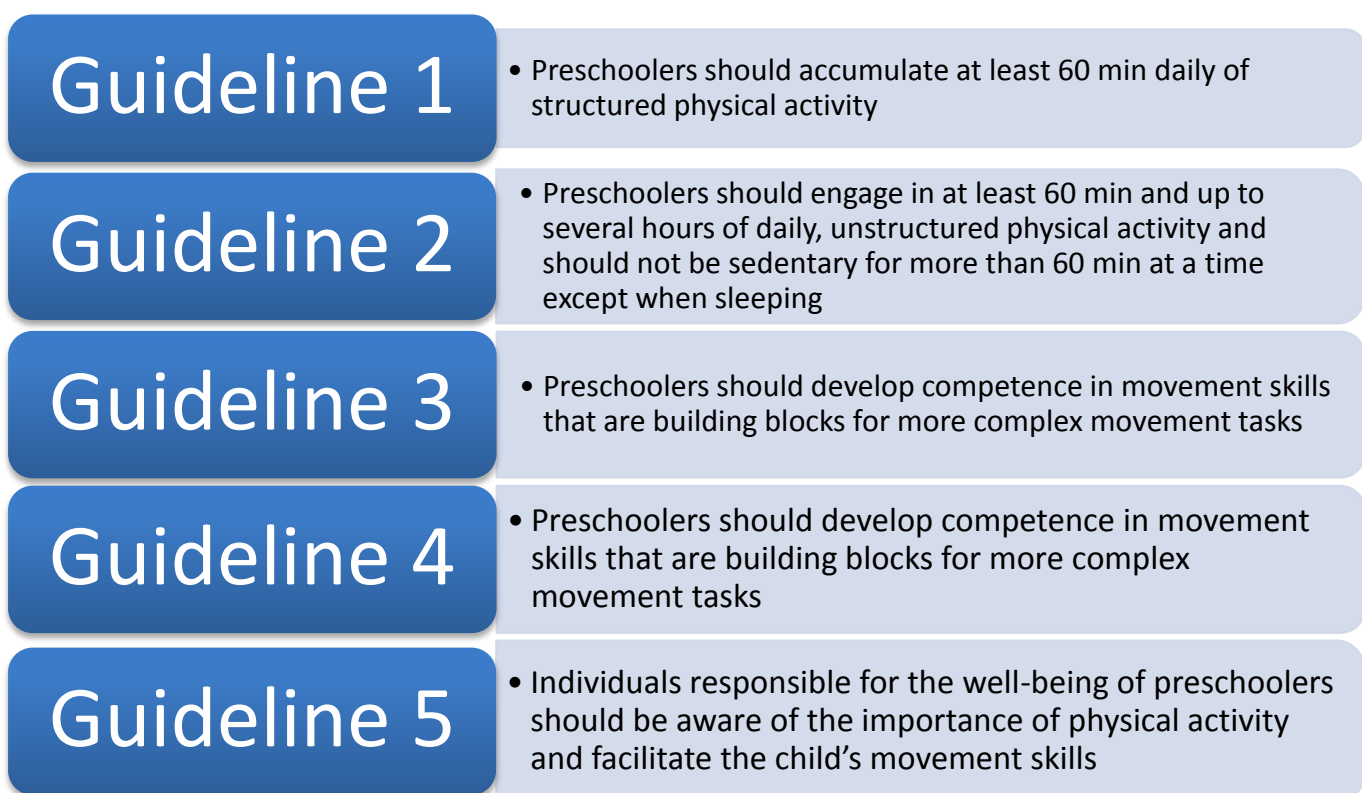
Physical activity is part of the curriculum in South African schools. The aims of teaching physical education in Grade R as indicated in the DoBE CAPS document

(2012 4) include serving the purpose of equipping learners with physical ability and ensuring that children acquire and apply knowledge and skills that are meaningful to their own lives.

Benefits of physical activity are well documented in research, involvement leads to behaviour and cognitive functioning that may result in improving learners' academic achievement (Coe, Pivarnik, Womack, Reeves & Malina, 2006); increasing physical activity and improving physical fitness and muscular endurance (Centres for Disease Control and Prevention, 2006).

According to the National Association for Sports and Physical Education (2002) guidelines for physical activity in preschool children are as follows:

Figure 3: Guidelines for physical activity in preschool



The guidelines are meant to assist practitioners to ensure that Grade R learners are physically active. A sedentary lifestyle contributes to overweight and obesity according to Timmons, Naylor and Pfeiffer (2007:123). The immediate and long-term health consequences of being obese are indicated in the table below:

Table 2.2 Immediate and long-term health consequences of obesity

Short-term health consequences:	Long-term health consequences:
<ul style="list-style-type: none"> • social isolation, low self-esteem, depression (Daniels, 2006; Reilly, 2005), • negative body image (Daniels, 2006), • hypertension, hyperlipidemia (Daniels, 2006; Reilly, 2005), • Cardiovascular dysfunction, insulin resistance, asthma, Type 1 diabetes mellitus, and podiatric problems (Daniels, 2006; Reilly, 2005). 	<ul style="list-style-type: none"> • Persistence of obesity into adulthood including cardiovascular disease, Type 2 diabetes mellitus, and premature mortality (Daniels, 2006; Reilly, 2005).

The health consequences of obesity indicated above may persist into adolescence and adulthood according to Nathan and Moran (2008). To avoid this, it is vital that interventions to prevent obesity are introduced early in learners' lives.

There is growing evidence in research that features of physical and social environments influence levels of physical activity (Heath, Brownson & Kruger, 2006). Literature indicates that physical activity among pre-school learners can be improved by use of portable play equipment, including riding and pushing or and pulling toys, jumping toys, ball play, and floor play (Hannon & Brown, 2008:235).

The DoBE CAPS document (2012) indicates that the development of the learner's gross and fine motor skills is fundamental in the Foundation Phase and that the introduction of creative skills is essential in refining and controlling the gross and fine motor skills. Literature reveals that focusing on writing and motor co-ordination without training the child's muscles first, may lead to tired hands, poor handwriting, and difficulty in holding, manipulating objects and cutting which requires stability of some parts of the shoulder and muscles and allow muscle tone. Children with low muscle tone may have trouble with gross motor activities, such as jumping, running,

and climbing. Since muscle tone affects our posture, it may be difficult for these children to sit for long periods of time (Rubin, 2013:4).

Monitoring and evaluation of health programmes in the curriculum for Grade R must be part of the overall monitoring and evaluation system designed to ensure quality in the Foundation Phase (Department of Basic Education, 2011:9).

- **School Nutrition Policy**

The School Nutrition Policy was adopted in 1994 to alleviate hunger and malnutrition in schools in previously disadvantaged communities. An Integrated Nutrition Strategy for South African schools was formulated and adopted for the transformation of health system and subsequently developed into an Integrated Nutrition Programme discussed below:

- **National School Nutrition Programme (NSNP)**

Meals are provided to all Quintiles 1, 2 and 3 public schools from Grade R to 7 (Department of Education, 2009:3). Schools classified under Quintiles 1, 2 and 3 are regarded as poor and thus, receive more funding and are no fee paying. These poverty ratings for schools are determined nationally for funding purposes (Department of Education, 2009). A survey conducted by the Department of Basic Education (2012:14) indicated that the NSNP reached 8 850 208 learners in 2011. Primary schools that benefit from the NSNP in the Gauteng province 1 109 with 329 362 learners and 5 174 food handlers.

South Africa's NSNP stands on three key pillars which are to: have a school feeding program in place; to use school gardens to stimulate local farm production; and promote healthy lifestyles (Global Child Nutrition Foundation, 2010). The focus of the NSNP on the underprivileged and vulnerable children as indicated by UNICEF (2004) is based on the following:

- 25% of children under five suffer from moderate to severe stunting;
- 12% of children under five suffer from moderate to severe underweight;
- 3% of children under five suffer from moderate to severe wasting;
- 33% of children under six suffer from subclinical vitamin A deficiency; and

- 21% suffer from nutritional anemia.

The driving force behind the implementation of NSNP at schools is the high poverty rate in South Africa. According to Statistics South Africa (2008/2009), during September 2008 and August 2009, approximately 26,3% of the population was living below the food poverty line (R305 per capita per month), while roughly 38,9% and 52,3% were living below the lower-bound poverty line (R416 per capita per month) and the upper-bound poverty line (R577 per capita per month) respectively. The poverty rate increased during this period compared to a time before the economic melt-down. Most children in Grade R come from these impoverished households.

Learners are receive breakfast and lunch. Brown, Beardslee and Prothrow-Stith (2008:8) argue that having breakfast has benefits for learners. These include cognitive and educational benefits comprising educational preparedness and educational outcome measures and health related benefits comprising adequate energy supply for better physical functioning.

Both the school and learners benefit from the NSNP. The schools increase enrolment and attendance rates as children would only receive meals on days when they attend. It is argued that by providing more nutrients to the child and providing the child with a meal enables him or her to concentrate better and learn more (Grantham-McGregor, Chang & Walker, 1998). Scrimshaw and SanGiovanni (1997) indicate that nutrition, especially adequate intake of micronutrients, can strengthen the immune system and reduce the incidence and severity of infectious diseases among children, thereby contributing to school attendance.

Nutrition, particularly in the short-term, is believed to impact upon individual behaviour, such as concentration and activity levels. These behaviours according to Sorhaindo and Feinstein (2006) have the potential to affect school performance and interaction with peers, and compromise self-esteem. According to Adelman, Gilligan and Lehrer (2008: 28), the effect of the NSNP on grade repetition, drop-out rates, learning achievement, and school performance are all inter-related.

The main findings of a research conducted by Sorhaindo and Feinstein (2006) indicate that the nutritional deficiencies prior to school entry have the potential to impact upon cognitive outcomes in school-aged children. Learners in Grade R are in

the first year of their schooling years, it becomes imperative therefore to deal with problems of under and or over nutrition at this stage before they escalate and cause serious problems. Sorhaindo and Feinstein (2006) further state that children with nutritional deficiencies are particularly susceptible to the moment-to-moment metabolic changes that impact upon cognitive ability and performance of the brain. Maintaining acceptable levels of glucose throughout the day adds to enhancing cognition.

The NSNP as indicated by van Stuijvenberg (2005) claims that a meal must be served before 10am to enhance learning capacity, and that school meals should include: amp, beans, rice, canned fish, soya, fortified maize meal, fortified bread, and fruits and vegetables. The Nutrition Policy indicates that meals that are delivered to schools include a variety of starch dishes, proteins and vegetables. The menu in the recipe book, entitled "Mnandi 4 sure" was compiled by provincial school nutrition programmes and distributed to schools to assist volunteer food handlers to prepare a variety of meals that are palatable and nutritious.

The meals indicated above are prepared by volunteer food handlers employed by the Department of Education. A volunteer food handler is a parent (usually female) who volunteers to offer services for the preparation, cooking, and serving of meals to learners, in return for a monthly stipend of about R900.00 per month. According to NSNP (2009/10), one food handler should be appointed for every 200 learners.

According to Buhl (2009:10), challenges regarding the provisioning of NSNP in South Africa include a lack of national and regional uniformity in the programme implementation and meal components. In some provinces learners get two meals while in some only one meal is provided. There is also a lack of resources, basic supplies and clean water. This lack of resources hinders the provision of NSNP in schools. Insufficient linkages to local agriculture and food vendors, corruption and theft according to Buhl (2009:10) also hinder the stability of NSNP in South African schools.

In the foregoing paragraphs the development and implementation of health policies and programmes are discussed. It is necessary to include information on healthy environments as one of the key settings for promoting children's health. The school built and physical environments are discussed below.

2.6 EARLY PHYSICAL LEARNING ENVIRONMENTS

Learning environments are environments which people occupy with the aim of learning. Kukemelk, Lillemaand and Tondi (2006:295) state that the learning environments enhance the motivation and self-regulation of learners. Brewer (2007:78) maintains that “the first task in creating a learning environment that works is planning the physical space of the classroom”. The physical environment according to Maxwell and Evans (2005: 1) is a critical part of any child care programme and has an important role in children’s behavior and development.

2.6.1 The school built environment

According to Shallcross (2004:59), a pleasant welcoming reception area; door mats placed at strategic points; rooms, corridors and stairs which are clean and in good repair; adequate heating and ventilation; clean toilets and change rooms; well-managed school grounds; and evidence of learners’ involvement in their environment through murals, vegetable patches, recycling bins are an indication of a healthy learning environment.

According to UNESCO (2010:4), the cleaning and maintenance of the school surroundings and classrooms is important to the health of learners. Learners learn best when physical settings are clean, well maintained, bright and secure. This kind of an environment keeps learners focused on doing their work.

School environments that are healthy can influence and challenge the community to keep the environment where children live healthy as well as maintaining the cleanliness in their homes. According to the United Nations Children’s Fund (UNICEF) (2009: 5), 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.

According to Young (2008:5-6), the frequent cutbacks in maintenance and renovation coupled with widespread thoughtless, ineffective cleaning of school facilities sends negative, uncaring messages to learners and educators. Schiller (2012) suggests that school managers need to treat their school buildings as “living buildings” to ensure sanitation and cleanliness according to LEED (Leadership in Energy and

Environmental Design) standards. Maintenance of a school emphasizes effective vacuuming and regularly scheduled extraction cleaning of all parts of the building, including carpet. This programme is highly effective in keeping the school building healthy (Young, 2008:5-6).

Johnson, Christie and Wandle (2005) and Hellen (2012:23) argue that children need to explore, venture into new experiences and develop their capacities from a very early age. Outdoor play spaces therefore must contain enough space for children to discover experiment, manipulate, reconfigure, expand, influence, change and push their limits. If such spaces are provided, informal learning experiences can be realised. According to the Constitution, Section 24 of the Bill of Rights (South Africa, 1996) everyone has a right to an environment that is not harmful to their health or well-being the one that is nurturing environment. In such a healthy environment children can acquire skills and meaningful experiences by participating in outdoor activities. School play grounds are therefore imperative and are increasingly recognised as an integral and valued component of the learning environment (Thane, 2006).

Quality playgrounds and spaces offer an opportunity for outdoor activities that are unstructured. Such environments according to Francis (1999), enhance learners' physical, emotional, social and intellectual development. Quality playgrounds provide spaces for recreation and socialisation and an opportunity to improve children's cognitive skills, language skills, ability to focus on learning and social and emotional development (Clements, 2001; NAECCDS/SDE, 2001; Steinhagen & Iltus, 2004).

Malone and Tranter (2003) argue that conflict and withdrawal are more likely when children are crowded together and equipment and materials are limited. In cases where sufficient spaces exist, insufficient equipment will limit children's options, leading to boredom and aggression.

To support a healthy learning environment and accomplish a maintenance scheme according to UNICEF (2009:5), school managers can encourage children to start healthy environment clubs, where they organize maintenance tasks, set up competitions around these tasks and promote safe water, sanitations and healthy schools and healthy homes messages.

Sufficient litterbins need to be available in classrooms, toilets, corridors and playgrounds, so that learners are encouraged to keep these areas litter free. Learners can be motivated to investigate issues for themselves, for example, concerns related to litter control and or general improvement of the physical environment of the school (Shallcross, 2004:59).

2.6.2 The physical environment of the classroom

Kimmel *et al.*(2000) and Khattar *et al.*(2003) emphasise the importance of ventilation in educational establishments. Research indicates that lack of ventilation can lead to health problems especially asthma and respiratory conditions. Inadequacies of indoor air in schools continue to be reported (Lee & Chang, 2000; Khattar *et al.*, 2003) and linked to ill-health (Ahman *et al.*, 2000).

Health effects of overcrowding in the classroom according to Marshy (1999), include:

- serious direct and indirect health risks to young children:
- causing or exacerbating respiratory illness;
- susceptibility to disease, the severity of diseases, the spreading of illness, and the mortality due to disease increase resulting from social and physical overcrowding;
- exacerbating health risks related to insufficient and poor water supply and poor sanitation systems in schools;
- physical and emotional overburdens for practitioners; and
- direct impacts on the physical development and psychological well being of learners.

Overcrowding is encountered in Grade R classrooms in South Africa. According to Cumberworth, Dilliard, Emelife and Mehler (2009:12), overcrowding is the number of learners that could physically fit into the school without breaking fire and building codes and other legal regulations. Thus, this definition is based on a school's physical capacity. The National Centre for Education Statistics (NCES) (1999) considers any school over 106% of its physical capacity to be overcrowded.

According to the Department of Basic Education, (2011:4) the recommended practitioner-learner-ratio in Grade R is 30:1. A study conducted by the Department of Basic Education, Department of Social Development and UNICEF (2011:10)

indicates that Pupil-teacher ratios in Grade R classes vary extensively. A large number of schools, 98 in the sample (33%) had practitioner-learner ratios in excess of 40 in their Grade R classes. According to this report class sizes of this magnitude are problematic and do not meet the needs of early childhood development.

The average space in a school allocated for each learner must be 2m² and 2.6m² for Grade R and for a class size a maximum of 30 learners (Department of Basic Education, 2013)

To alleviate this problem Grade R classes in most schools use mobile classes. Mobile classes have been criticized for health and safety concerns (Kennedy, 2000), their unappealing facade (Chan, 2009), and poor construction quality (Chan, 2009).

Challenges that schools encounter in promoting and maintaining healthy environments are discussed below:

2.7 CHALLENGES IN MAINTAINING HEALTHY SCHOOL ENVIRONMENTS

Challenges that are discussed in this section include non-compliance to policies, lack of monitoring, dysfunctional health committees, lack of synergy and ignorance regarding roles. Compliance to regulation is defined by Parker, Kuuttiniemi and Klaasen (2000:66) in two ways: the first is obedience by the target group with regulatory rules or with government policy objectives and the second, refers to a regulatory approach to securing compliance that relies primarily on persuasion and co-operation, rather than on legal sanctions and punishment. Compliance in this research means conforming to rules and regulations.

2.7.1 Non-compliance to policies

One of the challenges is that schools do not comply and adhere to school health policies. Compliance according to Parker *et al.* (2000:11), has conditions:

- the first pertains to the awareness of the target group about the rule. It is important for the group to also understand the rule as lack of clarity in a rule may bring about unintentional non-compliance. According to the California Department of Education (2003: 39), a clearly stated policy that defines the co-ordinated school health system and expresses support for this system can greatly facilitate effective implementation.

- the second entails the willingness of the target group to comply to the stated rules. Leaders can use economic incentives to motivate compliance as a strong enforcement of rules are regarded as discouraging thus, leading to noncompliance;
- the third involves the ability of the group to comply to the regulations. This condition depends on the provision of necessary information and other technical support to the target group implementing the policy.

The framework for policies for health promotion according to Cushman, Clelland and Hornby (2011:247), incorporates three synergistic elements: curriculum learning and teaching, the ethos and environment of a school, and links with parents and the wider community. Health policies pertaining to all three elements need to be implemented effectively in order for all stakeholders to benefit. All implemented programmes need to be monitored.

2.7.2 Lack of monitoring of programmes

Lack of monitoring, ignorance and negligence of the health committees, managers of schools and districts have created problems that put learners' health at risk. Environments where managers fail to protect learners' health could be accountable for vulnerable diseases which can attack learners because of health hazard school premises. According to UNICEF (2009:2) school authorities need to foresee imminent risk or possible dangers that could affect children within the school, its vicinity or wider community.

Monitoring according to Parker *at al.* (2000:50), is done to make enforcement efforts of a policy more effective and to determine effects, impacts and outcomes of a health programme. The data collected in monitoring and evaluation will give an indication of environmental results, health effects and a decline or increase in injury rates. Behavioural outcomes, enforcement actions and resource efficiency can also be determined during monitoring and evaluation.

Health committees are a cornerstone in the implementation of health programmes. This is the committee that is responsible for the operationalisation of implementation of health policies and programmes

2.7.3 Health committees that is dysfunctional

Health committees that are not fully functional are one of the major causes of unhealthy school environments. According to the National policy on HIV/AIDS (South Africa, 1996b: 26), the main duties of the committee entail: advising the Governing Body or Council on all health matters including HIV/AIDS; being responsible for developing and promoting the school or institution plan of implementation of HIV/AIDS and; reviewing the plan from time to time. Health and environment committees are formed to ensure that precautionary measures are adhered to for elimination of health threats. Health committees are effective to the extent they perform these duties.

A school health team may be designated to coordinate and monitor health-promoting policies and activities. If a school does not have a health team, planning to improve the school's healthy environment can be hampered. Specific task forces can be organized to focus on specific health concerns such as health surveillance and evaluation, health service delivery, sanitary facilities, water quality, food preparation and safety, waste management, disease management, pesticide use, structural facilities, renovation and grounds (WHO, 2003:21).

2.7.4 Lack of collaboration and synergy

Developing effective partnerships with parents have been indicated by Inchley, Muldoon, and Currie (2007) as the most challenging part of bringing the necessary collaborative impetus to school-based health promotion.

In collaboration, individuals or organisations work together to address problems and deliver outcomes that are not easily or effectively achieved by working alone. Relationships in collaboration are attractive to organisations because the synergies realised by combining effort and expertise produced benefits greater than those achieved through individual effort (Moore & Skinner, 2010).

Partnership is an arrangement whereby partners pool their competencies and commitments, manage a venture jointly and share equally in risks, benefits and losses (Draxler, 2008:31). According to Shallcross (2004:59), it is important for schools to recognise that involvement in issues require ability to manage beyond its borders. In order for the SMT to do this they have to inform the SGB of the school's

intention of getting involved in health promoting activities; invite interested parties to put forward their points of view; suggest possible solutions consistent with sustainable development of the environment; and ensure that action is undertaken (Shallcross, 2004:59).

2.8 CONCLUSION

In this chapter the rationale for the creation and maintenance of healthy learning environments was discussed. This chapter indicated the importance of brain development, physical and emotional well-being. It was imperative to discuss the management of health programmes that are developed from a WSA. The programmes included the development of policies, health education, national school nutrition programmes and physical education. Early physical learning environments include the school environment which is composed of the surroundings and buildings while in the classroom environment factors such as ventilation, space and how these contribute to learners' health were discussed. Challenges in the creation and sustenance of healthy environments were also discussed.

CHAPTER 3

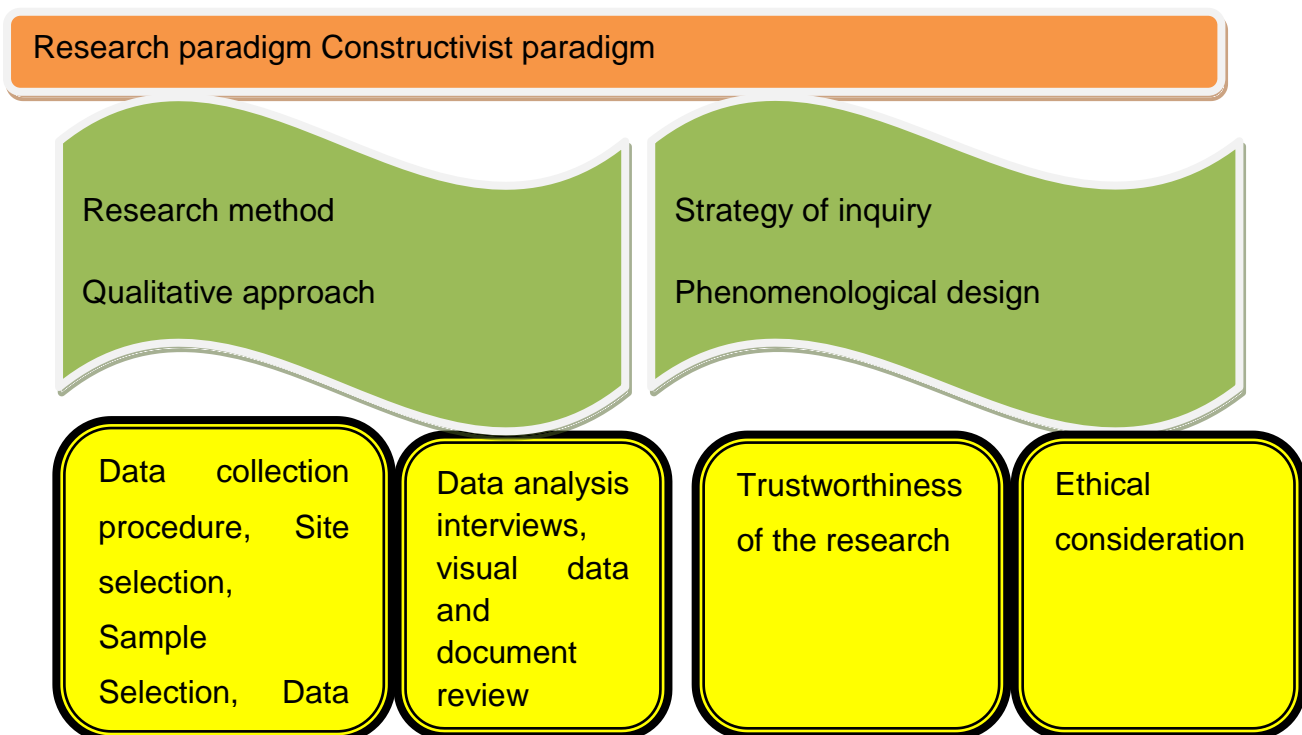
RESEARCH METHODOLOGY

3.1 INTRODUCTION

In chapter one, the focus of this study was based on the introduction and the background, statement of the problem, research questions, aims and objectives of the study, conceptual framework, research methodology, research design, strategy of enquiry, population and sampling, data collection, data analysis and ethical issues. In chapter two the focus was on the literature review on the essence of healthy learning environments.

This chapter outlines procedures that I followed in gathering relevant data needed for the aim of my research study. The sampling methods and techniques in which data was collected, were as follows: the approach used in this study, the design, research participants, sample selection, sample size, site selection, data collection methods, analysis and interpretation. To reach the aim of this study I generated data by means of interviews, photography, documentation and narratives. The figure below presents a summary of this chapter.

Figure 3.1: Summary of chapter 3



It was necessary to discuss the paradigm of this research as the fundamental model of reference that was used to organise my observations and reasoning.

3.2 RESEARCH PARADIGM

In this section I explain how a social constructivist paradigm was used in this research. This paradigm is defined in chapter 1 (*cf.* 1.6). My goal was to rely as much as possible on the participants' views of the situation being studied and to make sense of the meanings the participants have about the role of SMTs in promoting healthy school environments for Grade R learners. As McMillan and Schumacher (2010:347) suggest, I relied heavily on the perspectives, feelings, and beliefs of the Grade R practitioners, health co-ordinators and SMT members.

Terre Blanche, Durrheim and Painter (2006:282) indicate that a social constructivist paradigm is relative in that there are many truths and the description of reality is merely accounts and constructions by participants. As argued by De Vos *et al.* (2011:7) the participants were actively involved in the process of data generation and thus became partners in the total endeavour. Participants were engaged in interviews, they took photographs and they wrote authorial narratives of each photo taken.

This research paradigm influenced the manner in which I conceptualised the rest of the process including the choice of the research method.

3.3 RESEARCH METHOD

The method of research for this study is qualitative in nature. The method is described in chapter 1 (*cf.* 1.7). I employed the qualitative research approach in this study in order to understand participants' perceptions and experiences of the role of SMTs in health promotion. I achieved this understanding by analysing the many contexts of the participants and by analysing their meanings of situations and events. This is in line with McMillan and Schumacher (2006: 315) who indicate that qualitative research is concerned with understanding social phenomena from participants' perspectives.

I interacted with the Grade R practitioners, school managers and health coordinators in their natural environments which are the schools, where all these participants

were working. The evidence of the school environments and settings is presented in 3.5.1 below. Interviews were conducted after tuition time. According to Mare (2007: 51), qualitative research typically studies people or systems by interacting with and observing the participants in their natural environment and focusing on their meanings and interpretations. Two sessions with each of the participants were conducted namely, one for interviews which lasted for an hour, another for the authorial narratives on the pictures taken. The latter was to verify information on the narratives.

The research design best suited for this research is discussed below.

3.4 STRATEGY OF ENQUIRY

Phenomenology is the research design used for this study as indicated in chapter 1 (cf.1.8). The use of phenomenology was underpinned by its principles which focus on ascertaining and articulating vital characteristics of a certain phenomenon which in this research is promotion of healthy environments for Grade R learners.

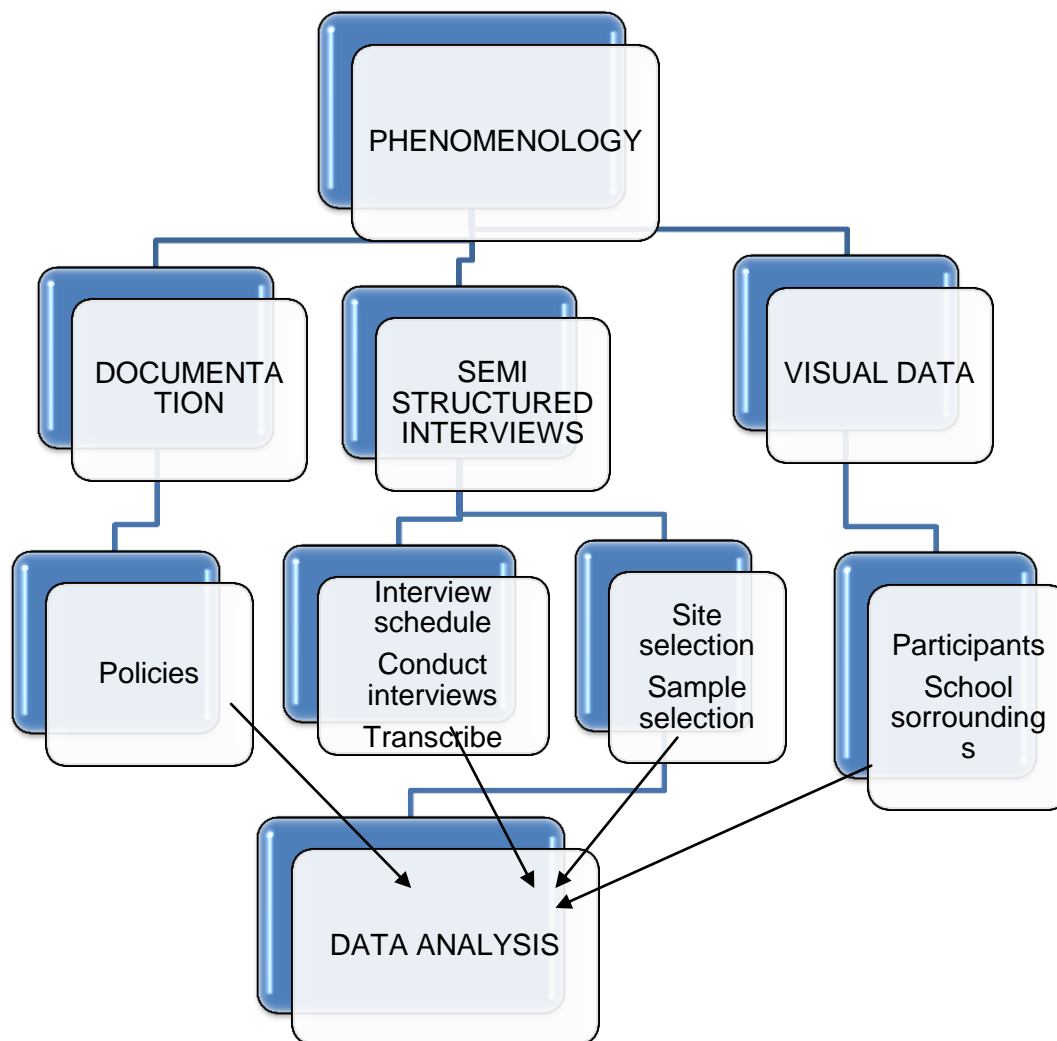
According to Creswell (2009: 8), the phenomenological approach aims to understand and interpret the meaning that participants give to their everyday lives. I chose this approach because it enabled me an opportunity to understand health co-ordinators and Grade R practitioner's perceptions, perspectives, their lived experiences and the role of SMTs in the promotion of healthy learning environments from the participants' point of view.

Naturalistic methods were used in analysing the conversations the researcher had with the participants. Thus, attempts to understand promotion of healthy environments was grounded in participants' experiences of that reality. I had to lay aside my prevailing understanding of the role of school management in promoting healthy environments and revisit my immediate experience of this phenomenon to allow new meanings to emerge as suggested by Gray (2009:22).

Researchers using this strategy will mainly utilize long interviews with up to ten people as methods of data collection. Multiple individuals, who have experience (cf. 3.2) of how healthy school environments are managed, were identified (De Vos *et al.*, 2011).

The diagram below summarizes the research methodology used in this study.

Figure 3.2 Summary of research method



3.5 DATA COLLECTION PROCEDURE

Multiple data collection (*cf.* 1.9) was conducted in this research; data was collected through interviews, documents, photographs and narratives. Supplementary techniques including visual techniques; documents, interview data and narratives were generated in this research as suggested by McMillan and Schumacher (2010: 362). I selected these to help me interpret, elaborate and corroborate data obtained from participants.

I collected data through interviews, by visiting individual participants in their respective schools which was a convenient place for them, to gain in-depth understanding of their perception on the role of school management in promoting

healthy environments for Grade R learners. As indicated in McMillan and Schumacher (2010: 355) in-depth interviews use open response questions to obtain data on participant's meanings how individuals conceive of their world and how they explain or make sense of the important events in their lives. In the interview schedule (Appendix 5) the broad questions can be divided into four categories: the first pertaining to health programmes available for Grade R learners; the second relating to the role of the SMT in promoting healthy environments; the third entails the involvement of Grade R practitioners in promoting health programmes and the fourth pertaining the challenges the SMTs encounter in their endeavours.

I selected semi-structured interviews so that I may be able to probe in an attempt to seek clarity on the participants' responses. I employed face to face interviews that would enable me to have eye contact with the participant giving me a clear understanding of their perceptions on the role of school management in promoting healthy learning environments for Grade R learners. De Vos *et al.* (2011: 296) maintain that in general, researchers use semi-structured interviews in order to gain a detailed picture of a participant's beliefs about, or perceptions or account of, a particular topic. Interviews that I conducted with participants were long conversations that lasted for one hour with each individual participant.

I also opted to collect visual data to provide visible depiction of the surroundings of Grade R learners and the visible efforts of the SMT in promoting healthy environments. My intention of presenting visual data form was to provide readers with a depth and nuance of insight that was hard to achieve with text alone as suggested by William and Brown (2009:81). I used this method as a form of evidence of the environments of Grade R learners. Photographs also provided a detailed recording of facts including the presentation of lifestyles and living in schools and working conditions of the Grade R practitioners. The participants in this research were encouraged by their role of being photographers, documenting a subject of their choice. The instruction given to the participants was to take six photos, two depicting an area where SMTs play their role, two where they were not effective and another two where they were trying to improve the condition.

Gray (2009:186) argues that photographs capture processes that are too rapid for the human eye. Participants took photographs of the surroundings of Grade R

classes to provide strong evidence of data collected through interviews and documentation.

Photographs that were taken in this research were of the school surroundings, Grade R classes, toilets, buildings, food gardens and the first-aid kits. They were also asked to write narratives of each photograph taken that would provide photographic evidence. A disposable camera that could be used to take 27 photos was supplied to each school. The first three photos were used to train participants on how to use the camera and the remaining photos were divided between four participants who made use of one camera.

I also asked participants to write authorial narratives for each photo taken. Each participant wrote descriptions of the picture taken, to accompany and expand upon the photographic evidence of what the environments of Grade R learners looked like. Participants wrote authorial narratives so that the writing style might be personal, readable and applicable for a broad audience, and the level of detail may make the narrative real and alive, carrying the reader directly into the world of the participants. McMillan and Schumacher (2010: 382) support the use of visual data collection methods claiming that narrative presentation of evidence and the diversity of visual representation of data are a hallmark of most qualitative research.

3.5.1 Site selection

The Sedibeng West District permitted me to gather information in their schools (Appendix 2). I selected four primary schools all with Grade R classes, two schools from Bophelong and two schools from Boipatong. Both townships are the oldest in the Vaal Triangle. The purpose of selecting these schools was to gather information from experienced and knowledgeable participants of old schools and to identify challenges and developments of these schools regarding the school environments for Grade R learners.

All of the selected primary schools from Bophelong and Boipatong are classified as disadvantaged schools in quintile 1.

School A

The Grade R class started in 2012 in this school, with only one class, consisting of 31 learners and one practitioner. During the time of the research, the number of learners increased to 46 learners without additional practitioner. The guideline stipulated in the Grade R policy (Department of Basic Education, 2011:4) indicates that the Grade R class is supposed to accommodate only thirty learners as per recommended practitioner which is 1:30 therefore, the class was over populated during the time of the research as its ratio was 1:46.

The Grade R learners could not be accommodated in one of the classrooms in the schools, they were therefore, using a mobile class. The mobile class had two toilets inside, for learners and two washing basins which I believe were not enough for all the learners. The size of the mobile class was 9, 7 x 6, 8m² with 7 small windows on the left side of the class and 7 bigger ones, sized 1x1, 4m² on the right side.

The practitioner was qualified to teach Grade R learners she obtained a certificate NQF level 4 in 2010 and started teaching in 2012. The Department of Basic Education (2011:6) proposes a diploma in Grade R as an initial qualification and that the Grade R practitioners with ECD level 4 and 5 have an option to complete the higher certificate and advanced certificate. The practitioner in school A still needs to improve her qualifications to meet the requirements of the proposed initial qualification for Grade R practitioners. The figure below depicts a mobile class in school A.

Figure 3.3: The Grade R class in school A



The picture of a mobile class for Grade R learners in school A shows the front view of the class. It accommodates 46 learners. The class is situated near the boys' toilets as shown in the picture. Toilets are used by Grade 1-7 learners. The windows of the class are very close to the toilets which could expose learners to unpleasant smells that come from the toilets. The surrounding of the class is dusty with no grass for learners to play. The mobile class does not have fencing which separates it from the other classrooms in the school. The dustbin is next to the door which is also not healthy for learners. There are trees at the back of the class which seem to be very close to the class, this means they could fall on the roof of the class if the area might experience strong winds. These surroundings are not healthy based on the toilets that are too close to the class, the dustbin, the dust in front of the class and the trees.

I interviewed four participants from school A. Participants comprised of the principal, one head of department for Foundation Phase, one Grade R practitioner and a health coordinator.

School B

This school had two Grade R classes, which started in 2010. It started with 53 learners, 27 in one class and 26 in the other class. The ratio at 1:27 and 1:26 was not far from the Department of Basic Education (2011) stipulation of 1:30. During the time of research the enrolment had increased to 66 learners with 2 Grade R practitioners. Two mobile classes were used for Grade R classes where 33 learners were placed in each class. This means these classes were also overpopulated, however, the practitioner learner ratio of 1:33 in this school was better than in school A, because they exceeded with only three learners in each class when compared to school A which had 16 extra learners.

As in school A each mobile class had two toilets and two basins for washing hands. The size of the mobile class is 9, 7 x 6, 8m² with 7 small windows on the left side of the class and 7 bigger ones sized 1x1.4 m² on the right side.

Both practitioners were qualified to teach Grade R learners but still had to upgrade their qualifications. The first practitioner obtained a certificate in ECD (NQF level 4) in 2008. The second practitioner obtained a certificate NQF level 4 in 2011 and was also furthering her studies to obtain higher certificate in Grade R practices. According to stipulation of the Department of Basic Education (2011:6), regarding basic qualifications both practitioners were qualified. The figure below depicts a picture of a mobile class in school B.

Figure 3.4: This is the Grade R class in school B



This picture shows the side view of the class. The surroundings of the class are also shown in the picture. The class is situated at the back of the Grade 7 classes. The surroundings of the class as shown in the picture were not well maintained. Stones and papers were all around the class. The lawn is not neatly mowed and maintained. Although the class provides shade for learners in which to sit, learners were sitting outside the class with no supervision of the practitioner. There is no fence around the mobile class.

Four internal stakeholders were interviewed in school B. Participants comprised of the principal, one head of department for Foundation Phase, one Grade R practitioner and one health coordinator.

School C

School C had two Grade R classes which started in 2011 with two practitioners and 47 learners, 24 in one class and 23 in the other. The number of learners in Grade R had increased to 68 during the time of the research. Each class had 34 learners with a ratio of 1:34. The Grade R classes were overpopulated like in the other schools

mentioned above. The classes were overpopulated by 4 learners in each class, but at least they were also better when compared to schools A and D.

The building of new suitable classes for Grade R learners were still in progress at the back of school classes. They were using two classrooms in the school premises at the time of the research.

Both practitioners in school C were qualified to teach Grade R learners. One educator had a Junior Primary Diploma (JPTD), she was about to complete an Advanced Certificate in Education (ACE). The practitioner indicated that she could not get a teaching post after she completed her diploma in teaching and decided to apply for a post as a Grade R practitioner. The other practitioner obtained NQF level 5 and was still furthering her study doing the ACE. The picture below depicts Grade R classes in school c.

Figure 3.5: Grade R classes in school C



The picture above shows classes in a school building that were used to accommodate Grade R learners in school C. The Grade R learners were waiting for the completion of suitable newly built classes which were still in progress.

On the wall of the class there were drawings and paintings, numbers and letters of alphabet indicating that the class was for learners in the lower grades. There is a dry tree in front of the class which could be harmful for learners when they play or run. Although the surroundings looked clean but they were dusty. The picture below shows the newly built classes in school C

Figure 3.6: Newly built class



As indicated above classrooms for Grade R in school C were still under construction, but were about to be completed. The building was to accommodate four Grade R classes. The surroundings still shows the building material used for construction. These classes were at the back of the school, far from other classes in the school building. I think it is a good idea to have Grade R classes far from the rest of the school to allow them enough space for their extra-curricular activities.

I interviewed four participants in school C, the principal, one head of department for Foundation Phase, one Grade R practitioner and a health coordinator.

School D

In this school there were three Grade R classes which formed part of the Foundation Phase with three Grade R practitioners. Grade R classes started in 2008 with 42 learners and only one practitioner, with a ratio of 1:42. The number of learners in Grade R increased during the time between 2008 and 2012 to 110 learners. This school had the highest number of Grade R learners in all the participating schools.

Two classes had 37 learners and one class had 36 learners with a ratio of 1:37; 1:37 and 1:36. From this data it can be deduced that this school had a history of learner overpopulation in Grade R. The number of learners exceeded the recommended ratio by 7 learners in two classes and 6 in the third class. However school D was also better, compared to school A.

Figure 3.7: Grade R classes in school D



The picture above shows one of the Grade R classes in school D. The wall is decorated with shapes to clearly represent a learning environment for Grade R learners. There were tables in front of the classrooms, one table with small pieces of soap. This could indicate that the tables were used for basins of water for hand washing.

I interviewed three participants in school D, the principal, one Grade R practitioner and a health coordinator. The two Foundation Phase Heads of Departments refused to be interviewed. The picture below shows classrooms for Grade R learners. Grade R was accommodated in the school classrooms.

All pictures of Grade R classes indicated above were taken by participants, these pictures therefore do not show everything about the physical environment and there is no picture showing the classrooms inside. This could be because participants only focused on capturing evidence of efforts in health promotion and where they thought SMT members were failing.

3.5.1.1 Sample selection

The four participants that formed part of this enquiry were from four selected primary schools. Only schools with Grade R classes were chosen for this research. All four primary schools were under the Sedibeng West District. A sample of participants was chosen from these schools. As indicated earlier the intent was to get rich data from the participants, the selection criteria was therefore based on participants that were working with Grade R as practitioners, health coordinators and as managers.

The sample selection was purposive, participants selected with a purpose in mind, those who were knowledgeable about health promotion for Grade R learners. According to Creswell (2002:206), in purposeful sampling, researchers intentionally select individuals and sites to learn or understand the central phenomenon. My focus was on participants who would provide relevant and rich data based on their contribution to the promotion of healthy learning environments for Grade R learners.

A stratified purposive sampling was suitable to serve the purpose of the study best (*cf.* 1.9). The intention was to have data from identified different strata in order to compare their responses because I believed that their responses may differ. The strata of data in this research were SMT members (n=7), Grade R practitioners (n=4) and Health coordinators (n=4).

Table 3.1 Sample size

No of schools	Schools	No of participants	Participants
4 Primary schools	A	4 Participants	1 principal, 1 SMT member, 1 practitioner and 1 health co-ordinator

	B	4 Participants	1 principal, 1 SMT member, 1 practitioner and 1 health co-ordinator
	C	4 Participants	1 principal, 1 SMT member, 1 practitioner and 1 health co-ordinator
	D	3 Participants	1 principal, 1 practitioner and 1 health co-ordinator
TOTAL	4 Schools	15	15

The table above shows a breakdown of the participants in this research. Three schools had four participants each and one had three participants due to the refusal of HODs in this school to participate in the research.

The data collection process, capturing, analysis and interpretation are discussed in the section below.

3.5.2 DATA COLLECTION PROCESS

I personally submitted a letter requesting permission to conduct interviews in schools in the Sedibeng West District, in the Department of Education in Johannesburg (*cf.* Appendix 1). After the reply granting me permission was received (*cf.* Appendix 2) all school principals of the chosen schools were consulted to request their permission for interview processes in their schools. The aim of collecting data from their sites was explained and the letter issued by the Sedibeng West District permitting me to conduct interviews in their schools was produced. After permission was granted, I set appointments for dates and times for interviews with participants concerned.

3.5.2.1 Data capturing

I used the tape recorder (*cf.*1.10) to record information from interviewees because I realised that the tape recorder was vital in collecting data as it captured everything that the participants were saying. Permission was asked from interviewees to record their voices. The tape recorder was tested first before each interview started. After

every interview I took out the cassette and labelled it according to sequences of interviews that enabled me to know where each data was stored. The tape recorder was tested before the next interview to prevent mishaps.

Notes were also taken during the interviews in case the information recorded was not audible enough. After the interviews I compared the written notes and the audio-taped interviews to ensure that the notes contained the recorded information.

3.5 2.2 Transcribing

The information was transcribed immediately after each interview session, while I still remembered the information because I did not want to lose or forget any of the information I collected. I listened to the audio-taped interviews and wrote down the responses of participants from the tape recorder; rewound it when the data was not clearly audible to understand what was said by interviewees. I also read the written notes of each participant, and included this information in the transcripts. I did this for several times so as to make sure that I do not lose any data and also familiarise myself with the data.

The information transcribed was typed into transcripts (*cf.* Appendix 6). I also read the transcripts several times to understand meanings of what participants were saying so that I may consult them again if the meaning was not clear. Thus, I immersed myself in the data. The transcripts of participants from different schools were reviewed to form codes and later themes.

3.6 DATA ANALYSIS

According to Creswell (2009: 184), data analysis is an on-going process involving continuous reflection about the data. After information was collected from various sources the analysing step followed. Data analysis involved reading through the data repeatedly, and engaging in activities of breaking the data down into codes and categories (*cf.* Appendix 7).

Analysis involved a process of breaking down data into smaller units to reveal their characteristic elements and structure in order to make sense of the text. McMillan and Schumacher (2006: 364) argue that qualitative data can be broken down by means of coding, categorizing, and interpreting data to provide explanations of a

single phenomenon of interest. To provide explanations of the role of SMT in health promotion, coding of words were done by the help of atlas.ti in this research.

3.6.1 Analysis of interview data

Interview data analysis in this study was done through Atlas.ti. According to Smit (2005:65), Atlas.ti is a powerful work bench for qualitative data analysis, particularly for large sections of text, visual and audio data. I used data analysis software for easier management and analysis of large amount of raw data because I worked with a large amount of data, namely interview data in order to know what was actually analysed and to do meaningful comparisons.

After transcribing the audio interview recording into a text, I began to analyse. I read the transcripts while listening to the recordings. I then loaded the text into Atlas.ti computer software. I classified data into categories as Smit (2005:70) indicated that Atlas.ti renders a code and retrieve function, and provides support for theory building by facilitating connections between codes to develop higher order classification and categories, formulating propositions that imply a conceptual structure that fits the data.

Although atlas.ti codes and categories data were used, I still had to print out copies of transcripts to read the data several times to understand all the responses so that I could create a meaningful text. I could not rely entirely on the atlas.ti as I had no experience or prior training regarding the use of the software.

Codes were developed by the software and grouped into code families. I had to print out copies of the categorised data, read through the pages to make sure that all important information was captured and categorised. I had to go back to the data on the software programme to add the codes that I missed. When I was satisfied I therefore started grouping the categories into themes electronically.

The method employed to identify themes in this research was the inductive method. MacMillan and Schumacher (2006: 364) state that the main purpose of using the inductive process in the analyses of qualitative data is to allow the research findings to emerge from the frequent, dominant or significant themes inherent in the raw data, without the restraints imposed by a more structured theoretical orientation. It enabled me to classify significant themes inherent in the raw data collected.

The table below shows the inductive process employed in this research in the classification of themes:

Table 3.2: The coding process

Read transcripts and loaded the into Atlas.ti computer software	Developed codes	Grouped codes into families	Reduce overlap and redundancy among the categories	Selecting quotes supporting the categories from the atlas.titranscripts
71 pages of transcripts	Many codes found	30-40 themes	20 themes	4 themes

Source: Adapted from McMillan and Schumacher (2010: 367).

The seventy one pages of the transcripts could not be attached to this dissertation as the document would be too big, only the transcripts of data obtained by means of in-depth interviews from two schools were attached (*cf.* Appendix 6).

The data yielded four themes. These were:

- Schools were at different levels regarding the role of SMT in health programmes that were supporting the curriculum (*cf.* 4.3). This theme did not come as a surprise to me as this was the reason that led to my investigation of this topic. Nutrition was the only programme amongst those that were supporting the curriculum where all SMTs in participating schools were playing their role, while they were not effective in other health programmes.
- Most SMTs played their role in the curriculum-based programmes (*cf.* 4.3). This theme is taken seriously in schools because it is examination oriented. It is guided by a policy (CAPS) that needs to be adhered to, thus I expected managers to fully play their role in ensuring effective implementation of this theme.
- The SMTs did not play their role pertaining to the physical environment in all participating schools (*cf.* 4.3). In all schools there were challenges regarding

physical environment that were hindering the effectiveness of the implementation of health programmes for Grade R learners. This also did not come as a surprise to me because of the condition one could see in participating schools.

- Schools were at different levels regarding general roles pertaining to provision of effective leadership (*cf* 4.3). Implementation of policies was also problematic in schools (*cf* 4.3). In certain schools' policies were effectively implemented while in other schools there was no compliance. Participants complained of not being supported by school management. I expected this as the appearance and conditions in schools could convey a message that there were policies that were neglected by SMTs.

3.6.2 Analysis of visual data

Photographs are regarded as supplementary techniques by McMillan and Schumacher (2006:359). Photographs are useful for validation of data, as they document non-verbal behaviour and communication, and can provide a permanent record. I used photographs (*cf* 1.10) to validate data that was collected by means of interviews and documents. Another aim of using photographs was to enable participants to communicate or express their perceptions regarding Grade R environments through pictures as visuals document a non verbal behaviour.

Documents that were used in this research included health policies and environmental policies.

3.7 TRUSTWORTHINESS

Trustworthiness had to be emphasised through addressing credibility, transferability, dependability and conformability.

Credibility – Naturalistic terms are developed through examining the study design and methods used to drive findings (Gray, 2009:194). Terre Blanche *et al.* (2006: 91) indicate that credible research produces findings that are convincing and believable and that the credibility of a qualitative research is established while the research is undertaken. The researcher continually looks for discrepant evidence to the hypotheses she or he is developing as a means of producing a rich and credible account.

The credibility in this research was verified through data triangulation. Data was collected from different sources. Different data collection sources were used to corroborate, elaborate or illuminate the research in question. These sources included interviews, documentation, photographs and narratives.

Transferability is intended to ensure that the findings are applicable to real world settings. Thus, this research was conducted in natural settings as discussed in 3.5.1 above. This research is not intended to generalise but to understand the perceptions and experiences of participants regarding the role of SMTs in health promotion for Grade R classes. Detailed and rich descriptions of contexts generated by means of interviews, photographs, documents and narratives are provided in this research.

Dependability refers to the degree to which results are repeatable, however, I did not expect to get the same results as previous researchers of the same phenomenon. It is achieved through rich and detailed descriptions of the data procedure and sites selection thus, providing an audit trail.

Conformability refers to whether the data helps to confirm the general findings and lead to the implications. As indicated above, the process of data generation, data analysis and interpretation are provided in this research presenting an audit trail that is traceable.

3.8 ETHICAL CONSIDERATIONS

As most educational research deals with human beings, it is necessary to understand the ethical and legal responsibility of conducting such a research (McMillan & Schumacher, 2010:117). Whenever human beings are the focus of investigation, there is a need look closely at the ethical implications of what is to be done.

I therefore asked the permission from the Sedibeng West District office, principals of participating schools and all participants. They were informed about the nature of the research.

Informed consent –In order to gain the permission from the research participants I explained my intentions to collect and all methods I was going to use in data

generation. I also explained that participants were free to withdraw from the interviews if they were no longer interested.

Assurance was given to participants regarding the confidentiality of information and their names and schools. Ethical considerations were explained to the principals and all participants. The assurance was given that their views will be kept safe and treated as confidential. Their names were not mentioned in the research instead participants were presented as participant 1A, 1B and so forth. I coded names of schools as A, B, C and D.

Permission to conduct research - To conduct this research, a letter of request was written to the Department of Education. After receiving the approval, the letter granting permission to conduct the research was distributed to principals as proof to conduct research in the Sedibeng West District primary schools.

No deception- Data was not fabricated in this research. Data indicated on transcripts was from the responses of the research participants. The data was from the interviews, photographs and narratives obtained from schools during interviews. All participants were asked to be audio taped during interviews and they all agreed. The audio tapes, the negatives of photos taken by participants, narratives and transcripts are kept safely for future reference.

No plagiarism – The data from the literature review was not plagiarized, all sources that I used are indicated in the reference list.

3.9 LIMITATIONS OF THE STUDY

According to De Vos *et al.* (2011: 118), potential limitations are often numerous even in the most carefully planned research study and it is important that they be mentioned.

Limitations in this research included that some of the participants, especially practitioners were not comfortable to share information because they thought their views regarding the role of management in promoting healthy environments for Grade R learners might be exposed to their managers, especially schools where managers were not playing their role in promoting healthy environments for Grade R

learners. HODs for the Foundation Phase in school D refused to participate in the interviews.

Another limitation was that most participants were not good photographers; most of the pictures taken could not be used in this research. One could not easily see what the pictures depicted, some showed half of a building and contents in first aid boxes were not clearly visible.

3.10 CONCLUSION

In this chapter the process of the empirical research was provided, starting with the research paradigm, research design, and the research method. Ethical issues were mentioned and measures to ensure credibility of this research were undertaken. Selection of sites and sample were also dealt with. This chapter gave an overview on how the empirical research was implemented.

The next chapter deals with data analysis and interpretation.

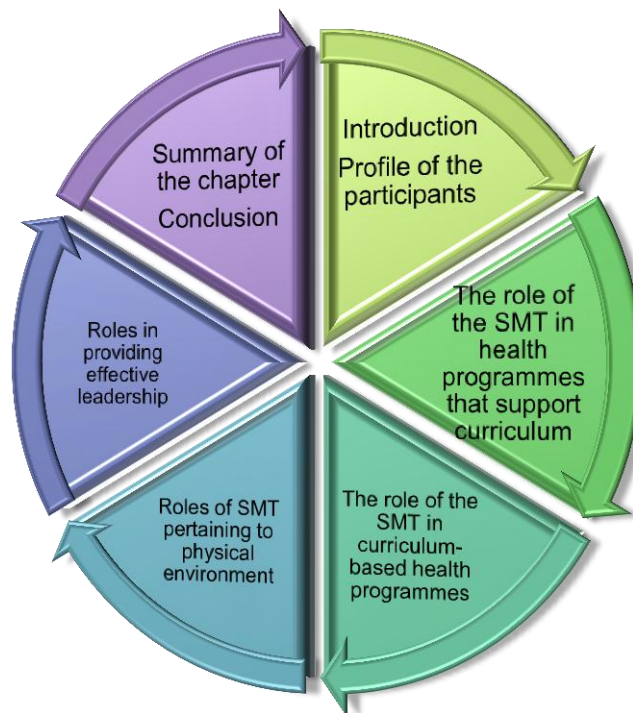
CHAPTER 4

PRESENTATION AND DUSCUSSION OF RESULTS

4.1 INTRODUCTION

In the previous Chapter my focus was on the presentation of the research methodology. The data that was collected through interviews, documents, visual data and narratives is presented in this chapter. The aim of this chapter is to present and discuss the results from Grade R practitioners, principals, HODs and health and safety co-ordinators in schools in the Sedibeng West District. The information on the profile of all the participants and the triangulated data are presented. A summary of this chapter is shown in the figure below.

Figure 4.1: Summary of chapter 4



4.2 PROFILE OF PARTICIPANTS

The profile of the research participants in this research are as follows:

Table 4.1 Participants and their roles in schools

SCHOOLS	PARTICIPANTS
School A	<p>Participant 1 - (Female) Health and safety co-ordinator</p> <p>Participant 2 - (Female) Grade R practitioner</p> <p>Participant 3- (Male) Principal; Participant 4 - (Female) Foundation Phase HOD</p>
School B	<p>Participant 1 - (Male) Principal</p> <p>Participant 2 - (Female) Grade R practitioner</p> <p>Participant 3-(Female) Foundation Phase HOD.</p> <p>Participant 4 - (Female) Health and safety co-ordinator</p>
School C	<p>Participant 1 - (Female) Grade R practitioner</p> <p>Participant 2 - (Male) Health and safety coordinator</p> <p>Participant 3- (Male) Principal</p> <p>Participant 4 -(Female) Foundation Phase HOD.</p>
School D	<p>Participant 1 - (Female) Grade R practitioner</p> <p>Participant 2 - (Male) Principal</p> <p>Participant 3 - Health and safety co-ordinator</p>

Most participants were females. This is so because educators in the Foundation Phase in South African schools are predominantly females. The males that participated are principals of the participating schools and a health and safety co-ordinator. In most participating schools the participants were at least four except in

school D where there were only three participants. Both HODs in the latter school were not willing to participate in the study.

4.3 RESULTS OF THE EMPIRICAL DATA

This section presents themes emerging from the responses of Grade R practitioners, health coordinators, principals and HODs. Extracts from responses were used to create explanation and meaning of themes. The first theme was that of health programmes that support curriculum for Grade R learners. These health programmes included nutrition, first aid and visits by nurses.

Role of SMT in health programmes that support curriculum

The NSNP was indicated as available in all the participating schools. From the participants' responses it seemed that the Grade R learners also benefitted. This is what they said about nutrition as one of the health programmes:

"The programmes that are here at my school are only the feeding scheme that is the only programme that I know (participant 1A)". "Feeding scheme is the only one that I know (participant 2A)"; "The first one is nutrition (participant 3A)." "Nutrition programme where learners get breakfast and lunch every day at school (participant 4A)." "They have feeding scheme programme (participant 5B)." "Nutrition (participant 6B)." "We have programme nutrition (participant 7B)." "They also have feeding scheme programme, most of the learners, Grade R learners eat at school every day" (participant 8B)." "We have here at school feeding scheme which feeds Grade R learners every day (participant 9C)." "Feeding scheme (participant 10C)." "We do have a nutrition programme (participant 11C)." "We have a feeding scheme programme where learners are supplied with food every day (participant 12C)." "Feeding scheme (participant 13D)." "We have nutrition (participant 14D)." "Feeding scheme (participant 15D)."

According to the responses of participants, it is evident that the feeding scheme was one of the programmes implemented in all participating schools. All fifteen

participants indicated the availability of the feeding scheme in their schools and other participants specifically indicated that Grade R learners eat at school every day.

It is commendable that the NSNP was also available for Grade R learners in schools. Most learners in Grade R also come from poverty-stricken communities like all other learners in the participating schools. These learners need nutritious meals to grow up healthy.

The availability of the nutrition programme in these schools is in line with the policy regarding the NSNP(2009/2010).The NSNP is an educational intervention aimed at enhancing the educational experience of the most needy Quintile 1-3 public primary school learners, (Grade R to seven). According to literature the NSNP has many benefits for learners. It promotes punctual school attendance, alleviates short term hunger, improves concentration and thus contributes to general health development. It also addresses the children's ability to learn. The availability of meals for Grade R learners is thus, important to curb the nutritional deficiency and its negative impact as indicated by Sorhaindo and Feinstein (2006) (*cf.* 2.5.2.5).

The participants' responses regarding the menu for learners are indicated below. This information came from two schools, school A and school C.

“Different menus are prepared every day and they also get a fruit once a week which I think is healthy for Grade R learners (participant 1A).” “They are served with soft porridge, power mix or motive and they enjoy it (participant 3A).” “In feeding scheme learners are given food, starting with breakfast, power mix or morvite are given to learners and then lunch follows (participant 11C).

Participants who mentioned that different menus were served in schools were managers, a principal and an HOD. The responses show that some managers, including those of school A (participant 1 and 3) at least were aware of what was happening regarding the nutrition programme. An indication that learners were enjoying their meal is supported by a response from participant 3A.

Children get tired of eating the same food, the availability of a menu in schools ensures that different types of food are cooked. Not knowing what to expect in a

meal could serve as an appetiser to get children more interested in food. It is also good to ensure that learners get balanced nutritious food.

Providing different menus is in line with the policy of the NSNP school menu (2009/10) which indicated different meals to be served every day in primary schools (cf. 2.5.2.1). According to the Gauteng Province primary school menu (2012/2013) instant cereal must be served for breakfast and rice and pilchard, samp and beans, maize and soya means and split peas, green and yellow vegetable and a fresh fruit once a week for lunch.

It shows in the following responses that learners were served two meals per day in almost all the participating schools.

“In nutrition programme learners get food in the morning and at eleven o’clock (participant 2A).” “When our learners come to school, before they go to classes; they have a very nice breakfast, at 11:40 they get their lunch (participant 3A).” “Nutrition programme where learners get breakfast and lunch every day at school (participant 4A).” “In nutrition learners receive food every day (participant 7B),” “In nutrition programme Grade R learners eat breakfast and lunch every day Monday to Friday (participant 11C).” “In nutrition programme Grade R learners eat breakfast and lunch every day Monday to Friday (participant 15D).”

In all participating schools two meals were served every day, breakfast and lunch.

It is good that learners in participating schools got breakfast that giving them energy to start their day and concentrate in class and lunch to sustain their energy throughout the day.

Serving two meals per day is in line with the policy on NSNP (2009/2010:4) which indicates that it is important to feed learners before 10h00 so as to give them energy to concentrate and be alert in classes. The policy also indicates that breakfast is the most important meal of the day to be served to all learners in schools. Compliance with the Guidelines for the implementation of the programme varies from one province to the other. According to the NSNP (2009/2010:23), Gauteng remains the only province providing breakfast (cf. 2.5.2.1). All participating schools in this research are in the Gauteng province.

The following participants indicated that in their schools there were food handlers, who assisted in cooking and serving food to learners.

“The food is prepared by people who are hired for feeding scheme (participant 1A).” “There are people hired to prepare food for learners and to clean the kitchen (participant 2A).” “We hired people for the preparation of food (participant 3A).” “There are people who are hired to cook food for learners (participant 4A).” “In nutrition there are people hired to cook for learners (participant 5B).” “The feeding scheme committee hired people, who cook for learners and they give learners food every morning and every lunch (participant 6B).” “There are parents who are hired to cook and clean the kitchen where the food is being prepared (participant 10C).” “In the feeding scheme there are helpers hired to prepare food for learners, they give learners food every day (participant 12C).” “During nutrition programme their food is prepared in the kitchen by the ladies, who are hired by the department of education (participant 14D).”

Participants from all schools indicated that in their schools there were people hired for the preparation of food for learners. Two participants (participants 1A & 6B) in their responses indicated that people hired also help with the cleaning of the kitchen.

It can be applauded that in the participating schools there were people who focused on cooking for learners; this could enable educators to focus on their work. Learners would also have their food on time every day. Having people that are responsible for a task make them accountable for their role. The cleaning of the kitchen emphasises hygienic practices.

Having food handlers in schools is in line with the NSNP (2009/2010) which states that they must be appointed amongst unemployed parents. According to a guide for secondary schools on the NSNP (2009/2010:5), the SGB is responsible for identifying unemployed parents from the community, and to recruit them as volunteer food handlers (*cf.* 2.5.2.1).

It was necessary to include a picture depicting a cooking area in school C to support the role the helpers play in keeping the cooking area clean.

Figure 4.2: A kitchen in school C



The cooking area in school C was kept clean. In this picture everything seemed to be in order, with a table for the preparation of food and pots on top of the cupboards. A participant who took the picture of the kitchen wrote a narrative about the picture, and this is what was written, *“The picture of a kitchen which is kept clean always.”*

The cleanliness of the cooking area could be ascribed to the food handlers’ awareness of their duties.

According to the NSNP (2009/2010) it is appropriate that the cooking area is kept clean in schools not only for food safety but also for hygienic purposes. Food handlers are expected to maintain a high level of personal hygiene (*cf.* 2.5.2.1).

It was necessary to include a picture that depicts a food storage area, as one of the areas of the NSNP policy.

Figure 4.3: Food storage in school B



One of the participants in school B took a picture of the area where food is stored in her school. In her narrative the participant indicated that, *“food is kept in a clean place, the trunks are for rice, samp, beans etc and the other storage is for fruit and vegetables”*.

It is praiseworthy that dry food is stored in closed, air-tight containers and fruit and vegetables in a separate container which seems to be well ventilated.

The availability of storage system in the picture above is in line with literature. The Department of Education, NSNP (2008:24-25) recommends that dry food such as maize meal and samp be stored in air-tight containers (*cf.* 2.5.2.1). According to the Department of Education (2009/2010:11), there should be separate storages for food items and food should be stored in a well ventilated room. Food must be placed on platforms or containers should be used to store food.

It was necessary to include a picture that depicts a storage area for fruit and vegetables as an indication that food was stored in different areas in school B.

Figure 4.4: Fruit storage in school B



The storage allowed for circulation of fresh air around the fruit. The container had separate sections for different types of fruit and vegetables. A participant who took the picture of the fruit and vegetables storage in her school indicated the following in her narrative, *“A picture where we store fruit and vegetables to keep them fresh.”*

It can be applauded that in this school they had storage where fruit and vegetables could be kept fresh for longer periods of time. It could be because of the monitoring at provincial level that the school was able to maintain food safety measures.

The storage for fruit and vegetables complied with the Department of Education National School Nutrition Programme (2008:26) recommending that it should be stored in a cool area with adequate air circulation. Insulators are hired at provincial level

on contract annually consistent visits and minimal monitoring of the NSNP (Department of Basic Education, 2009/2010).

It seems that schools comply with the policy through the availability of the nutrition programme, serving different menus, hiring of food handlers and providing relevant storage for food and following NSNP guidelines regarding nutrition.

Regarding monitoring and evaluation of the implementation of the nutrition policy this is what the participants said:

“I go to the kitchen where food is prepared to check cleanliness of the area, to check cleanliness of the people preparing the food and also to check if they are wearing appropriate aprons and hats, and I will also personally go and check where the food is stored, (participant3A).”; “The principal also check food in the kitchen (participant 9C).” “We check the food supplied by the supplier (participant 11C).”

All three participants indicated that nutrition was monitored by the managers. This was done by checking storage; food handlers, the kitchen and the food supplied.

It was good that managers checked cleanliness in the area of preparation for food and storage. Food handlers would not do their duties effectively if they were not monitored, and the danger of serving food from a dirty unhygienic area would be the order of the day.

Monitoring of the NSNP is in line with the policy (2009/10: 6) indicating that when choosing a cooking area, schools should ensure that it is hygienic and is clear of any potential for food contamination. The cooking area must always be kept in a neat and hygienic condition to avoid food contamination and spreading of germs (cf. 2.5.2.1).

Participants from two schools, A and D, when asked how nutrition is monitored and evaluated in their schools responded as follows:

“They don’t come and check when learners are eating; they don’t care whether classes where learners are eating in are clean or dirty (participant 1

A).” *“They do not monitor when learners are eating (participant 13D).” “They do not check when learners are eating (participant 15D).”*

Participants in school A and B indicated that their managers do not check when learners are eating.

According to the responses above it is clear that managers of schools A and D did not show any interest in monitoring whether learners ate in clean areas or not. This implies that cleanliness in areas where learners ate was not a priority for the SMT in these schools. Participant one mentioned that learners ate in their classrooms meaning that there was no designated place for Grade R learners to eat.

According to the policy of the Department of Basic Education (2009/2010) on NSNP there is no indication that learners should be checked in their classes when eating.

In summary, from the data provided, there was availability of nutrition that benefited Grade R learners in the participating. Different menus were provided at breakfast and at lunch; there was commitment in ensuring that learners were fed on time by food handlers who were also responsible for cleaning the kitchen. Proper storage for food was shown in the pictures. Managers checked cleanliness in areas of cooking and storage. Practitioners complained about managers who were not checking cleanliness when learners were eating in classes, while they were responsible for their own classes and could do the checking.

The second programme under those that are supporting the curriculum that was mentioned pertains to the control of communicable diseases at schools. This is how participants responded regarding the availability of this health programme:

“We also have first-aid (participant 3B).” “The fourth is first-aid (participant 8B).” “The other one is first-aid (participant 6B).” “We have first-aid kit where Grade R learners are attended when they have minor injuries (participant 9C).” “First-aid kit (participant 10C)” “Each class has got a first-aid kit (participant 11C).” “First aid (participant 15D)”

Participants from schools B, C and D indicated having first-aid kits in their schools. Most participants who revealed this were SMT members. A participant in school C even indicated that each class in her school had a first-aid kit.

First-aid kits are essential in schools especially for young children who are vulnerable to injuries. Without fully equipped first aid kits practitioners cannot attend to learners' minor injuries, thereby failing to promote the physical health of learners.

The availability of first aid kits is in line with the National Policy on HIV/AIDS (1996), which states that schools should have at least two first-aid kits available and that first-aid kits should be maintained.

It was necessary to include a picture that depicts a first-aid kit in school B as evidence of the availability of the kit.

Figure 4.5: First aid kit in school B



This picture indicates the following items: Savlon, cotton wool, plasters, instant ice pack, cotton buds, and rubber gloves. According to a narrative from participant 2B *this is the evidence of having first-aid kit in my school* the photo is proof that a first-aid kit was available in school B as mentioned above. The quality of the photo does not allow one to determine whether the contents were according to stipulation in the National Policy for HIV/AIDS or not.

It was good that in school B there was a first-aid kit which was an indication of the management of injuries and communicable diseases in the school. However, the first aid kit does not show most of the items indicated below. One of the reasons for having few items in the first aid kit could be that it is the responsibility of the school to buy first aid boxes and replenish when depleted. This becomes a problem for some schools as the focus might be on everything else except the first aid.

According to the National Policy for HIV/AIDS (SA, 1996) first-aid kits should contain the following: disposable latex gloves, rubber gloves, waterproof plasters, disinfectant, scissors, cotton wool, gauze tape, tissue, container for water, and a resuscitation mouth piece, eye wear and a protective face mask to cover nose and mouth. From what one can see in the above first aid kit, not all the items indicated here were available in the school.

However, there were participants who indicated the lack of availability of first-aid kits in their school. This is how they responded:

“Yes I do have a problem regarding that because first of all we do not have a first-aid kit for learners in case they get injured (participant 2A).” “In the Grade R class we are supposed to be having the first-aid kit in case anything happens, the practitioner must be able to help the learners using that first aid kit. We don’t have that first-aid kit (participant 3A).”

Participants that indicated the lack of availability of first-aid kits were from school A. Participants seemed to be aware of the policy in that they indicated that the Grade R learners were supposed to have a first-aid kit in their classes.

There is inconsistency in the participating schools regarding the availability of first-aid kits. All schools are mandated to have first-aid kits, but participants from school A indicated that their school did not have it. Unavailability of first aid-kits in school A can be detrimental to maintaining a healthy environment for Grade R learners and applying precautionary measures. Acknowledging that schools should have first aid kits is not enough, there is a need to attend to minor injuries as a form of blood management.

The unavailability of first-aid kit is not in line with the policy. According to literature, children are prone to injuries therefore minor injuries should not be ignored, but vigilance in attending to minor injuries may guard against major injuries.

It seems that there were participants who were faced with challenges regarding first-aid, below are challenges mentioned by participants from school D:

“When something is finished in the first-aid kit like savlon, or plasters, the management does not replace them (participant 13D).” “The management does

not refill the first-aid kit as it is supposed to; the contents in the kit are not sufficient. They do not check the first-aid kit (participant 15D)."

Participants from school D indicated that items in the first-aid kit were not replenished. Participant 3D indicated that a first-aid kit was available in their school (*cf.* theme 1).

It is worrying that the school has a first-aid kit that is not maintained. Both these participants alluded to the items were not replaced and not checked. From what the participant said, it can be deduced that the kit was not checked against a content list and that the school did not have a content list and a designated person to check the kit, hence she thought it was the responsibility of the school management. Another important factor is that of expired or depleted items. In the absence of a responsible person the kit can have the same contents for a long time, most of the items expired and thus, posing a danger to the little ones. This is not an indication of an effective implementation of a policy.

The lack of maintenance of the first-aid kit is not in line with the HIV/AIDS policy (1996), where it indicates that the contents of the first-aid kit should be checked each week against a contents list by a designated staff member of the school. It further states that expired and depleted items should be replaced immediately. As indicated above the school could be prioritising other things and not the first-aid kit. This is unfortunate as it deprives learners of the medical attention they are entitled to.

Another challenge that came up was that of training on first-aid. The participant in school D indicated the following:

"Yes we do encounter challenges, because we are not trained for first-aid kit, but we are expected to help learners (participant 13D)." "No, no body is trained for first-aid in this school; we are just using our knowledge to help learners (participant 15D)."

Participants from school D mentioned that they were not trained for first-aid. Participant 13D who is a practitioner for Grade R indicated they were expected to help learners even though they were not trained. Participant 15D, a school health and safety co-ordinator was also not trained. Participant 15D indicated that they were using their common sense.

This approach is dangerous for both learners and educators, in cases where an item in the first-aid kit was incorrectly used; the participant could be in trouble. Lack of training on first-aid could have negative implications for the learners as people may apply expired items only to cause more problems for the person who is helped.

Lack of training on first-aid does not comply with the National policy on HIV/AIDS (1996) which states that all learners, students, and educators and other staff members including sports coaches should be trained in handling and the use of the first-aid kits.

In summary, managers in the other participating schools were not effectively managing first-aid kit, while in other schools there was an indication that first-aid was managed well.

In schools B and C the checking of the first-aid kit was done:

“The HOD responsible for Grade R class checks the first-aid kit if contents are still enough or has not expired (participant 8B).” “The HOD also checks if the contents of first-aid kit are still available in all classes (participant 9C).” “Yes the HOD monitors the things in the first-aid kit (participant 10C).” “The other thing is that on 3 months basis we do what we agreed upon, they must check the first-aid kit, check everything, the expiry date (participant 11C).”

Three participants from school B and C mentioned that they checked first-aid kits in their school. Expiry dates and availability of contents were checked. The practitioner, a manager and a Grade R practitioner of school C mentioned the checking of first-aid kits in their school, contents of first aid-kits were checked regarding availability. Expiry dates were also checked. The checking was done on a 3 month basis.

Although it is good that there was monitoring of the first-aid kit in these schools, it is worrying that in school C this was done after 3 months. Three months is a long time. There can be items expire before they are checked and the kit can be depleted before the checking time. The danger would be when a child needs urgent attention and it is only then that educator realises that what he or she wanted to use is depleted or expired. Not checking the contents of the kit can also be detrimental to effective precautionary measures taken by a school.

According to the National Policy on HIV/AIDS (1996) the contents of a first-aid kit should be checked each week against a contents list. These schools therefore, were not following the policy regarding the checking of the first-aid kits.

In summary, three schools had first-aid kits; and in the fourth school there was no first aid kit available. There was no checking of first-aid kits in two schools and the items were not replaced, while the other two schools were checking contents of the first-aid kits, the checking in one school was not done on a weekly basis as the policy recommends but on a 3 month basis. Most participants never received training with regard to first-aid.

Another programme that was mentioned by the participants focused on health services by local health nurses. Participants indicated the following regarding the visits by local nurses to their schools:

“Nurses come to school once a year to check learners. They also come when there is an emergency immunisation (participant 3A).” “They send nurses every year to the school for immunisation and health check-ups(participant 4A).” “They visit our school once a year to check learner’s general hygiene, eyesight, hearing, mouth and teeth (participant 5B).” “In partnership with nurses learners are checked once a year by professional nurses (participant 6B),” “Nurses visit the school once a year (participant 7B).” “The nearby clinic sends nurses to the school every year (participant 8B).” “We also liaise with local clinic for health issues; nurses visit the school once a year (participant 9C).” “Health check-up by local nurses once a year (participant 10C).” “We also link with a nearby clinic nurses visit the school once a year (participant 11C).” “And nurses also visit the school once a year for a complete checks up (participant 12C).”

Participants from three schools indicated that nurses visit their schools once a year for check-ups (3 schools A, B and D) or when there was an emergency immunisation and general hygiene (2 schools A and B).Participant seven indicated that learners were referred to the clinic or special doctor for problems that need their attention.

It is worrying that visits were done annually in schools. The long period between visits can have negative implications for learners especially regarding follow-ups and referrals.

The annual visits are in line with the policy. According to the Integrated School Health Policy (2012) all new entrants must be assessed and schools visited once a year.

Participants from all four primary schools indicated that the following assessments were done by nurses when they visited their schools:

Nurses come to school once a year to check learner's cleanliness, eyesight, hearing and teeth, if they find a problem they refer learners to be seen by doctors at the clinic (participant 3A). "They send nurses every year to the school for immunisation and health check-up (participant 4A). "They visit our school once a year to check learner's general hygiene, eyesight, hearing, mouth and teeth. When there is a problem that needs special doctor they refer learners to the clinic or doctor (participant 5B). "In partnership with nurses learners are checked once a year by professional nurses, the following are checked: eyes, teeth, hygiene, ears, mouth and weight (participant 6B). "The nurses check learner's general health, eyes, hearing, hygiene and teeth (participant 7B). "The nearby clinic sends nurses to the school every year, to do a general health check where learners' ears, eyes, teeth, cleanliness, are checked (participant 8B). "We also liaise with local clinic for health issues (participant 9C). "Health check-up by local nurses (participant 10C). "We also link with a nearby clinic (participant 11C). "and nurses also visit the school once a year for a complete check up, that is eyes, ears mouth, hygiene and teeth of Grade R learners (participant 12C). "And we also have nurses who work with us, when children get injured; they are available in the school yard in a zozo from eight o'clock to four o'clock. They check eyes ears, mouth, hygiene and teeth (participant 13D). "Partnership with local nurses (participant 14). "They also have a once a year check up, where nurses check eyesight, teeth, mouth, cleanliness. (participant 15D)."

Participants mentioned the checking of learner cleanliness, eyesight, hearing, teeth, mouth, immunisation and hygiene. Participants (3A and 5B) mentioned that learners were referred to the doctor if there were problems.

The check-ups by professional health workers are essential in monitoring the well-being of learners and in case there were problems with the learners' health. Health problems could be detected early and be dealt with before they become barriers to learning.

The check-ups were therefore in line with the Integrated School Health Policy (2012:13) (*cf.* 2.5.2.1). The aim of these visits were based only on two aspects, yet the Integrated School Health Policy (2012) indicate that their goal is to contribute to the improvement of the general health of children and the environmental condition. Participants did not mention the checking of the physical environment by nurses. The referrals done by nurses were also in line with the Integrated school health policy (2012) which indicates that follow-ups and referrals where learners are identified as requiring health and other services that cannot be provided on-site through routine school health services, mechanisms must be in place to ensure that learners access these services.

The dental check-up was done differently in school B

“We have a dental health programme where we take learners every year to the dentist to be taught about healthy teeth (participant 5B).” “They support us when we have dental health trip to the dentist (participant 6B).” “We also have the dental healthy teeth and checking of their teeth (participant 7B).” “The programme is dental health; we take learners to the dentist (participant 8B).”

Three participants from school B indicated that for dental check-up learners were taken to the dentist. Participant 5B indicated that learners were taught by the dentist about healthy teeth. This health programme was implemented differently in school B.

It is laudable that participants in this school took the initiative in ensuring that learners receive dental care. What is not clear is why they had to take learners to the dentist if nurses visit the school to do check-ups. This could indicate ignorance on the side of the SMT on what the local clinic can help the school with or it could mean that came up with a strategy to augment health services provided by local nurses.

Taking learners to the dentist is not in line with the Integrated School Health Policy (2012) which states that nurses have to visit schools to assess learners on oral health (*cf.* 2.5.2.1). But it is good that the school did not only rely on the free service provided by the nurses.

In school D the situation was different as the school had a School-Based Health Centre; participants in this school indicated the following:

“And we also have nurses who work with us, when children get injured; they are available in the school yard in a zozo from eight o’clock to four o’clock. When it is time for immunization or health check up they just inform us and we accompany learners to their zozo which started in 2012. The community is also using their services (participant 13D).” “Partnership with local nurses, they are situated in the school yard (participant 14D).” “We are also in partnership with nurses; they help sick and injured children, they are right here in our school. When there is a problem with learners they take letters from the office to be consulted by nurses. They also have a once a year check up, where nurses check eyesight, teeth, mouth, cleanliness (participant 15D).”

Participants in school D mentioned that there were nurses available in their school yard from eight in the morning until four o’clock in the afternoon, for health check-ups and immunisation.

The availability of a SBHC in this school is good for immediate attention of sick and injured learners. However, the SBHC also serves the community; this could pose a danger to learners because of freedom of movement in the school yard. From my observation the gate could be open even to perpetrators posing as sick people.

The availability of the SBHC in this school is in line with the literature. Keeton, Soleimanpour and Brindis (2012:137) state that accessing care on site also benefits both the learner and the school, where learner absenteeism rate will be reduced (*cf.* 2.5.2.1). According to Mason-Jones *et al* (2012:2), a school that is a location for delivering healthcare services, where young people are and accessible to families, can provide a comprehensive and non-stigmatizing health services and can provide links between schools and communities.

In summary, schools were at different levels regarding the visits by local nurses. Three schools were visited annually while the fourth school had a School-Based Health Centre. The visits and the SBHC focused on cleanliness, eyesight, hearing, teeth, mouth, immunisation and general hygiene. Learners were sent to the dentist for dental check-ups in school B.

The theme below pertains to health programmes that are part of the curriculum, thus have to be taught in classes. The first health programme that is curriculum related mentioned by participants was physical education.

Role of SMT in curriculum-based programmes

Physical Education is part of Life Skills in the Foundation phase. The participants indicated the following regarding its availability:

“Physical Education is also available within the classrooms through subjects like life skills (participant 1A).” “We’ve got Physical Education, In physical education, I am referring to life skills, here I am talking about what they do, what the teacher or practitioner teaches them (participant A3).” “Physical Education through life skills (participant A4).” “Health programmes applicable at our school are Physical Education (participant 6B).” “We have Physical Education (participant B7).” “The third one is Physical Education (participant 8B)” “We have physical education (participant 9C).” “Physical Education (participant 10C).” “Physical Education (participant 11C).” “We have Physical Education (participant 12C).” “Physical Education (participant 13D).” “We have Physical Education (participant 14D).” “Physical Education (participant 15D).”

All participants from schools A, B, C, and D mentioned that Physical Education was available as it was taught in Grade R classrooms through Life Skills. *This was mentioned by three participants in school A, three participants in school B, all the participants of school C, and all the participants in school D.*

It seems that there was a consensus regarding the availability of this programme in the participating schools. Physical Education is mandated, all Grade R practitioners

have to teach it. It is praiseworthy then that these schools implement this important programme.

The teaching of Physical Education is in line with the CAPS policy. According to the DoBE CAPS (2012), Physical Education is one of the four study areas in Life Skills for Grade R class. It aims to equip learners with foundational skills, values and concepts of early childhood that are taught and developed.

The following participants stated that there was monitoring and evaluation of Physical Education in their schools:

“In terms of Physical Education, as the principal I also do some kind of sampling, go to the class and see if the teacher has taught curriculum the way it has to be, if the teacher has reached the acceptable standard in reams of syllabi coverage and school based assessments, that will definitely make me know that these learners has done this health promoting programmes (participant 3A).” “Our HOD also comes to class to check and monitor during life skills period when we do health programmes (participant 6B).” “As an HOD, every Month I check the files of the practitioners if health programmes have been taught, and (participant 7B).” “The HOD is checking the schedule coverage with the practitioners if the practitioners cover the schedules and if they do health programmes with learners. They also monitor the work that was done by learners (participant 8B).” “As an HOD, every Month I check the files of the Practitioners if health programmes have been taught (participant 9C).” “I sometimes visit their classes and I notice that they do Physical Education, I also check learner’s books and Grade R practitioner’s files to see if the programmes of health issues in life skills is followed (participant 12C).” “I visit their classes to check if learners are exercising, the HOD also check their work and report the deputy principal who also report the progress report to me (participant 14C).”

According to the above responses, monitoring and evaluation of physical education is done through class visits. Managers from schools A, B and C indicated that they were checking curriculum coverage and whether practitioners reached acceptable standards. The monitoring was done through comparing files of practitioners and learners’ books to ensure that topics were followed accordingly.

It is good that managers in the participating schools were monitoring the teaching of Physical Education in the Grade R class. Learners' books and the practitioners' files were checked. This method cannot be the only measure to determine whether health promotion programmes are implemented in his school or not.

The monitoring of work is in line with the DoBE CAPS (2012) document, indicating that assessment should be done by the Foundation Phase HOD and the facilitator assigned for Grade R. These class visits should be included in the HOD management plan.

However, there were participants who indicated that Physical Education was not monitored in their schools.

"They don't come to the class and monitor how the practitioner teaches (participant 1A)." "They do not monitor when we teach learners physical education (participant 13D)." "They do not monitor physical education for Grade R (participant 15D)."

According to the quotes above managers do not visit Grade R classes to monitor physical education.

Managers who do not monitor the teaching of Physical Education are not playing their role effectively and efficiently. Monitoring of classes would ensure that a healthier learning environment is provided for Grade R learners, as they would understand the importance of being active at an early age. The reason for a lack of monitoring could be that school managers think physical education is not important in Grade R or that they are ignorant of the stipulation in the CAPS document.

Lack of monitoring of this programme is not in line with the policy. According to DoBE CAPS (2012), class visits should be included in the HOD management plan.

Participants indicated that Grade R learners do Physical Activities in their schools, and this is what they said:

"We've got Physical Activities (participant 3A)." "Physical Activities, and the activities to develop fine motor skills (participant 5B)." "Physical Activities (participant 6B)." "We have Physical Activities (participant 7B)." "Number five is Physical Activities (participant 8B)." "We have Physical Activities where

learners exercise for health purposes (participant 9C).” “Physical Activities (participant 10C).” “Physical Activities that are beneficial to Grade R learners (participant 11C).” “We have Physical Activities where learners are trained for physical fitness and health sake (participant 12C).” “Physical Activities (participant 13D).” “Physical Activities (participant 14D).” “Physical Activities (participant 15D).”

Twelve participants from schools A, B, C and D mentioned that learners in their schools do Physical Activities.

It is important to understand the importance of being active while learners are still developing. Physical activity is imperative for learners’ development. Cognitive, physical and health benefits are documented in the literature. It is also essential for their emotional wellbeing.

The availability of physical activities in these four primary schools is in line with the CAPS document (2012:12) where it mandates schools to embark on physical activities so that learners can directly experience the benefits of such participation and be better able to understand the importance of a physically active lifestyle.

Participants indicated having focused on different physical activities that benefit Grade R learners. This is what participants said:

“We mainly do indoor exercises like clapping of hands, finger exercises and jumping (participant 1A).” “Physical Activities and the activities to develop fine motor skills (participant 5B)” “In Physical Activities we develop learner’s gross motor and fine motor skills, by doing brain gym and other exercises using bodies to make it strong and healthy (participant 6B).” “We have Physical Activities where learners exercise for health purposes (participant 9C).” “Physical Activities that are beneficiary to Grade R learners, our playground duties develop learners in totality when we focus on eye-hand coordination we normally write (participant 11C).” “We have Physical Activities where learners are trained for physical fitness and health sake (participant 12C).”

The focus of Physical Activities indicated by participants was on the development of fine and gross motor skills in schools A and B. Fine motor development and physical fitness activities were included in school C.

It seems that participants were aware of the focus of physical activities that learners had to do even though two schools paid more attention to fine and gross motor skills, neglecting physical fitness and others mentioned in the CAPS document. If activities ensuring healthy physical development are not all emphasized in early years, practitioners may not be able to deal with avoidable health problems that could cause permanent disabilities to learners.

According to CAPS (2012) the development of both fine and gross motor skills is important (*cf.* 2.5.2.1). However, most of the activities that appear in the policy document are not mentioned by participants in all four schools, activities such as creative games and skills. The neglect of these activities could be because some practitioners do not know how to do such activities. There is no training provided to practitioners on physical activities.

In summary, Physical Education is well managed at schools, while few Physical Activities are managed as participants merely mentioned the availability and implementation of Physical Activities. There were Physical Activities that appear in the CAPS document but were not mentioned by participants, this could mean that managers were neglecting other areas in physical activities.

Participants who indicated that monitoring and evaluation of Physical Activities were done in their schools, responded as follows:

In terms of Physical Activities, really, I see them outside. I used to visit them and saw them throwing the balls to one another doing catching, and throwing, playing mini-cricket, I've seen them, so that is part of monitoring (participant 3A). "Yes they do, during break the principal come and watch us what are we doing and he also asks learners what they are doing (participant 5B)." "I also check when they are doing Physical Activities (participant 7B)." "I visit their classes to check if learners are exercising (participant 14D)."

Participants from four schools indicated that they monitored Physical Activities. Their classes were also visited to check if their learners were exercising. Participant five was monitoring learners during break time.

Managers were only interested in monitoring if learners were exercising. Exercises that develop fine and gross motor skills were not checked. Times and days when

Physical Activities were monitored were not mentioned, only break time was mentioned.

The time for monitoring Physical Activities was not in line with the CAPS (2012) document where two hours are allocated for exercises per week. It is during the periods for Physical activity that monitoring can be done. It is worrying also, that managers were not checking the activities done by learners. The reason for this could be that managers were not aware of the physical activities for Grade R learners.

Lack of monitoring of physical activities in line with the literature, where it is indicated that those in charge of well-being of learners should be aware of the importance of Physical Activities and facilitate the children's movement skills (National Association for Sports and Physical Education (2002) (cf. 2.5.2.1).

Participants highlighted a lack of facilities for Grade R learners as a reason for not doing Physical Activities:

“Physical Activities because of the lack of space and facilities, the school does not have facilities such as merry go rounds (participant 1A)” *“Yes they are many. We don't have inside and outside equipment for Physical Activities (participant 2A).”* *“We do not have relevant equipment for Physical Activities” (participant 4A).”* *“They do not benefit most in Physical Activities because we do not have equipments for physical activities (participant 6B).”* *“They don't benefit on Physical Activities because of lack of space and equipments to perform Physical Activities”* *“Yes, they are not fully engaged in Physical Activities because there are no Physical Activity equipments outside (participant 9B).”* *“We don't have outside facilities like jungle gym etc. (participant 10C).”* *“Yes. We don't have inside and outside equipment for Physical Activities (participant 13D).”* *“Yes. Learners do not have things to play with to develop their skills, things like seesaw, sand pit and other equipments (participant 15D).”*

Participants above were from four different schools, they indicated that they did not have equipment which Grade R learners must use for physical activities.

Lack of equipment was a problem for Grade R learners in the participating schools. When there are no strategies in place to have all necessary material for the

implementation of a health programme learners suffer. Not being physically active could have a negative effect on Grade R learners' holistic development.

Lack of equipment for physical activity is not in line with literature. Learners therefore do not enjoy part of the benefits of involvement in physical activity mentioned by Coe *et al.* (2006) and the Centre for Disease Control and Prevention (2006) (*cf.* 2.5.2.1) cannot be achieved in such situations.

Another challenge highlighted by participants from schools was a lack of space and facilities for Grade R learners and this is what they said:

“Even the playground is not big for them to play (participant 1A)” “We don’t have enough space for physical activities” “We lack in terms of the playground; learners don’t have their own fenced area as it is supposed to be (participant 3A).” “Physical activities because of the lack of space and facilities” “We don’t have enough space for physical activities. We do not have relevant equipment for physical activities” (participant 4A).” “Another thing is space; our school yard is not big enough to give learners space (participant 5B).” “We don’t have enough space for physical activities (participant B6).” “We also have a challenge with our grade R class which is not fenced and cannot keep learners in their own yard for playing (participant 7B).” “They don’t benefit on physical activities because of lack of space and equipment to perform physical activities. We don’t have enough space in our school to provide the area with physical activities and outside playing can take place (participant 8B).” “They also don’t have a playground (participant 9C).” “We don’t have playgrounds for Grade R learners (participant 11C).”

Participants from schools A, B, and C mentioned that Grade R learners did not have space to perform such activities. Three participants indicated that they did not have playgrounds for learners.

It is important that learners were involved in physical activities for their physical development and healthy living. It is a concern that Grade R learners did not have enough space, and playground for physical activities as indicated by participants in all participating schools.

This is not in line with the literature where Malone and Tranter (2003) (cf. 2.5.2.1) indicate the negative effects of not having playgrounds and quality spaces for outdoor activities. Literature also states that insufficient equipment limits children's options, leading to boredom and aggression. It is a concern that learners in their early years of schooling are exposed to such harsh environments.

Participants indicated implementing health education by teaching learners, this is what they said:

The practitioner teaches them about health issues (participant 3A).” Physical education: in class they are taught how to take care of themselves and the environment (participant 4A).” “The programmes are actually part of curriculum, so physical education, washing of hands, brushing of teeth, healthy food, personal hygiene, and all those programmes they is actually incorporated in life-skills programmes and are taught in Grade R class (participant 5B).” “In physical education, we teach them that eating healthy fresh fruits and vegetables is good for healthy bodies. (participant 6B).” “In health education practitioners teaches them during life skills about health, how to take care of them, how to keep their environments clean (participant 7B).” “We have physical education where Grade R Learners are taught about health issues (participant 9C).” Health education and activities: During life-skills period learners are taught how to take care of themselves, healthy eating life-styles (participant 10C).” “We have physical education where learners are taught about healthy living (participant 12C).”In physical education I the practitioner teaches them about healthy living during life skill periods (participant 13D).” “Healthy living in physical education is taught in the class according to the programme of the department of education (participant14D).” “In physical education the practitioners do them as part of teaching (participant 15D).”

Participants mentioned teaching learners about health issues, physical education, healthy living and the environment. All the programmes mentioned were in the curriculum.

It seems as if it is easier for participants to implement and monitor health programmes that are curriculum-based. One of the reasons could be that there is a

clear guide on what to do and a time frame. Practitioners and managers also feel obliged to teach learners as the topics have to be examined.

The teaching of Physical Education, health issues, how to take care of self and environment, washing of hands, brushing of teeth, healthy food, personal hygiene, and healthy living are in line with the CAPS document. According to DoBE CAPS (CAPS, 2012), the above mentioned activities are areas of study in Life Skills for the Grade R class.

In summary, visits by nurses were effectively done. This area was not under the jurisdiction of the managers. The physical education was effectively managed. I think this is because managers were held accountable for the implementation of learning areas in the CAPS document. The management of physical activities was however not so effective.

Responses regarding the effective implementation of the HIV policy were as follows:

The HIV and Aids policy has got committee, committees in the school are there to make sure that policies are implemented (participant 3A).” “We have HIV/AIDS policy learners are taught about HIV/AIDS, so they are effectively implemented (participant 7B).” “We have HIV/AIDS policy, because learners are taught about HIV/AIDS, “Yes, we have HIV/AIDS policy where learners are taught about HIV/AIDS, (participant 9C).” “Yes I think they are effectively implemented because Grade R learners are taught about not to touch people who are bleeding and about HIV/AIDS, which appears in both policies of blood and HIV/AIDS (participant 12C).” “Yes, we have blood policy and HIV/AIDS policy. Yes they are effectively implemented, because we teach learners about HIV/AIDS policy, about health issues (participant 13D).”

Participants indicated that the policy on HIV/AIDS was effectively implemented. They mentioned that learners were taught about HIV/AIDS, health issues and precautionary measures including blood management.

It is good that learners were taught about HIV/AIDS and the topics mentioned are all relevant for Grade R learners.

Teaching about HIV/AIDS is in line with the policy indicating that the purpose of the national HIV/AIDS policy act 27 of 1996 for learners and educators in schools is to develop knowledge, skills, values and attitudes in order that they may adopt and maintain behaviour that will protect them from HIV infections and to support the infected and affected.

In summary, Physical Education was available in participating schools. Managers were monitoring Physical Education although two practitioners were not monitored. In such schools there was no guidance or motivation from the SMT that could ensure commitment of practitioners. There were physical activities in schools and the focus was mainly on fine and gross motor skills which were effectively monitored. There were problems regarding space and facilities that were a barrier to effective implementation of Physical Activities. The SMT failed to provide space and facilities for Physical Activities. Study areas on personal and social well-being content drawn from the CAPS document were not investigated in depth in this study. The only part addressed was on teaching about HIV/AIDS. Information regarding HIV/AIDS was taught to enable learners to take precautionary measures concerning the pandemic.

The next theme is based on the role of SMT pertaining to physical environment.

ROLE OF SMT PERTAINING TO PHYSICAL ENVIRONMENT

Participants mentioned blockages of toilets as one of the challenges in school A. This is how they responded:

“The other problem we are encountering is blockage of toilets. They are always leaking and the school is forever calling plumbers to the school to unblock them but they keep on blocking again (participant 1A). “Now our sewerage system has got a problem because there is a lot of bottlenecking when you go towards the main hole and ultimately we have got in a week, more the one blockage (participant 3A). “The school is an old school, pipes are fixed in the toilets and they burst every now and again which affect the health of grade R learners. When dirty things come out little ones want to play with it (participant 4A).”

Participants indicated that the blockage of toilets in their school was occurring frequently. Participant 3A mentioned more than one blockage in a week. These participants were from the same school. Participants mentioned that they had to call plumbers to unblock toilets.

The smell from blocked toilets is harmful to the lungs and may cause communicable illnesses like lung diseases and diarrhoea. It is an unbearable situation if toilet pipes are always leaking, especially where young learners are involved and can easily catch infections. If the blockage of toilets happens occasionally this could mean the whole system of pipes needs to be changed.

Having toilets that block is not in line with literature where it indicates that clean toilets are an indication of a healthy environment (*cf.* 2.5.2.1).

It was necessary to include a picture that depicts a blocked toilet in school A as evidence of the challenges in the school.

Figure 4.6: Blocked toilet in school A



The toilet in this picture is a health risk to learners. There is also no indication of water to flush the toilet and the toilet seat is broken. This sends an uncaring message to learners who are forced to use this toilet. In her narrative, Participant 2A

indicated that *“The toilets are disgusting, but the young children cannot hold it in for the whole day, they have to use the toilet at some point”*.

This toilet is not far from the Grade R learners’ class in school A (*cf.* 3.3). The flies coming out of the toilet when it is hot can cause health problems for the young ones. It seems that the lack of maintenance is the main cause of this disaster in this school.

A toilet like this is not in line with the stipulation of the Department of Education (2013) (*cf.* 2.5.2.1) that ablution facilities at schools must ensure privacy and promote health and hygiene standards that comply with all relevant laws.

Stagnant water was mentioned as another challenge in schools A and B. This is what the participants said:

“Because of the stagnant water near the Grade R classes the Grade R’s are unable to play and run around as they wish, because there is a lot of water and mud (participant 1A).” “The stagnant water around Grade R classes causes bad smell (participant 2A).” The other challenge is stagnant water which causes unpleasant smell (participant A3).” “The smell from stagnant water is also not good for learner’s health (participant 5A).” “The stagnant water is causing a bad smell which affects learner’s health (participant 7B).”

Participants mentioned that there was stagnant water near Grade R classes. They indicated that the unpleasant smell from the water was affecting learner’s health.

The stagnant water near Grade R classes is a challenge in schools A and B and this makes it difficult for learners to play and run around as they wish. This is dangerous to learners because they may slip, fall and get injured. Stagnant water can be a breeding ground for mosquitos. The stagnant water if not attended can lead to serious health issues for learners.

The problem indicated by participants here is not in line with literature as according to the United Nations Children’s Fund (2009: 5) creating a healthy school environment provides proper hygiene. It seems that the inability of the SMT to attend to matters such as burst and leaking pipes and blocked toilets hinder the progress in ensuring healthy environments at schools.

It was necessary to include a picture that depicts stagnant water in school A as evidence of another challenge in the school.

Figure 4.7: Picture of a stagnant water in school A



This is the picture showing stagnant water. There were papers in the water and the area was filthy and muddy. This picture was taken by a health co-ordinator. In her narrative she wrote *“The picture of stagnant water to show how bad the situation is for Grade R learners in our school.”*

This picture shows how health hazardous the learning environments were for Grade R learners. The unpleasant smell from this area puts learners at risk of diseases. The situation if left unattended might lead to an outbreak of an epidemic.

This situation is not in line with literature as according to Denman, Moon, Parsons and Stears (2002: 37) (*cf.* 2.6.1) the state of buildings, sanitation facilities including clean toilets, and access to clean and fresh drinking water contribute to the health and well-being of learners.

Another challenge highlighted by participants from school C was that of unpaved areas at their school and this is what they said:

Yes we do encounter problems, our school yard does not have paving except for the front part of the admin block, and this makes the school to be dusty and harmful for Grade R learners (participant 9C). “The school has not

pavement so the dust can cause sinus and other lung related diseases (participant 10C).” “Our school is old and does not have paving around Grade R classes; this causes dust that is unhealthy for learners (participant 11C).”

Participants from school C mentioned that their school yard was not paved. Participants in this school were concerned about the unpaved school yard, indicating that they encountered problems because of the unpaved surroundings.

Unpaved school yards seem to be affecting the health of Grade R learners. It also seems that the lack of paving or lawns leads to an environment that is full of dust.

The Minimum Uniform Norms and Standards for public schools (Department of Basic Education, 2013) does not mention anything about paving and lawns. Omission of this important factor could have been overlooked because of financial implications. The concern from the participating schools indicates that this is important to them.

The unpaved school yards led to a more serious challenge, dust. Participants responded as follows regarding dusty environments:

“The school is also dusty (participant 1A).” “Dust is also one of the challenges for learners’ health (participant 3A).” “The school is an old school, the environment for Grade R learners is very dusty (participant 4A).” “And also another challenge is dust, it is very dusty and especially in winter the dust (participant 5B).” “Our school is situated in a dusty place; learners get sick now and then because of dust (participant 6B).” “Our school is an old school, there is lot of dust which makes our learners sick, and they suffer from a lung related sickness caused by dust (participant 7B).” “We have got a big problem with dust. Our school is an old school, so dust hampers the health of learners, so our learners suffer illnesses like TB, Sinusitis, Bronchitis and other illnesses (participant 8B).” “Our school yard does not have paving except for the front part of the admin block, and this makes the school to be dusty and harmful for Grade R learners (participant 9C).” “The school has not pavement so the dust can cause sinus and other lung related diseases (participant 10C).” “Our school is old and does not have paving around Grade R classes; this causes dust that is unhealthy for learners (participant 11C).” “We have a challenge of a dusty environment which is not healthy for Grade R learners

and as a result causes illnesses like flu which affects their lungs (participant 12C).” “Our school is an old school; the environment is dusty and unhealthy for Grade R learners (participant 14D).” “The environments are also dusty which is also not good for Grade R learners (participant 15D).”

Participants of all schools mentioned that there was a problem of dust in their schools. Thirteen participants were complaining that dust was a challenge for Grade R learners. Participants from all four participating schools alluded to the problem of dusty environments. They all face the same challenge, dusty environments.

Participants seemed to be aware of the dangers of dusty environments, even managers were concerned. It is unfortunate that nothing was mentioned about improving these conditions in their schools. Another concern about the situation could be that the dusty area was a play-ground for learners.

Dusty environments affected the health of learners. This is how participants mentioned areas affected.

“Dust is also one of the challenges for learners’ health (participant 3A).” “Our school is situated in a dusty place; learners get sick now and then because of dust (participant 6B).” “Our school is an old school, there is lot of dust which makes our learners sick, and they suffer from a lung related sickness caused by dust (participant 7B).” “We have got a big problem with dust. Our school is an old school, so dust hampers the health of learners, so our learners suffer illnesses like TB, Sinusitis, Bronchitis and other illnesses (participant 8B).” “Our school yard does not have paving except for the front part of the admin block, and this makes the school to be dusty and harmful for Grade R learners (participant 9C).” “The school has not pavement so the dust can cause sinus and other lung related diseases (participant 10C).” “Our school is old and does not have paving around Grade R classes; this causes dust that is unhealthy for learners (participant 11C).” “We have a challenge of a dusty environment which is not healthy for Grade R learners and as a result causes illnesses like flu which affects their lungs (participant 12C).” “Our school is an old school; the environment is dusty and unhealthy for Grade R learners (participant 14D).”

Participants mentioned that dust could cause lung related illnesses such as TB, sinusitis, bronchitis and flu. There was no proof provided for this effect of dust on learners' health. There was also a participant who mentioned that dust hampers the learners' health and those who indicated that dust was unhealthy for learners but did not indicate how.

It is a concern that the environment for learners was in a condition that put their health at risk that could affect them for the rest of their lives.

It was necessary to include a picture that depicting dusty environments in school B as evidence.

Figure 4.8: Dusty environments in school B



Grade R mobile classes in school B were situated in dusty environments. There was no paving or grass that could prevent dust from causing health hazards. The picture was taken by the principal of school B. In his narrative he said: "*The picture of a dusty environment in the area surrounding Grade R classes.*"

This was not a welcoming and motivating environment for learners. The neglect of the physical environment in this school can be attributed to frequent cutbacks in maintenance and renovation (Young, 2008) (*cf.* 2.6.1) due to lack of funds.

A participant mentioned monitoring of a general cleaner in her school:

“Monitoring general cleaner to make sure that the class is cleaned every day. Trees are planted around the school for fresh air and pollution, I check if plants are watered everyday by cleaners (participant 4A).”

Only one participant indicated monitoring of cleaning in her school, this was only based on the classroom and physical environment:

A participant from school A indicated in her narratives, *“Trees are planted around the school to provide oxygen for the school”*. Dirty classrooms can contribute to health hazards. The importance of a healthy physical environment of the school building is discussed in Chapter 2 (*cf.* 2.6.1).

According to UNESCO (2010:4), the cleaning and maintenance of the school surroundings and classrooms help learners to learn best.

In summary, blocked toilets and stagnant water in schools were an indication of failure of the SMT to fulfil their role pertaining to promoting healthy physical environments for learners. Although blocked toilets were not used by Grade R learners as some had toilets in their mobile classes (*cf.* 3.5.1), when they blocked they were a threat to the learners’ health. Unpaved environments contributed to the dusty areas that affected learners’ health. Despite the above challenges SMT fulfilled their role in ensuring cleanliness of classrooms and planting of trees to alleviate pollution.

The fourth theme pertains to the role of the SMT in providing effective leadership

PROVISION OF EFFECTIVE LEADERSHIP

The support from the School Management Team can have a positive impact in the implementation of health programmes.

“The first thing is we support in what we have, we give, we supply to her, what we don’t have (participant 3A).” “Grade R practitioner is supported fully through workshops and there is a head of department assigned to grade R to make sure that the programmes are implemented accordingly and according

to plan (participant 4A).” “HOD will support them with curriculum needs and other issues (participant 5B).” “They support us when we have dental health trip, they encourage us to keep classes’ clean (participant 6B).” “We really give them the support that they need (participant 7B).” “Basically what the SMT is doing is to support and to try and see that they get all the necessary resources and equipment so that this health programmes can be implemented (participant 8B).” “They support us on things that we suggest for implementation of health programmes (participant 9C).” “They develop us where we lack understanding; they also support us when learners are sick by organising transport to the clinic or hospital (participant 10C).” “The support that we give is to monitor and do recommendations, create a healthy environment for healthy living (participant 11C).” “We support them when they lack resources for health issues we try to organise things like first aid kit, we make sure that the environment around Grade R classes is healthy and clean (participant 12C).” “We support them (participant 14D).” The SMT does not support us at all (participant 1A).”

Participants indicated that managers supported Grade R practitioners and health and safety co-ordinators in their efforts to promote health for Grade R learners. Managers from schools A and D indicated that they were supporting Grade R practitioners and health and safety co-ordinators, even though most of the practitioners and health and safety co-ordinators responded differently to what their managers were saying. From the eleven participants indicating that they get support from the managers, only two were Grade R practitioners, one was the health and safety coordinator and nine participants were managers.

From different responses of participants this means that managers support the general health programmes and not health programmes that focus on Grade R specifically.

However, there were participants who indicated that they were not supported by their managers. This is what they said:

”I don’t get any support from SMT since I have been here at school (participant 2A).” “But the Management does not support us where they are

supposed to, we don't get any support from SMT (participant 13D). "I don't get support from SMT (participant 15D)."

Participants who mentioned that there was no support from managers were practitioners and health and safety co-ordinators from two schools, A and D.

If managers do not support, guide, and develop Grade R practitioners and health and safety co-ordinators in their efforts to promote healthy learning environments for Grade R learners, healthy environments will not be realised in these schools.

The lack of support is not in line with literature where it indicates the leadership roles of the SMT including, developing and clarifying policies, providing financial and human resources and providing support and guidance regarding the implementation of health programmes.

In response to the question on, what role SMTs play in promoting healthy learning environments for Grade R Learners the participants revealed the following:

The role that I play as the school principal is I am doing planning, control, monitoring, support and evaluation (participant 3A). "My role is more on the site or resources, (participant 7B)." *"The main role of SMT is to support and to develop areas where we can provide resources and space where health programmes can be implemented effectively (participant 8B)."*

Participants indicated that the role they play is planning, control, monitoring and supplying material for Grade R learners. Participant 8B mentioned that he provided resources and space where health programmes could be implemented effectively.

It is good that managers seemed to be fulfilling their role in promoting health programmes for Grade R learners.

The provision of leadership is in line with the Integrated School Health Policy (2012:22) (*cf.* 2.5.2) indicating that effective monitoring and evaluation depends on active reporting, monitoring and evaluation of the programmes to ensure learners coverage and identify gaps and barriers to implementation.

However, there were participants who responded differently from what participants mentioned above indicated:

“According to me, I don’t see them playing any role in supporting or promoting healthy learning environment because they don’t do anything with Grade R learners (participant 1A).” “I don’t see them playing any role because if they did, the environments for Grade R learners would be healthy, but it is not (participant 2A).” “They do not play any role from my side, because the environment is still not healthy for learners, there are electricity plugs that are not covered, and they don’t come to classes to check health and safety (participant 13D).” “They do not seem interested in Grade R learner’s environments and other learning issues. They make it the burden of Grade R practitioners alone. They don’t play any role regarding Grade R classes; the environment is not healthy at all for learners (participant 15D).”

Participants from school A and D indicated that their managers were not playing any role in promoting healthy environments for Grade R learners. Participant fifteen indicated that their managers were not interested in Grade R classes and this was not fair to practitioners to carry the burden alone. Participant two quoted dangerous areas such as uncovered electricity plugs, which can attract learners to play with, when the practitioner was not aware and the results could be death.

It is a concern that the above participants did not mention a single area where managers fulfil their role. This could mean that participants in these schools were not given guidance or support to implement health programmes. If the task of implementing health programmes is left entirely on the hands of the practitioners and health coordinators. Failure is guaranteed and learners would be deprived of their right to clean environment.

This is not in line with literature which indicates that leaders guide people to achieve the schools’ objectives in the school situation (Mokhobo, 2007: 51) (*cf.* 2.5.2).

There were participants who indicated that monitoring and evaluation of health programmes was not functional in their schools. These participants were referring to health programmes in general. This is what they said:

“I have never seen them monitoring when we take learners out for body exercises; here at our school the Grade R practitioner is all by herself, the SMT does not monitor Grade R learners to see how much they are suffering

in the school (participant1A).” “I never saw them monitoring and evaluating health programmes for Grade R class (participant 2A).” “No one monitors and evaluate on this part (participant 13D).” “The SMT members do not play their part in this school. I have not seen them monitoring and evaluating programmes for Grade R learners (participant 15D).”

Four participants: two Grade R practitioners and two health and safety co-ordinators from two different schools, school A and D indicated that they had never seen their managers monitoring and evaluating health programmes at their schools.

Successful implementation of health learning programmes depends on effective management of health programmes. It is a concern that a Grade R class is not monitored as it is a newly phased-in class as part of the Foundation Phase. Practitioners need all the support they can get from managers to lay a good foundation in preparation for Grade 1.

Monitoring was in line with the policy. According to the Integrated School Health Policy (2012:22) effective monitoring and evaluation depends on active reporting, monitoring and evaluation of the programme to ensure learner coverage and to identify gaps and barriers to implementation. From what the participants said there was no indication of effective monitoring and evaluation.

Managers were supporting the curriculum and the implementation of health programmes, however there was still a gap where managers failed to guide in supporting Grade R practitioners. There were different responses regarding the implementation of health policies

Four participants indicated that policies were implemented in their schools:

In the management I also make sure that rules in policies are followed correctly in order to create a healthy learning environment for the Grade R learners (participant 3D).” “Some are implemented (participant 8B).” “They are implemented (participant 10C).” “Yes they are effectively implemented (participant 11B).”

Participants above mentioned that policies were followed and effectively implemented in order to create healthy learning environments. These participants

were not specific about which policies were followed or implemented. Participant eight said some were implemented; this could mean that not all health policies in his school were effectively implemented.

Not implementing health policies is not in line with literature. According to Scherz (2006: 66), it is important to follow the guidelines of policies to influence the attitudes and behaviour of the staff members and learners.

Participants indicated that they had health policies in their schools but they were not effectively implemented:

“Yes ma’am we do have policies but they are not effective. We used to attend workshops rendered by the district in Vereeniging that helped us improve the school. They even offered materials such as guidelines to be used to improve the quality of healthy environments for learners but they are not used for helping Grade R learners (participant 1A).” “Even if the school have policies, I have not seen any. I don’t see them as effectively implemented (participant A2).” “No policies guiding the implementation of health programmes. Grade R is a new class to the school. Since 2012 some policies are still drafts are still drafts and thus we cannot say the school have standing policies that are implemented. (participant 4B).” “Some are implemented some are not because of the challenges and the lack of resources (participant 8B).” “Even if the school have it, I have not seen any. I don’t see them as effectively implemented because I am still struggling (participant 13D).” “Yes, we have HIV/AIDS policy, blood policy which I don’t think they are effectively implemented (participant 15D).”

Three participants from school A and D indicated that policies were not effectively implemented. Participant one attended workshops to improve the school. Guidelines to be used for healthy environments were offered but the school did not take them into consideration. If the school was not guided by policies, this could mean that there was a problem in promoting healthy learning environments for Grade R learners. Two participants were saying even if their schools had policies.

It is worrying that participant four the Foundation Phase HOD indicated that the school did not have standing policies that were implemented for the Grade R class.

Not having policies could mean that there was nothing guiding practitioners and health coordinators in their efforts in implementing health programmes.

Not having policies is not in line with literature. Policies according to literature provide guidance of how health programmes are to be implemented, and that has to be controlled by managers, to make sure that they are correctly followed (*cf.* 2.5.2.1). This could mean that some participating schools were not complying with any of health policies.

In summary, there were policies that were followed and implemented in one school only. HIV/AIDS policy was available in one school but not effectively implemented. However, there were schools that did not even have policies. The only policy that seemed to be effectively implemented was the policy of nutrition. Probing questions could have revealed specific policies that were implemented and those that were not.

4.5 CONCLUSION

Most of the factors mentioned by participants as contributing to the promotion of healthy learning environments for Grade R learners were also highlighted in the literature. The focus was on the role school managers were playing in programmes that support curriculum, curriculum-based programmes, promoting healthy physical environments, in being effective in their managerial tasks pertaining to health promotion, and effective implementation of health policies.

In this chapter the textual and visual data were presented and discussed. Data presented yielded four main themes which have been discussed. This chapter highlighted the good practices as well as challenges in the role manager's play in promoting healthy environments for Grade R learners.

The next chapter deals with the conclusion, results and recommendations.

CHAPTER 5

SUMMARY OF FINDINGS, RECOMMENDATIONS AND CONCLUSIONS

5.1 INTRODUCTION

In the previous chapter the visual and textual data generated by means of interviews, documents and photographs was analysed and interpreted. Themes that were relevant to the study were developed and presented. All four themes addressed the research objectives. The layout of this chapter is indicated in the figure below:

Figure 5.1: Summary of Chapter 5



5.2 OBJECTIVES REVISITED

The intention for the presentation of this section was to report on whether the objectives were achieved or not.

Table 5.1: How objectives were achieved

OBJECTIVE 2 – PHASE 2		
To determine the role of the SMT in health programmes that supports the	Chapter 4 – This chapter analysed and interpreted	Achieved

curriculum. The objective was dealt with by collecting visual and textual data from SMT members, health coordinators and practitioners from the participating schools.	raw data collected from participants about health programmes that support the curriculum	
OBJECTIVE 3 – PHASE 2		
To determine the role the SMT play in curriculum-based programmes that address health issues. Data collected by means of semi-structured interviews, narratives, documents and photographs emphasized the role played by the SMT. I couldn't get to classrooms to observe the teaching and check books.	Chapter 4 – This chapter also analysed and interpreted raw data regarding roles that SMT in curriculum-based programmes that address health issues	Achieved
OBJECTIVE 4 – PHASE 2		
To investigate the role of the SMT in promoting healthy physical environments. Data was collected through observation when visiting schools during the time of the research. I also relied on photos taken by participants and their narratives. Most photos taken were about physical environments	Chapter 4-This chapter also analysed and interpreted data on the role of SMT in promoting healthy physical environments	Achieved
OBJECTIVE 5-PHASE 2		
To investigate the role of the SMT in providing effective leadership to spearhead health promoting programmes and the implementation of health policies. Data was collected by	Chapter 4- In this chapter the role of the SMT in providing effective leadership to spearhead health	Achieved

means of visual, textual and own observation	promoting programmes was also analysed and interpreted	
OBJECTIVE 6 - PHASE 2		
To come up with recommendations for school managers to enable them to attain a more effective role in the promotion of healthy learning environments	Chapter 5 – In this chapter the recommendations on how school managers can attain a more effective role in promotion of healthy learning environments for Grade R learners in the Sedibeng West District	Achieved

5.3 SUMMARY OF LITERATURE

In this section the literature review chapters which are chapters one and two are summarised. This summary is to understand the intention of the study as a whole. I focused on separating the main intentions of the study as summed up in the problem statement (*cf.* 1.2) and the aim and objectives of this research (*cf.* 1.4).

5.3.1 Summary of Chapter 1

This chapter familiarized the reader with the concept of the management of healthy learning environments for Grade R learners and laid down a foundation of what was to be expected in the rest of the study. The problem statement indicated that in order for learners to develop holistically and continue thriving, healthy learning environments are imperative. It is envisaged that effective management of healthy learning environments will curb vulnerability and consequences thereof.

5.3.2 Summary of Chapter 2

The focus of Chapter 2 was to highlight the essence of the management of healthy learning environments at schools. It was important to understand the concept healthy environments before elaborating on its management. The chapter elaborated on the rationale for healthy learning environments. This section highlighted the importance of healthy learning environments in improving learners' learning and academic performance, brain development, enhance well-being and minimise health risks (*cf.* 2.2). It was necessary to discuss theories of development; it was found that learners in Grade R are in the psychosocial stage according to Erikson and in the pre operational stage according to Piaget. This stage is dominated by imagination; language development and emergence of skills (*cf.* 2.3).

The management of healthy environments includes the approach used, policy development and implementation, focus on curriculum programmes such as health education and physical activity and an intervention programme NSNP (*cf.* 2.5). Physical learning environments are divided into: school environment including the surroundings, buildings and toilets and physical environment of the classroom including ventilation and size of the classroom (*cf.* 2.5). Challenges in the creation and sustenance of healthy environments were found to be non-compliant to policies, lack of monitoring of health programmes, health committees that are not functioning and lack of teamwork among internal and external stakeholders (*cf.* 2.7).

5.4 SUMMARY OF THE EMPIRICAL RESEARCH

This section summarizes Chapter three which focused on the research methodology used in this study and Chapter four based on the analysis and interpretation of data. The methods used in the collection of data, the types of data collected and the findings are presented in this section.

5.4.1 Summary of Chapter 3

A social constructivist research paradigm guided the empirical research in this study. This paradigm is based on the assumptions that reality is socially constructed and that people's perspectives, feelings and beliefs are key.

A qualitative research method (*cf.* 3.3) used was in line with social constructivist paradigm and the phenomenological strategy of enquiry (*cf.* 3.4) complemented the qualitative approach, in that it attempted to understand social phenomena from participants' perspectives.

The sample in this research was made up of (n=15) principals, HODs of the Foundation Phase, health and safety co-ordinators and Grade R practitioners from four participating schools in the Sedibeng West District. Data collection methods used, included semi-structured interviews, narratives, visual data and documents (*cf.* 3.5). The textual and visual data are triangulated in Chapter 4. The open and axial coding was used to generate themes for analysis of data by means of atlas.ti. After identification codes were grouped to form categories or themes, the process also included the use of the inductive method to identify themes in this research. Four themes were a product of the inductive process (*cf.* 3.6).

5.4.2 Summary of Chapter 4

The profile of the participants was presented first, and then the analysis and interpretation followed. Themes were linked to the research questions, thus, it was important to determine which themes answered which research question. Themes and the research questions they answered are indicated in the table below:

Table 5.2: Themes and the research questions

Research question	Theme
What is the essence of healthy learning environments in schools?	This question was addressed in the literature in chapter two
What is the role of the SMT in health programmes that support curriculum?	Theme 1 -Concepts under this them are nutrition, first aid and health
What role does the SMT play in curriculum-based health programmes?	Theme 2 -Concepts under this theme are physical education and HIV/AIDS

What is the role of the SMT in promoting healthy physical environments?	Theme 3- Concepts under this theme are school built environments and the school physical environment
What is the role of SMT in providing effective leadership to spearhead health programmes?	Theme 4- Concepts under this theme are management of curriculum, management of health programmes and implementation of health policies
What recommendations can be made school managers to enable them to play a more effective role in the promotion of healthy learning environments	Addressed in section 5.5 below

5.4.3 Findings from the literature

Data from the empirical research indicated the following regarding research question one:

What is the role of the SMT in health programmes that support the curriculum?

Participants indicated different roles regarding programmes that are supporting the curriculum (*cf* 4.3)

- Nutrition is effectively managed. There was availability of different menus on a daily basis. Food handlers prepared and kept the kitchen clean. Appropriate storage for food was available. Grade R is part of the nutrition programme in the participating schools
- First-aid not as effectively managed as nutrition. In two schools it was effectively managed, although the checking of the contents was not on a weekly basis at least there was checking of contents while in the third school

first aid kit were not checked at all and used items were not replenishing. The fourth school did not have a first-aid kit

- Health programme is running smoothly especially in school-based centers where they are having services on a daily basis. In schools that are visited by nurses annually, general hygiene hearing and eyesight are checked. The health services are not under the jurisdiction of the SMT therefore they are not managed at school level.

5.4.4 Findings from the empirical research

What role does the SMT play in curriculum-based health programmes?

Participants had different perspectives regarding the role of SMT in curriculum-based programmes

- Physical Education was effectively implemented as one of the areas of curriculum in the CAPS document which practitioner were compelled to adhere to the guidelines and thus the effective monitoring of the programme. However there were managers who were not monitoring this programme. It was difficult for learners to perform some of the physical activities because schools lacked space and facilities while some were effectively implemented. Physical Education was taught in classes. Learners gained knowledge.
- Personal and social well-being was not thoroughly investigated in this research. Important data could have been revealed if this programme was not neglected Learners were taught about HIV/AIDS. This means they were aware of the dangers they could face if they did not take precautionary measures.

What is the role of the SMT in promoting healthy physical environments?

Participants responded differently regarding the role of the SMT in a healthy physical environment supporting their responses with photos

- There were blocked toilets and leakage of pipes that resulted in stagnant water. Due to stagnant water the place was muddy and slippery and learners could fall and get hurt. The smell also affected the health of learners. The environments that were not paved. Areas where Grade R classes are dusty and affected learner's lungs However the SMT succeeded in their role by planting trees around Grade R classes.
- The SMT attained their role effectively regarding learners 'classrooms which were cleaned by general cleaners on daily a basis.

What is the role of the SMT in providing effective leadership to spearhead health programmes?

Participants mentioned different roles played by the SMT in providing effective leadership to spearhead health programmes and to the effective implementation of health policies.

- Class visits by managers was an indication of providing leadership to practitioners through checking of learners' books and practitioners' files, which they compelled to do, they submitted a report of their findings and strategies of intervention and the support given in their report. Implementation of health programmes were also supported by managers. However there were managers who did not succeed in providing effective leadership to spearhead health programmes to practitioners. Grade R classes were not monitored.

The finding regarding effective implementation of policies indicated that:

- Some of the policies were effectively implemented. A nutrition programme is one of the programmes that show an indication of effective implementation of the policy. However policies such as HIV/AIDS on the part if first aid, integrated school health policy and some aspects of CAPS document was not effectively implemented.

5.5 RECOMMENDATIONS

5.5.1 Recommendations for practical implementation of findings

In this section recommendations addressing the following research question are given.

Recommendations with regards to the objective two

To determine the role of the SMT in health programmes that support curriculum

The nutrition programme was monitored at district and provincial level, this monitoring contributed to better management of this programme. The health services were provided and managed by health institutions in the communities and in School-Based Health Centres. However, the blood management as means of precautionary measures by making available first-aid kits was problematic firstly, regarding the checking of the contents and secondly, not having first-aids kits and thirdly, the lack of training on first-aid. The policy does not say who is responsible for the training of educators and learners but just mandates training.

Managers in schools that are visited by nurses from clinics and those having School Based Health Centres can take advantage of the health experts in their communities and arrange for the training of the educators and learners. Red Cross and St John Ambulance are Non Governmental Organisations can provide first-aid training to teachers and learners for free.

This training would be intended to equip the trainees with basic skills. These skills could include treatment of minor wounds and burns, knowing to use an adhesive bandage or applying direct pressure on an area that is bleeding and or fracture. Training can also be provided for choking; determining adequacy of breathing and providing rescue breathing. These para- professionals would assist the educator who has undergone proper training.

There must be an educator in each school who has done a proper training in an accredited first-aid course and has received a certificate for that. It would be imperative for this educator to do regular refresher courses to maintain skills and update clinical knowledge, as there are regular changes in procedures regarding first aid.

Recommendations with regard to objective three

To determine the role the SMT play in curriculum-based programmes

The Physical Education programme was monitored and controlled in schools. Managers had to comply with the monitoring and controlling of this programme by checking learners' books and educators' files. This could have been done because learners' books are checked by district officials when visiting schools. However, monitoring and control of physical activities was neglected yet it is also curriculum-based. The focus on theory whilst neglecting the practice which could benefit learners is problematic.

There is a need for training managers and practitioners to gain knowledge regarding the importance of physical activities which develop fine motor skills, gross motor skills using exercises that promote Locomotors, Non-locomotors, Perceptual motor, Rhythm, Co-ordination, Balance, Spatial orientation, Laterality sports and games. From the responses of the participants it can be deduced that knowledge of activities in the mentioned categories is limited.

Training can be provided by Extra School Support Programme (ESSP) assistants who are assigned by the department of education to coach sports activities at schools. The Department of Basic Education launched a programme to assist underperforming schools with homework and sporting activities. Young adults who are unemployed but have matric, residing in the vicinity of underperforming schools are provided with accredited Levels 1-3 training on homework supervision, sport specific training on coaching and umpiring, arts and culture such as music, dances and creative arts

Although the ESSP assistants are para-professionals regarding sporting activities, their training can include activities suitable for Grade R. The ESSP assistants with Level 3 in sports can be made responsible for the Physical Activities in the Foundation Phase including Grade R. These assistants are still young and energetic and some Grade R practitioners are over the age of forty which makes it difficult for

them to do all the physical activities indicated in the CAPS document. The ESSP assistants can also assess the performance of learners in Physical Activities.

In each school district there is a unit for support services which includes sports. The district officials for sport can be responsible for monitoring and evaluation of the ESSP assistants.

Recommendations with regard to objective four

To investigate the role of the SMT in promoting healthy physical environments

This programme entails the classroom environment and the outside environment. The classroom environment was taken care of by general cleaners; managers in charge of monitoring the cleaning of classroom fulfilled their role effectively. The outside environment is the area that needs more attention of the SMTs. All participating schools had problems regarding the physical environment of Grade R learners. They were not paved, dusty, and muddy and had leaking pipes and stagnant water. Monitoring and evaluation by external stakeholders will help in giving direction to effective management.

Grade R funding allocated for maintenance and services by the norms and standards for funding Grade R sites can be utilized to improve the condition of physical environment. The funds allocated for Grade R class is prioritised for this purpose and thus it is recommended that the school finance committee include the Grade R practitioner in their committee as the relevant person who knows the needs for Grade R class. Management of Grade R finances can be monitored by SGB, SMT and district officials.

Recommendations with regard to objective five

To investigate the role of the SMT in providing effective leadership to spearhead health programmes

Managers were providing effective leadership to spearhead health programmes by visiting classes to check learners' books and practitioners' files, while some

managers did not show any effectiveness in monitoring Grade R classes. The implementation of health policies were at different levels at schools. Managers who were using policies and guidelines for health programmes were more effective, as compared to those who ignored such policies. An interesting finding in this research is that policies that were easier for schools to implement were those that are associated with specific criteria such as the Nutrition Policy according to the CAPS document.

It is imperative for school managers to develop organizational capacity that will assist the schools. The local nurses, doctors, dieticians and Non-Governmental Organisations can be requested to offer their services on a voluntary basis. These professionals can assist SMT members in training on the contents of each health policy. They can also assist in implementing, monitoring and evaluation of parts of the policy where the SMT feels inadequate

5.5.2 Recommendations for further research

Based on the gaps that this research revealed, a follow up of this research can be carried out on:

- In-depth investigation regarding aspects of personal and social well-being of learners.
- More research needs to be conducted on the links between School-Based Health and Education.
- Healthy schools award schemes are recommended for the development and monitoring of the implementation of health promoting schools.

5.6 CONCLUSION

This chapter investigated the role of the SMT in promoting healthy learning environments for Grade R learners. The research was conducted by means of a literature review which highlighted important factors regarding management of health programmes and the empirical research. The study highlighted important findings of which recommendations were made.

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LETTER OF
REQUEST TO
CONDUCT
RESEARCH

For Official Use

Ref. No.

GAUTENG DEPARTMENT OF EDUCATION



RESEARCH REQUEST FORM

REQUEST TO CONDUCT RESEARCH IN INSTITUTIONS AND/OR OFFICES OF THE GAUTENG DEPARTMENT OF EDUCATION

1. PARTICULARS OF THE RESEARCHER

1.1	Details of the Researcher	
Surname and Initials:	KOLOKOTO MG	
First Name/s:	Mamotsekua Gladys	
Title (Prof / Dr / Mr / Mrs / Ms):	MRS	
Student Number (if relevant):	12959545	
ID Number:	6601180525080	
Gender (Male/Female):	FEMALE	

1.2	Private Contact Details	
Home Address	Postal Address (if different)	
35 Alexander Str		
Duncanville		
Vereeniging		
Postal Code:1939	Postal Code:	
Tel: (016) 986 1517		
Cell: 0833461199		
Fax: (016)986 1517		
E-mail:		

2. PURPOSE & DETAILS OF THE PROPOSED RESEARCH

2.1	Purpose of the Research (Place cross where appropriate)	
	<i>Undergraduate Study - Self</i>	
	<i>Postgraduate Study - Self</i>	X
	<i>Post-Doctoral Study</i>	
	<i>Private Company/Agency – Commissioned by Provincial and/or National Government Department/s</i>	
	<i>Private Research by Independent Researcher</i>	
	<i>Non-Governmental Organisation</i>	
	<i>National Department of Education Commissioned Study</i>	
	<i>Commissions and Committees</i>	
	<i>Independent Research Agency</i>	
	<i>Statutory Research Agency</i>	
	<i>Independent Study by Higher Education Institution</i>	

2.2	If Post-Graduate Study – Please indicate by placing a “X” in the appropriate column		
	<i>Honours</i>	<i>Masters</i>	<i>Doctorate</i>
		X	

2.3	Full title of Thesis / Dissertation / Research Project
	THE ROLE OF SCHOOL MANAGEMENT IN PROMOTING HEALTHY LEARNING ENVIRONMENTS FOR GRADE R LEARNERS

2.4	Value of the Research to Education (Attach Research Proposal)

2.5	Student and Postgraduate Enrolment Particulars (if applicable)
Name of institution where enrolled:	University of North West
Degree / Qualification:	M.ED
Faculty:	MANAGEMENT
Department:	EDUCATION SCIENCES
Name of Supervisor / Promoter:	DR. SJ KWATUBANA

2.6	Employer (where applicable)
Name of Organisation/School:	Mqiniswa Primary School
Position in Organisation:	Educator
Head of Organisation:	Mr PV Malepeng
Street Address:	777 Xuma Street
	Vanderbjilpark
Postal Code:	1940
Telephone Number (Code + Ext):	016 986 1517
Fax Number:	
E-mail:	

2.7	PERSAL Number (where applicable)
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1	6	0	1	6	3	6	0
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3. PROPOSED RESEARCH METHOD/S

(Please indicate by placing a cross in the appropriate block whether the following modes would be adopted)

3.1 Questionnaire/s (If Yes, supply copies of each to be used)

YES		NO	√
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3.2 Interview/s (If Yes, provide copies of each schedule)

YES	√	NO	
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3.3 Use of official documents

YES		NO	√
<i>If Yes, please specify the document/s:</i>			

3.4 Workshop/s / Group Discussions. (If Yes, Supply details)

YES		NO	√

3.5 Standardised Tests (e.g. Psychometric Tests)

YES		NO	√
<i>If Yes, please specify the test/s to be used and provide a copy/ies</i>			

4. RESEARCH PROCESSES

4.1 *Types of Institutions.* (Please indicate by placing a cross alongside all types of institutions to be researched).

INSTITUTIONS	Mark with "X" here
<i>Primary Schools</i>	X
<i>Secondary Schools</i>	
<i>Technical Schools</i>	
<i>ABET Centres</i>	
<i>ECD Sites</i>	
<i>LSEN Schools</i>	
<i>Further Education & Training Institutions</i>	
<i>Other: Community based side</i>	

4.2 *Number of institution/s involved in the study.* (Kindly place a sum and the total in the spaces provided).

Type of Institution	Total
<i>Primary Schools</i>	8
<i>Secondary Schools</i>	
<i>Technical Schools</i>	
<i>ABET Centres</i>	
<i>ECD Sites</i>	
<i>LSEN Schools</i>	
<i>Further Education & Training Institutions</i>	
<i>Other: Community based side</i>	
GRAND TOTAL	

- 4.3 *Name/s of institutions to be researched. (Please complete on a separate sheet and append if space is deemed insufficient).*

Name/s of Institution/s
<i>SEE ATTACHED FORM</i>
<i>Mqiniswa primary school</i>
<i>Bophelong primary school</i>
<i>Seiso primary school</i>
<i>Ikokobetseng primary school</i>
<i>Dr Nhlapo primary school</i>
<i>Makapane primary school</i>
<i>Tshirela primary school</i>
<i>Iphahlolleng primary school</i>

- 4.4 *District/s where the study is to be conducted. (Please mark with an "X").*

District	
<i>Johannesburg East</i>	
<i>Johannesburg South</i>	
<i>Johannesburg West</i>	
<i>Johannesburg North</i>	
<i>Gauteng North</i>	
<i>Gauteng West</i>	
<i>Tshwane North</i>	
<i>Tshwane South</i>	
<i>Ekhuruleni East</i>	

District	
<i>Ekhuruleni West</i>	
<i>Sedibeng East</i>	
<i>Sedibeng West</i>	X

If Head Office/s (Please indicate Directorate/s)

NOTE:

If you have not as yet identified your sample/s, a list of the names and addresses of all the institutions and districts under the jurisdiction of the GDE is available from the department at a small fee.

4.5 *Number of learners to be involved per school. (Please indicate the number by gender).*

Grade	1		2		3		4		5		6	
<i>Gender</i>	B	G	B	G	B	G	B	G	B	G	B	G
<i>Number</i>												

Grade	7		8		9		10		11		12	
<i>Gender</i>	B	G	B	G	B	G	B	G	B	G	B	G
<i>Number</i>												

4.6 *Number of educators/officials involved in the study. (Please indicate the number in the relevant column).*

<i>Type of staff</i>	Educators / Practitioner	HODs	Deputy Principals	Principal	Lecturers	Office Based Officials
<i>Number</i>	10	6		4		

4.7 *Are the participants to be involved in groups or individually? Please mark with an "X".*

Participation	
<i>Groups</i>	
<i>Individually</i>	x

4.8 *Average period of time each participant will be involved in the test or any other research activity (Please indicate time in minutes)*

Participant/s	Activity	Time
20	interviews	1 hour

4.9 *Time of day that you propose to conduct your research. Please mark with an "X".*

School Hours	During Break	After School Hours
		x

4.10 *School term/s during which the research would be undertaken. Please mark with an "X".*

First Term	Second Term	Third Term
	x	

DECLARATION BY THE RESEARCHER

- 1. I declare that all statements made by myself in this application are true and accurate.***
- 2. I have read and fully understand all the conditions associated with the granting of approval to conduct research within the GDE, as outlined in the GDE Research Briefing Document, and undertake to abide by them.***
- 3. Should I fail to adhere to any of the approval conditions set out by the GDE, I would be in breach of the agreement reached with the organisation, and all privileges associated with the granting of approval to conduct research, would fall away.***

Signature:

Date:

DECLARATION BY SUPERVISOR / PROMOTER / LECTURER

I declare that: -

- 1. The applicant is enrolled at the institution / employed by the organisation to which the undersigned is attached.**
- 2. The overall research processes meet the criteria of:**
 - **Educational Accountability**
 - **Proper Research Design**
 - **Sensitivity towards Participants**
 - **Correct Content and Terminology**
 - **Acceptable Grammar**
 - **Absence of Non-essential / Superfluous items**

Surname:	KWATUBANA
First Name/s:	SIPHOKAZI JOANNA
Institution / Organisation:	NWU (VAAL CAMPUS)
Faculty:	EDUCATION
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Signature:	
Date:	16/11/2012

N.B. This form (and all other relevant documentation where available) may be completed and forwarded electronically to Ebrahim Farista (ebrahimf@gpg.gov.za) or Nomvula Ubisi (nomvulau@gpg.gov.za). The last 2 pages of this document must however contain the original signatures of both the researcher and his/her supervisor or promoter. These pages may therefore be faxed or hand delivered. Please mark fax - For Attention: Ebrahim Farista at 011 355 0512 (fax) or hand deliver (in closed envelope) to Ebrahim Farista (Room 911) or Nomvula Ubisi (Room 910), 111 Commissioner Street, Johannesburg.

APPROVAL
FROM THE
DEPARTMENT
OF
EDUCATION

APPROVAL
FROM THE
DEPARTMENT
OF
EDUCATION



education

Department: Education
GAUTENG PROVINCE

For administrative use:
Reference no. D2013/122

GDE RESEARCH APPROVAL LETTER

Date:	10 July 2012
Validity of Research Approval:	10 July 2012 to 30 September 2012
Name of Researcher:	Kolokoto M.G.
Address of Researcher:	35 Alexander Street
	Duncanville
	Vereeniging
	1939
Telephone Number:	016 421 1140 / 083 346 1199
Email address:	sipho.kwatubaba@nwu.ac.za (Supervisor)
Research Topic:	The role of school management teams in promoting healthy environments for Grade R learners
Number and type of schools:	EIGHT Primary Schools and FIVE ECD Sites
District/s/HO	Sedibeng East and Sedibeng West

Re: Approval in Respect of Request to Conduct Research

This letter serves to indicate that approval is hereby granted to the above-mentioned researcher to proceed with research in respect of the study indicated above. The onus rests with the researcher to negotiate appropriate and relevant time schedules with the school/s and/or offices involved to conduct the research. A separate copy of this letter must be presented to both the School (both Principal and SGB) and the District/Head Office Senior Manager confirming that permission has been granted for the research to be conducted.

The following conditions apply to GDE research. The researcher may proceed with the above study subject to the conditions listed below being met. Approval may be withdrawn should any of the conditions listed below be flouted:

1. The District/Head Office Senior Manager/s concerned must be presented with a copy of this letter that would indicate that the said researcher/s has/have been granted permission from the Gauteng Department of Education to conduct the research study.
2. The District/Head Office Senior Manager/s must be approached separately, and in writing, for permission to involve District/Head Office Officials in the project.

Making education a societal priority

Office of the Director: Knowledge Management and Research

9th Floor, 111 Commissioner Street, Johannesburg, 2001
P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506
Email: David.Makhado@gauteng.gov.za
Website: www.education.gpg.gov.za

David Makhado

3. A copy of this letter must be forwarded to the school principal and the chairperson of the School Governing Body (SGB) that would indicate that the researcher/s have been granted permission from the Gauteng Department of Education to conduct the research study.
4. A letter / document that outlines the purpose of the research and the anticipated outcomes of such research must be made available to the principals, SGBs and District/Head Office Senior Managers of the schools and districts/offices concerned, respectively.
5. The Researcher will make every effort obtain the goodwill and co-operation of all the GDE officials, principals, and chairpersons of the SGBs, teachers and learners involved. Persons who offer their co-operation will not receive additional remuneration from the Department while those that opt not to participate will not be penalised in any way.
6. Research may only be conducted after school hours so that the normal school programme is not interrupted. The Principal (if at a school) and/or Director (if at a district/head office) must be consulted about an appropriate time when the researcher/s may carry out their research at the sites that they manage.
7. Research may only commence from the second week of February and must be concluded before the beginning of the last quarter of the academic year.
8. Items 6 and 7 will not apply to any research effort being undertaken on behalf of the GDE. Such research will have been commissioned and be paid for by the Gauteng Department of Education.
9. It is the researcher's responsibility to obtain written parental consent of all learners that are expected to participate in the study.
10. The researcher is responsible for supplying and utilising his/her own research resources, such as stationery, photocopies, transport, faxes and telephones and should not depend on the goodwill of the institutions and/or the offices visited for supplying such resources.
11. The names of the GDE officials, schools, principals, parents, teachers and learners that participate in the study may not appear in the research report without the written consent of each of these individuals and/or organisations.
12. On completion of the study the researcher must supply the Director: Knowledge Management & Research with one Hard Cover bound and an electronic copy of the research.
13. The researcher may be expected to provide short presentations on the purpose, findings and recommendations of his/her research to both GDE officials and the schools concerned.
14. Should the researcher have been involved with research at a school and/or a district/head office level, the Director concerned must also be supplied with a brief summary of the purpose, findings and recommendations of the research study.

The Gauteng Department of Education wishes you well in this important undertaking and looks forward to examining the findings of your research study.

Kind regards



Dr David Makhado

Director: Knowledge Management and Research

2012 / 07 / 11

Making education a societal priority

Office of the Director: Knowledge Management and Research

9th Floor, 111 Commissioner Street, Johannesburg, 2001

P.O. Box 7710, Johannesburg, 2000 Tel: (011) 355 0506

Email: David.Makhado@gauteng.gov.za

Website: www.education.gpg.gov.za

REQUEST TO
SCHOOL
PRINCIPALS

35 Alexander Str
Duncanville
Vereeniging
1939
24 April 2013

REQUEST TO CONDUCT A RESEARCH

Dear Sir/Madam,

This is to seek permission to conduct research in your school. I am exploring THE ROLE OF SCHOOL MANAGEMENT IN PROMOTING HEALTHY LEARNING ENVIRONMENTS FOR GRADE R LEARNERS. The research is a qualitative study and will require participants to respond to a number of interview questions which will be followed by taking of pictures of the following areas: classrooms, playgrounds and toilets for Grade R learners.

The participants to this study will include the Grade R practitioners, principals of schools with Grade R classes, HODs for Foundation phase and health coordinators. Participants will be required to be honest and sincere in their responses. All information provided will be treated with the confidentiality, the name of the school and the participants will not be mentioned in the research report.

Thank you

Yours Faithfully,

Mrs MG Kolokoto

CONSENT

FORMS

Interview consent form: research participants

The study has been clearly explained to me by the researcher, Me MG Kolokoto and I have had a chance to ask questions and have them answered to my satisfaction. I have freely chosen to take part in this study. I am aware that I can change my mind about participating in this study at anytime and stop the interview without any penalty. I have been informed that agreeing to take part in this study will not be of any personal benefit to me. I have also been informed that my answers to questions will remain confidential and that this consent form will not be linked to the answers I give. I have been given contact numbers that I may call if I have any questions or concerns about the research.

Participant's Full Name

Consent for audio taping and visual data capturing

I have been asked for my permission to allow the interview to be tape-recorded so that the researcher has a record of the information that I provide during the interview. I have had the procedures involved in the tape recording explained to me, including how the confidentiality of the information that I provide will be protected, and I am satisfied with the explanation. I have been told that I can ask for parts of the tape to be edited or ask for the recording to be stopped at any time if I feel uncomfortable about what I say being recorded. I therefore agree to give the researcher permission to tape record what I will be saying during the interview session.

I have also agreed to capture factors that indicate success and or failure of the SMT in playing their role in the promotion of healthy environments for Grade R learners. I am aware that I will use a disposable camera to capture the visual data. I agree to write a short narrative to expand upon the photographs I will have taken.

Participant's Full Name

Participant's signature

INTERVIEW

SCHEDULE

INTERVIEW SCHEDULE

SMT MEMBERS (INCLUDING THE PRINCIPAL)

1. Which health programs are applicable for Grade R learners in your school?
2. What role do you play as an SMT member in promoting healthy learning environments for Grade R Learners?
3. Do you encounter challenges in promoting healthy learning environments for Grade R learners? If yes what are they?
4. Are you part of planning to promote a healthy learning environment for Grade R learners in this school? If so what role/s do you play? If not why?
5. How are the health programs for Grade R in your school implemented? Who is responsible for their implementation? Who is responsible for monitoring and evaluation?
6. Do you have policies that guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?
7. Does the SMT monitor and evaluate health programmes for Grade R at your school? If so elaborate on how they monitor and evaluate the programmes?
8. From which health programmes do you think Grade R learners benefit most? Why?
9. Which programmes can be added at your school to enhance the promotion of healthy learning environments in your school?
10. Do you think the SMT plays its role effectively in this regard?

INTERVIEW SCHEDULE

GRADE R PRACTITIONERS

1. Which health programs are applicable for Grade R learners in your school?
2. What role is the SMT playing in promoting healthy learning environments for Grade R learners?
3. Do you encounter problems concerning the promotion of healthy learning environments for Grade R learners? If yes what are they?
4. Are you part of planning to promote healthy learning environments for Grade R learners in your school? If so what roles do you play? If not, why?
5. How are the health programs for Grade R in your school implemented? Who is responsible for their implementation? Who is responsible for monitoring and evaluation of health programmes in your school?
6. Do you have policies that guide the implementation of health programmes for Grade R learners at your school? If yes, do you think they are effectively implemented?
7. Does the SMT monitor and evaluate health programmes for Grade R at your school? If so, how do they play this role?
8. From which health programmes do Grade R learners benefit most? Why?
9. Which programmes do you think can be added to enhance the promotion of healthy learning environments at your school?
10. What support do you get from the SMT to ensure effective implementation of health programmes?

TRANSCRIPTS

INTERVIEWS FOR 4 PRIMARY SCHOOLS IN THE SEDIBENG WEST WHICH WERE CODED AS SCHOOLS A,B,C AND D.

SCHOOL A

PARTICIPANT 1: HEALTH AND SAFETY COORDINATOR

PARTICIPANT 2: GRADE R PRACTITIONER

PARTICIPANT 3: THE PRINCIPAL

PARTICIPANT 4: FONDATION PHASE HOD

Prior to the beginning of the interviews I promised participants that I am not taking the information they are giving me anywhere, I am just gathering data for my research study. They must feel free to answer questions. I am not going to mention their names or names of schools.

1. Which health programs are applicable for Grade R learners in your school?

Participant 1: The programmes that are here at my school is only the feeding scheme that is the only programme that I know. Grade R learners receive food every day, menu change day by day according to the department of nutrition programme. They receive a fruit once a week. The foods they get are in good standard, such as food that contains proteins, vitamins and carbohydrates.

2. What role is SMT playing in promoting healthy learning environments for Grade R Learners?

Participant 1: According to me, I don't see them playing any role in supporting or promoting healthy learning environments because they don't do anything with Grade R learners, and grade R learners have a lot of needs such as their own playground, playing resources as they learn through play. Since they are still small and need a lot of attention, they need things like puzzles; building blocks, sand pit, but in our school Grade R learners, they don't have such resources. So the SMT do not consider Grade R needs at all up there.

3. Do you encounter challenges concerning learning environments for Grade R learners? If yes what are they?

Participant 1: Yes ma'am, we encounter problems in our school because grade R learners do not have enough security, because as you know, they are not supposed to mix with other learners in the school. The Grade R section does not have proper fencing that prevents the rest of higher Grade learners' access to them. Even the playground is not big enough for them to play on, during break nor does it have playing facilities such as marry go rounds. Our taps are also not satisfactory because they are old. They are leaking and are too high for our shorter learners to use. The other problem we are encountering is blockage of toilets. They are always leaking and the school is forever calling plumbers to the school to unblock them but they keep on blocking again. Because of the stagnant water near the Grade R classes the Grade R's are unable to play and run around as they wish, because there is a lot of water and mud. The SMT do not consider that problem as health hazard. As the co-ordinator of health and safety I once advised them to call a professional somebody to unblock pipesbut they keep on calling local community members who do not solve the problem of leakage and blockage because that problem is still there and it is not healthy for Grade R learners.

4. Are you part of planning to promote a healthy learning environment for Grade R learner? If so what roles do you play? If not why?

Participant 1: No ma'am I don't take part in planning to promote a healthy learning environment within the school, the SMT never includes me nor does it take my invitation to showing initiative seriously. I've requested several meetings which weren't a success.

5. How are the health programs for Grade R learners in your school implemented? Who implements them? Who is responsible for monitoring and evaluation?

Participant 1: We have nutrition programmes in our school. The school hired cooks to prepare meals for learners. Different menus are prepared every day and they also get a fruit once a week which I think is healthy for Grade R learners. They also use clean utensils for eating.

Physical education is also available within the classrooms through subjects like life skills. We mainly do indoor exercises because of the lack of play ground. Grade R Practitioners are responsible for the Grade R's health education. The SMT is responsible for monitoring and evaluating the Grade R programme but I have not seen them doing so since the beginning of

the classes. There is no progress at all. The SMT does not offer help to the Grade R Practitioners.

6. Do you have policies that guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 1: Yes ma'am we do have policies but they are not effective. We used to attend workshops rendered by the district in Vereeniging that helped us improve the school. They even offered materials such as guidelines to be used to improve the quality of healthy environments for learners but they are not used for helping Grade R learners.

7. Does the SMT monitor and evaluate health programmes for Grade R at your school and how do they do it?

Participant 1: The SMT does not monitor Grade R classes and Grade R learners to see how much they are suffering in the school.

8. From which programmes do Grade R learners benefit most? Why?

Participant 1: Nutrition because they eat every day.

9. Are there programmes that Grade R learners are not benefiting from? Why?

Participant 1: Physical activities because of the lack of space and facilities.

Unhealthy environments: Because of blocked toilets, stagnant water learners may get sick. Dilapidated building may also fall over learners while playing because they do not have a better place to play and their class is not fenced to protect them.

10. Which programmes do you think can be added that will best benefit the Grade R learners?

Participant 1: First of all if the school can organise the first aid kit for Grade R learners.

Physical activities: For physical and mental wellness, learners need more space and resources. Play equipments should be organised.

11. What support do you get from the SMT to ensure effective implementation of health programmes?

Participant 1: The SMT does not support us at all. As a co-ordinator of health and safety I even see my committee not functional because there is no progress in the school concerning the health of Grade R learners. We are not involved in SMT meetings to make inputs or maybe give feedback of health workshops we attend.

1. Which health programs are applicable for Grade R in your school?

Participant 2: Feeding scheme is the only one that I know.

2. What role is SMT playing in promoting healthy learning environments?

Participant 2: I don't see them playing any role because if they did, the environments for Grade R learners would be healthy, but it is not.

3. Do you encounter challenges concerning learning environments for Grade R learners? If yes what are they?

Participant 2: Yes I do have a problem regarding that because first of all we do not have a First Aid kit for learners in case they get injured.

4. Are you part of planning to promote a healthy learning environment for Grade R learner? If so what role do you play? If not why?

Participant 2: I am not part of planning and I don't play any role because the SMT does not involve me in any of their Grade R planning if they do plan, because it seems as if there is nothing planned to promote a healthy learning environments for Grade R learners.

5. How are the health programmes for Grade R in your school implemented? Who implements them? Who is responsible for monitoring and evaluation?

Participant 2: In nutrition programme learners get food at eleven o'clock, the co-ordinator of nutrition program and the principal are responsible for monitoring and evaluation

6. Do you have policies that guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 2: Even if the school have it, I have not seen any. I don't see them as effectively implemented because I am still struggling, learners are suppose to have see-saw to swing, where they climb to develop their muscles, there must be a sand pit to

relieve stress. They don't exercise with jumping or sliding resources. No puzzles or bids, no building blocks for small muscles.

7. Does the SMT monitor and evaluate health programmes for Grade R at your school and how do they do it?

Participant 2: I never saw them monitoring and evaluating health programmes for Grade R class.

8. From which programmes do Grade R learners benefit most? Why?

Participant 2: I only see them benefiting from nutrition and health education done in class during life skills periods.

9. Are there programmes that Grade R learners are not benefiting from? Why?

Participant 2: Yes they are many. We don't have inside and outside equipment for physical activities.

The environment is not healthy for Grade R learners, toilets are sometimes blocked, and stagnant water has an unpleasant smell for learners, the class is not fenced, no grass outside the class.

10. Which programmes do you think can be added that will best benefit the Grade R learners?

Participant 2: Physical activities to develop learners mentally and physically, healthy environments to protect Grade R learners from getting ill, First Aid Kit be organised for Grade R learners, fenced environment for Grade R learners.

11. What support do you get from the SMT to ensure effective implementation of health programmes?

Participant 2: I don't get any support from SMT since I have been here at school. Even if I approach the SMT to discuss my challenges they don't react. I am the only one who go to them for assistance of which I don't get. They don't come to ask if I am coping or not. I thought they will give Grade R learner's first preference as it only started this year. But they just don't care about the Grade R class.

1. Which health programmes are applicable to grade R learners in your school?

Participant 3: I have four programmes that I have in our school for grade R programmes. The first one is nutrition, we've got physical education, we've got physical

activities, and we've got also partnership with the department of health. Now if I may talk about nutrition, what is happening here, it is the food that we give to learners for healthy living? Now these learners have got a menu for everyday from Monday to Friday. If I must tell you, on Mondays our learners, during lunch time, get rice, tinned fish plus butternut as vegetables. On Tuesday they get samp and sugar beans. On Wednesdays, we give that split peas and porridge, cabbage, and butternut. On Fridays, we give them again samp and sugar beans. And I must tell you, once a week we give them a fruit, it can be an orange, an apple, pear, but definitely they get the fruit. In physical education, I am referring to life skills, here I am talking about what they do, what the teacher or practitioner teaches them. In life skills they do healthy living, they do social development; they do personal development and the do physical development and movement. Now, by healthy living I mean that the practitioner teaches them about the food they eat. The practitioner teaches them about health issues like; we must be able to wash our hands before we eat, we wash our hands when we come from maybe the toilet, and how we wash our hands and many others. In healthy living the practitioner is teaching them about the environmental health issues, teaching them about communicable diseases, like for instance, HIV and Aids, TB, you know, things like you must not spit out everywhere because our school has a lot of dust, you don't have to spit everywhere, that dust can come back to other learners. And also abuse. In social development our learners are also taught about nation, about abuse, about their dignity as learners and the important stages of our lives. In personal development, they are taught how to feel good about themselves, how to be compassionate, self management and an early stage about problem solving skills. And lastly, they are taught physical development and movement. In the class, learners do those jumping and some kind of movements. In the class, and sometimes the practitioner takes them outside and they do some playing. They can play maybe soccer, or something, but they do movements and these movements help them with their healthy development. And the other one is physical activities. What physical activity is, they engage in physical activity, the practical part of what is being done in class. They go outside with the practitioner, start playing and do all those movements, maybe throwing the ball to one another, doing the games where they chase one another; you know all those rhythms and movements that is for healthy development of children. The last one is the partnership with the department of health. We have got a very strong partnership with our local clinic, our local sisters. They usually

when there is an outbreak of a certain disease like measles, or whatever. They phone us to tell us they will be at school to do immunisation to those who did not get those kinds of immunisations and sometimes they even come to share with learner's healthy living in terms of looking after their own bodies.

2. What role do you play in promoting healthy learning environments for grade R learners

Participant 3: The role that I play as the school principal is I am doing planning, control, monitoring, support and evaluation, and how do I do this? In terms of nutrition, I was part of planning the menu; I was not left out when the menu was planned. In, most cases I go where the menu was prepared, I check the cleanliness of the area, i check if the people who are preparing the food are clean enough. I check if they are wearing aprons and the hats which are used by the chefs, I check if the food is well prepared and I also just go where learners are eating and check if learners are really getting what they are supposed to be getting. I support those people who are giving the service, if they need something, they will talk to me and I provide. That is enough support to them. And, the evaluation part: I also check if there is something wrong, I will talk to them and rectify things that are not done well. For an example, during dusty days, you cannot give learners food outside, you take the food maybe into the classrooms and dish to them while the door is closed so that we don't have dust getting into the food of the children. So I strongly believe that I am playing a very important role in promoting healthy environments for grade R learners. The other one is that we plant trees around the school and particularly next to the grade R class as to ensure that the environment is healthy for the learners, maybe the plants and the grass, they act as wind breakers, and they also help in terms of the learners' health.

3. What challenges do you encounter in promoting a healthy learning environment for grade R learners?

Participant 3: The challenges are there. The first challenge is that we've got a new class. This is our first year of grade R class so there are a lot of things that we don't have. The department has not as yet supplied us with enough furniture, so we lack funds for the furniture. We lack in terms of the playground, learners don't have their own fenced area as it is supposed to be. In the grade R class we are supposed to be having

the first aid kit in case anything happens, the practitioner must be able to help the learners using that first aid kit. We don't have that first aid kit. I spoke about the fund, the department has not yet given us allocation for grade R and we as the school are supposed to buy some of the thing like stationery, puzzles, and many other for the grade R. Now, parents are supposed to be paying where we use it to pay the practitioner and also do these things I am talking about like stationery and many other important things. Parents don't pay, we've got a problem and we are not able to buy the things like swings for the learners. We should be having a very good environment where learners will play and develop all their movements and muscles. Now again, our school is an old school which is dilapidating, honestly speaking, our infrastructure when we put in the grade R class we used the same infrastructure like sewerage system. When we erected the mobile kitchen we still used the same sewerage system. Now our sewerage system has got a problem because there is a lot of bottlenecking when you go towards the main hole and ultimately we have got in a week, more the one blockage and we have to call people who must unblock it and those people have to be paid, so it is a very big challenge. Our learners come from a poverty stricken area. They are coming from families which do not have money. Now the problem is sometimes these learners come to school without having food. If they come to school without having food, it is only at school where these learners will get food and this is a challenge to me as the principal because during the holidays, our children suffer, they really suffer because they didn't have food. So it is a problem, or let me rather say a challenge.

4. What planning is needed in the promotion of healthy school environments?

Participant 3: the planning that is needed to the promotion of healthy school environment, we need to have number 1, paving, the whole school must be paved because our area is so dusty and this dust can cause chest-related ailment diseases like Tuberculosis, asthma and sinuses and when it is wet, the area has got lot of mud and surely this mud is going to dragged into the classroom, so if there is paving we will surely eliminate most of these diseases.

The other thing is fence, the grade R class has to be fenced, we must just have some kind of palisade that will ensure that those learners are in their own small yard for the mere fact

that they must not run around because running around will cause injuries, and again, apart from running around, because our school is too small, learners mix with big learners. Eventually when they run or play around, I have seen an incident where they bump into one another, the child fell down and got injured. So if they are inside their own place we don't have a lot of things to account for.

The grass or the lawn, we need to make the place beautiful by putting down or growing the grass or lawn. This will help us to eliminate also the dust, we won't have a lot of dust and when learners play on the grass, is going to be injury free, so the lawn is going to help us.

We are going also to develop the sandpit. The sandpit is going to help us so that learners play inside the clean sand. When they will be playing there, they will be developing the fine muscles and learners will be enjoying it in a safe area.

We are going to plant more trees, particularly the shrubs. The shrubs are going to help by being windbreakers, providing oxygen and making the area beautiful. It will even help us to demarcate the grade Rs from other classes. So these are the plans that are going to be done for our grade R class.

5. How is planned health programmes implemented at grade R level?

Participant 3: implementation of the grade R programmes we do it this way: the first one is nutrition, everyday from Monday to Friday, when our learners come to school, before they go to classes; they have a very nice breakfast. You must not forget that some of them don't have breakfast at home. So we give them breakfast here at school. They are served with soft porridge, power mix or motive and they enjoy it. At 11:40 they get their lunch. If they are supplied by the menu of that day, everyday has got its menu. They are also provided with a fruit for balancing their diet. They get a fruit once a week, it can be Tuesday, Wednesday or Thursday, but they definitely get a fruit and this fruit is season-based because when it is winter we mostly serve them with orange so they get vitamin C.

The other one is physical education. This is implemented when the practitioner teaches our children physical education. What is this? They are taught they must always clean their hands before they eat when they come from toilet they must make sure their hands are clean. And basins and toilets are inside the classroom. The soap is also on the basins so they are taught how to wash hands. They are taught again that when you sneeze, you cover

your mouth and that moisture on your hands you must go and remove because you may touch yourself or touch another touch another child that is going to be a communicable disease form you to another child. They are also taught that they must take care of their bodies, they must wash their bodies, this they practice at home and they are also taught about blood. They know that they are not suppose to touch the blood of another person because this is going to, according to HIV and Aids policy, you do not touch another person's blood without protective gloves, the Playtex gloves. They are also taught about contagious diseases, diseases that can move from one person to another.

In terms of physical activities, our learners are playing. We have got implemented the things that we use like soccer, we play soccer, sometimes I've seen them doing mini-cricket, playing all those games that learners can interact. Fielding and gaming, they do practice it.

In terms of the partnership with the department of health that is implemented but is only done when there is a need, it is not a standing plan.

6. Which policies guide the implementation of health programmes and do you think they are implemented effectively?

Participant 3: there are a number of policies that guide the implementation of health programmes for grade R learners. The first one is CAPS. The CAPS programme is a policy; in the CAPS programme the practitioner is given things she must teach the learners. In all those teachings that the practitioner must do, there is life skills, and life skills is teaching our learners about healthy living, about social development in the community, about personal development and also about their physical development and movements. That is where they do the practical part, playing all those different games. The other policy is the health and Safety policy, in a school there must be a health and safety policy. The health and safety policy is the one in the school that informs us how healthy is the school, does the school have dangerous sports, are there manholes in the school that are open which will be unhealthy for learners? Do we have maybe an evacuation system in case of any incident or accident, so that is health and safety policy? It is very important that we have this type of policy in the school. I think this one is effectively implemented because in our school it is shown that there are areas which are unhealthy, for an example, we've got manhole where it is stipulated in our policy that the lid has been stolen. And it shows there that this is a potentially unhealthy area for our learners, like I said, I strongly believe that is implemented

but I'll come back and talk about the implementation part of all of them. The other policy is the HIV and Aids policy which is also developed here at school. The purpose of the HIV and Aids policy is that we must teach learners how to develop healthy living such that they don't have those myths about HIV and Aids and that they don't lack knowledge, that they don't touch the blood of an injured person. They must know how to use the gloves that they must be protected.

The other one is the policy which is in the form of a circular, circular 13 of 1998 which is talking about the culture of teaching and learning at school. One of the things that are stipulated in this circular is that there must be a healthy environment for learners in the school to learn, this is very important.

Another circular is circular 13 of 1991 which talks about the parameter of the school. It says the parameter of the school must always be fenced and that the gate must always be locked, why? This has got much more to do with health and safety in the school; we have got a tarred road in front of the gate, if the learners got out through the hole or an open gate that is health hazard to our learners.

The other one which is much more important is the [policy in the ELRC file which is under the general document, this policy is section 5 of ELRC promoting healthy schools. In this general document it talks about assisting learners about the problems they face in terms of health related issues. Things that threatens their lives because here in our country our learning environment are exposed in a number of health hazards or a number of learning environments that are potentially dangerous to the physical well-being of learners, the mental well-being, the social plus the emotional well-being of learners. So this policy of promoting healthy school helps to give healthy alternatives and activities that young can get involved in at school that will be able to enhance their physical health and emotional, mental and social development.

All this that I have spoken about, they are implemented effectively because if you look at CAPS, there is no way the teacher cannot follow the planned curriculum. If you talk about health and safety policy, there is a committee that is looking at health and safety in that when that health and safety committee is going to look at the functionality or the effectiveness of the policy. If you look at the circulars, the circulars, also the principal of the school must make sure that they are effectively implemented. The HIV and Aids policy has

got committee, committees in the school are there to make sure that policies are implemented.

7. How do you monitor and evaluate health programmes for grade R at your school?

Participant 3: in terms of monitoring and evaluating, what I do is that I use the committees that we have in the school and i also go and personally check things. Let me just give you an example of how I do things, in terms of nutrition as one the programmes, I go to the kitchen where food is prepared to check cleanliness of the area, to check cleanliness of the people preparing the food and also to check if they are wearing appropriate aprons and hats, and I will also personally check, I know the committees members they check, but I will personally go and check where the food is stored, I don't want a situation where the learner's food is stored on the floor, or where learners' food is stored where there can be rodents inside because the rodents may eat the food, but as soon as the food is touched by rodents or is opened, it means that it is contaminated, it must be removed, we don't give to our learners. So you can see that is monitoring and evaluating, checking all those bags if they are still intact and have been tampered with by those small rodents.

In terms of physical education, as the principal I get the information from the deputy which the deputy got from the HOD that I must also be enthusiastic to know what is happening beyond. I also do some kind of sampling, go to the class and see if the teacher has taught curriculum the way it has to be, if the teacher has reached the acceptable standard in reams of syllabi coverage and school based assessments, that will definitely make me know that these learners has done this health promoting programmes.

In terms of physical activity, really, I see them outside. I used to visit them and saw them throwing the balls to one another doing catching, and throwing, playing mini-cricket, I've seen them, so that is part of monitoring.

And lastly, the partners from the department of health, when they are here at school, I will personally go and monitor what is happening and check with them if all learners are there, and all those things is part of monitoring.

8. Do you think grade R learners benefit from these programmes? If so, how? In which programmes do they benefit most? If no, why?

Participant 3: yes, I will say definitely they benefit from these programmes. To start with, they wholly and fully benefit from nutrition. We are giving learners food in the morning when they come to school, during lunchtime, and sometimes I know we even give them a third meal. When we are running extra classes, even the grade R sometimes have brothers and sisters in the school, they benefit from that. So in terms of nutrition, they benefit. They get food.

In terms of physical education, they benefit because the teacher is doing the work and following the work schedule and that has got CAPS, and that if it's not followed, will be able to pick it up from the HDO and the deputy principal and the principal, when we evaluate according to our CMM (curriculum management model).

In terms of physical activities, even if they may not go outside, they do eat inside. I know that when they teach grade R, educators also include the jumping and the running in the classroom so they benefit from these things.

The one about the department of health, yes they benefit when it is needed. It is circumstantial. When there is an outbreak of measles and those who did not get immunisation. So yes they benefit, and the other question is, which programme do they benefit most? The programme they benefit most is the nutrition and physical education. In terms of physical activities, I cannot say they benefit fully because we have got challenges, we don't have swings, we don't have see-saw where learners play, where learners can enhance all movements that are required in terms of health. What I can say is that, yes in physical activities we have a challenge of things we will be using and then the reason for this is that we got a new grade R class. Parents don't want to pay so we ended up not being able to buy all those necessary structure for our learners

9. What support does the SMT render to grade R practitioners and co-ordinators of health committees in order to ensure effective implementation of programmes?

Participant 3: When SMT members visit the class they talk to the practitioner, the practitioner will be telling us that I need this, for an example, in the beginning of the year we had a very tough time, we did not have anything, the practitioner was saying I need the stationery, I need appropriate chairs and table, so all what the practitioner needs is that we

must be able to support. The first thing is in support is what we have, we give, we supply to her, what we don't have, we went to the district, asked from the facilitator if you can help us with this and this document and brought them to her so she can teach the learners. I remember at some stage I had to talk to the facilitator because our practitioner is also new, we must also call our facilitator to come and help our practitioner, so we are really, really trying to ensure that we support the practitioner so that she can also be able to co-ordinate things in her class.

The co-ordinator of health committee, we support them by making sure they are encouraged to do things, you see, they are the members of the staff. They are co-ordinating, so we just support them by making sure that they are helping. We encourage them and we always pat them on the shoulder so that they can be motivated and carry on with the good job they are doing.

In terms of nutrition, i support them. There are times, especially when you find that the school re-opens, there has not yet been a supply. What i do, i talk to the finance committee of the school, we just get some money that was small budgeted for nutrition, we got buy some food. For example, we can go and buy cabbage and porridge and we cook for them some healthy meal. And sometimes we find that on the way, in terms of nutrition, we don't have cooking oil. They come to me and we supplement, we get some money from the school funds and buy some cooking oil. I remember there was a stage which there was only cabbage, and sometimes we need to make it delicious, I went to buy some things to make it delicious.

In terms of physical education, yes I support because I made sure that the teacher has got relevant material that is needed in able to teach in class.

In terms of physical activities, yes, I am trying but I am challenged because of the money. Those swings and all those many things that learners need to play, they are expensive and are not to say that in a day or two we can buy them, so there is a challenge.

First aid kit: in this area, when a learner is injured, I take them to a nearby clinic where they are getting medical attention and sometimes it depends on the severity of the injury. I rush them to the hospital and if it's an area where it really needs an ambulance, we phone an

ambulance. And honestly speaking, on a number of occasions, they have responded very well because we phone them and they come quickly to the school.

1. Which health programmes are applicable to grade R learners in your school?

Participant 4: Nutrition programme where learners get breakfast and lunch every day at school. Breakfast consists of soft porridge e.g., power mix and morvite. For lunch, every meal includes vegetables, they also get a fruit once a week, Physical education through life skills.

2. What role do you play in promoting healthy learning environments for grade R LEARNERS?

Participant 4: monitoring general cleaner to make sure that the class is cleaned everyday. Trees are planted around the school for fresh air and pollution. Plants are watered everyday by cleaners.

3. What challenges do you encounter in promoting a healthy learning environment for grade R learners?

Participant 4: The school is an old school, pipes are fixed in the toilets and they burst every now and again which affect the health of grade R learners. When dirty things come out little ones want to [play with it because the surrounding is not fenced. they say the whole system needs to be re done and it is a process that will take a long time. If we need funds from the department, they say this are not a matter of a day or a month, there are people already on the waiting list, we will also have to follow suit.

We can't get money from our school as our school is a non-paying school. Parents are not fully supportive, don't take good care of their children, some come to school dirty and are left at home on their own (come from child-headed families).

Stagnant water because of blocked drains causes unpleasant smell which is also not healthy for grade R learners.

4. What planning is needed in the promotion of healthy school environments?

Participant 4: grade R surroundings need to be fenced; we need to buy more play grounds equipment for grade R and furniture which is suitable for grade R learners which need funds. The school need to plan more fundraising activities.

5. How is planned health programmes implemented at grade R level?

Participant 4: Nutrition: there is care givers hired to prepare food. They come to school every day. There is a donated kitchen which has everything, e.g. where they wash dishes, each child have a plate and a spoon and they are washed by the care givers. Menu is in such a way that there is a vegetable in every meal. Monday, butternut, Tuesday sugar beans, Wednesday split peas, Thursday butternut and cabbage, Friday sugar beans.

Physical training: they exercise in the playground twice a week.

Physical education: in class they are taught how to take care of themselves and the environment

6. Which policies guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 4: No policies guiding the implementation of health programmes. Grade R is a new class to the school. Since 2012 some policies are still drafts are still drafts and thus we cannot say the school have standing policies that are implemented. Both SMT and the practitioner are undergoing training once a term on guiding on how to go about. There is an HIV and Aids policy for the whole school which also need to be reviewed and amended.

7. How do you monitor and evaluate health programmes for grade R at your school?

Participant 4: district officials come to school to give support and guidance as grade R class is new.

8. Do you think grade R learners benefit from these programmes? If so, How? In which programmes do they benefit most? If no, Why?

Participant 4: Yes, I can say they do because, more especially on the nutrition programme because some come to school without eating anything and the last meal is from school. They even carry some home when there is plenty.

9. What support does the SMT render to grade R practitioners and co-ordinators of health committees in order to ensure effective implementation of programmes?

Participant 4: Health committee has a member of SMT like all committees within the school. In their meetings, a member of SMT will forward their needs and challenges to the SMT where they will be addressed accordingly.

Grade R practitioner is supported fully through workshops and there is a head of department assigned to grade R to make sure that the programmes are implemented accordingly and according to plan.

School B

PARTICIPANT 1: PRINCIPAL

PARTICIPANT 2: GRADE R PRACTITIONER

PARTICIPANT 3: FOUNDATION PHASE HOD

PARTICIPANT 4: HEALTH AND SAFETY COORDINATOR

1. Which health programmes are applicable to grade R learners in your school?

Participant 1: We have got the following programmes: concerning life-skills and health issues we teach learners when and how to wash hands and we also have washing of teeth .Physical activities, the activities to develop fine motor skills. They also have feeding scheme programme, most of the learners, Grade R learners eat at school every day.

They are also involved in HIV/AIDS programmes where the practitioner teaches basic things like when a person is bleeding they must not touch it , they must call an adult for help and they must not touch a person with open wounds.

2. What role do you play in promoting healthy learning environments for grade R learners?

Participant 1: My role is more on the site or resources, I must see that all the resources are available and maintained and I must also see that the practitioners have necessary learner teaching support materials. They've got programmes lesson plans that the classrooms are cleaned and I must also see that the physical facilities are available.

3. What challenges do you encounter in promoting a healthy learning environment for grade R learners?

Participant 1: Here at our school we have got lack of resource facilities. Our school is an old school. We have applied for Grade R classrooms and have been waiting for a long time; we received only one so far. Another thing is space, our school yard is not big enough to give learners space, and also another challenge is dust, it is very dusty and especially in winter the dust become really a problem to our learners.

4. What planning is needed in the promotion of healthy school environments?

Participant 1: I think macro as well as micro planning is needed. Micro planning involves internal whole school evaluation where nine areas are evaluated and the school development is drawn, and school improvement plan, and Grade R must also be part of that whole plan. And out of that we have to budget for Grade R for learning and teaching support materials, for maintenance, as well as services. So from the SGB and SMT side they must do that plan and then we must see that the resources are available and then curriculum wise the HOD must also be involved to support and monitor and help Grade R practitioner in whatever they need.

5. How are planned health programmes implemented at grade R level?

Participant 1: The programmes are actually part of curriculum, so physical education, washing of hands, brushing of teeth, healthy food, personal hygiene, and all those programmes they is actually incorporated in life-skills programmes and HIV/AIDS also as I have indicated earlier.

6. Which policies guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 1: Firstly it is South African school act, we have white paper five on ECD development in South Africa and then lately there's circular 33 of 2010 implementation of norms and standards for Grade R funding, and the most important is the constitution and the bill of rights to see that learners rights are also respected.

In our school I think it's implemented well, we are really trying our best to see that we look after the learners as their rights are infringed and we don't discriminate. Even those parents who cannot afford to pay for learners for an example if we have to make a trip to the dentist; learners whose parents cannot afford us always make a plan for them.

7. How do you monitor and evaluate health programmes for grade R at your school?

Participant 1: HOD for foundation phase is responsible for the Grade R's. She is helping me with monitoring and evaluating and reporting back at the SMT meeting. So at the SMT meeting we will get the reports, if we have to support with help that is needed we will plan and give support.

8. Do you think grade R learners benefit from these programmes? If so, how? In which programmes do they benefit most? If not, why?

Participant 1: Yes they do benefit for an example we teach them that they have to wash hands before they eat. Even after they play they have to wash hands. I think the programme they benefit most is physical education, they do it practically and motor skills are really developed, and I think this will also help them to be school ready for Grade 1

Another programme that is important is nutrition because learners they tend to buy from vendors and vendor do not always sell healthy food, we try to teach them which group of food are really healthy and which ones they must not eat and we also try to show them the importance of the balanced menu that are all necessary for food groups.

Environmentally, after breaks we teach them to pick up papers. We involve them to plant trees, we have glass recycling project because we also teach them that they must also look after their resources because one day in the future there will be no enough resources. No we don't have a programme where they don't benefit.

9. What support does the SMT render to grade R practitioners and co-ordinators of artic health committees in order to ensure effective implementation of programmes?

Participant 1: We help them to plan and to organise for programmes, we help them make policies and to implement policies, we provide them with timetables and year programme sand then HOD will support them with curriculum needs and other issues. Also in our parents meetings me as the principal and the HOD we address parents on health issues.

1. Which health programs are applicable for Grade R in your school?

Participant 2: health programmes applicable at our school is physical education, nutrition and life skills which is healthy living and physical activities. In physical education we develop learner's gross motor and fine motor skills, by doing brain gym and other exercises using bodies to make it strong and healthy.

When coming to nutrition we advise learners to wash their hands before they handle food. They eat at school every day. They have breakfast and lunch.

In physical education, we teach them that eating healthy fresh fruits and vegetables is good for healthy bodies. We also advise our learners to drink a lot of water to stay healthy.

In life skill healthy living is very important. We teach them that they must take care of themselves, teaching them how to wash their faces and bodies. Teach them songs like this: This is the way we wash our face early in the morning. We also teach them to brush their teeth using toothbrush and lukewarm water; we demonstrate that in class and at the dentist. We also teach them to wash their faces using face cloth, soap and lukewarm water, that is also demonstrated in class. We teach them to always wear clean clothes and comb their hair nicely.

2. What role is SMT playing in promoting healthy learning environments for Grade R Learners?

Participant 2: The HOD of foundation phase and the principal always check if we are teaching learners correctly, they also come when learners are eating to check the food and the place where they are eating. The HOD also checks the physical activities we do with learners. They also check the clean class.

3. Do you encounter challenges concerning learning environments for Grade R learners? If yes, what are they?

Participant 2: Our school is situated in a dusty place; learners get sick now and then because of dust. We don't have enough space for physical activities. We do not have equipment's for physical activities. Parents do not pay school fees for other resources.

4. Are you part of planning to promote a healthy learning environment for Grade R learner? If so what role do you play? Why?

Participant 2: Yes I am part of planning. The SMT and SGB when they plan something like a trip or maybe pave in front of Grade R classes they always make us part of the meeting for planning. They also ask for our inputs, like they ask us how we want things to run in our classes for an example, when to clean.

5. How are the health programs for Grade R in your school implemented? Who implements them? Who is responsible for monitoring and evaluation?

Participant 2: The feeding scheme committee hired people who cook for learners and they give learners food every morning and every lunch, they also clean the dishes and the kitchen. The Grade R teachers are responsible for health education for learners and they also do exercises with learners.

6. Do you have policies that guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 2: We have HIV/AIDS policy, we have health and safety policy, we have nutrition policy, yes they are implemented because learners are taught about HIV/AIDS, they are also taught about health and nutrition is also feeding them healthy food.

7. Does the SMT monitor and evaluate health programmes for Grade R at your school and how do they do it?

Participant 2: Yes they do, during break the principal come and watch us what are we doing and he also ask learners what are they doing. Our HOD also come to class to check and monitor during life skills period when we do health programmes. She also gives us health posters like healthy food and taking care of ourselves.

8. From which programmes do Grade R learners benefit most? Why?

Participant 2: They benefit most in nutrition because they eat every day. They eat healthy food and get omega 3 when they eat tin fish which helps them to build strong teeth. They also benefit in physical education where the teacher is teaching them healthy living

9. Are there programmes that Grade R learners are not benefiting from? Why?

Participant 2: They do not benefit most in physical activities because we do not have our own playground and physical activities equipment's.

10. Which programmes do you think can be added that will best benefit the Grade R learners?

Participant 2: I think if we can have lot of physical activities and their equipment's.

11. What support do you get from the SMT to ensure effective implementation of health programmes?

Participant 2: They organised paving for the part of Grade R classes. They support us when we have dental health trip, they encourage us to keep classes clean.

1. Which health programs are applicable for Grade R in your school?

Participant 3: We have physical education, physical activities and nutrition.

2. What role do you play in promoting healthy learning environments for grade R learners?

Participant 3: We supply grade R practitioners with the material they should use to promote healthily learning environments as an SMT we make sure that the environment and the surroundings for grade R learners are clean, we check they food, the ladies who are preparing, are they preparing in a clean areas and if they also store food in a clean place. We also check if there is no danger, was learners are playing.

3. What challenges do you encounter in promoting a healthy learning environment for grade R learners?

Participant 3: Our school is an old school, there is lot of dust which makes our learners sick, they suffer from a lung related sickness caused by dust. We also have a challenged with our grade Rclass which is not fenced and cannot keep learners in their own yard for playing. We are also not having enough equipment's for learners to exercise outside classrooms

4. What planning is needed in the promotion of healthy school environments?

Participants 3: We need to make play grounds for grade R learners, buy resources for physical activities such as see-saw make sand pit, organise fencing for grade R learners class.

5. How is planned health programmes implemented at grade R level?

Participant 3: In nutrition learners receive food every day, in health education practitioners teaches them during life skills about health, how to take care of them, how to keep their environments clean and they also do physical activities in class with the practitioner.

6. Which policies guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

PARTICIPANTS 3: Yes we do have policies, we have nutrition policy and it is effectively implemented, because learners do it every day, we have caps policy and the practitioners follows it when teaching life skills. We have HIV/AIDS policy learners are taught about HIV/AIDS, so they are effectively implemented

7. How do you monitor and evaluate health programmes for grade R at your school?

Participant 3: As an HOD, every Month I check the files of the Practitioners if health Programs have been taught, I also check when they are doing physical activities.

8. Do you think grade R learners benefit from these programmes? If so, how? In which programmes do they benefit most? If not, why?

Participant 3:Yes they do benefit from nutrition because they get food every day and physical education where they are taught about healthy living during life skill period and that is done every day too, but from physical activities they do not benefit a lot because they do not have facilities for physical activities.

9. What support does SMTrender toGrade R practitionersand co-ordinators of health committees in order to ensure effective implementation of programmes?

Participant 3: We help them to monitor people who are hired to clean their classes, to see if they are cleaned on daily basis. We also help them to check their work to make sure that they follow the programme set by the department of education to teach healthy living and

develop them where they do not understand by explaining what is needed also help them to check if food for learners is well prepared in the kitchen

1. Which health programmes are applicable to Grade R learners at your school?

Participant 4: we have got six programmes, the first one is HIV/AIDS the second one is nutrition or feeding scheme and the third one is physical education, the fourth is first aid and fire and prevention, number five is physical activities and the sixth programme is dental health.

2. What role is SMT playing in promoting healthy learning environments for Grade R Learners?

Participant 4: The main role of SMT is to support and to develop areas where we can provide resources and space where health programmes can be implemented effectively, so through the HOD who monitors and controls, as well as through myself the principal, we sit together as a team, we identify needs and we plan and will see where we can improve.

3. Do you encounter challenges concerning learning environments for Grade R learners? If yes, what are they?

Participant 4: Yes we have got quite a number of challenges. The first is we don't have enough space in our school to provide the area with physical activities and outside playing can take place and we also have a problem with taps, we only have few taps. We don't have water fountains and enough taps outside. Our main problem is we need lot of resources, with budget restricted. Then we also struggle with the parents, they are not paying school fees. We have got a big problem with dust. Our school is an old school, so dust hamper the health of learners, so our learners suffer illnesses like TB, Sinusitis, Bronchitis and other illnesses. We also have a challenge with our vendors that are selling snacks and food because most of the time they are selling sweets and chips that are not good for Grade R learner's health.

4. Are you part of planning to promote a healthy learning environment for Grade R learner? If so what roles do you play? If not, why?

Participant 4: Yes I am part of planning. I am part of SMT and we plan together to improve or better the resources for Grade R, also we look at our challenges as mentioned in the

previous question, what we can do to make this programmes work better so we do major planning but also more detailed planning the practitioner and the HOD are responsible for the Grade R. We are a team responsible for planning, and even here through internal school evaluation we also evaluate and identify dangers and we make recommendations and it become part of the school then improvement plan. We try and budget also for them.

5. How are the health programs for Grade R in your school implemented? Who implements them? Who is responsible for monitoring and evaluation?

Participant 4: we've got a special committee for nutrition programmes, so the committee is responsible to check that the kitchen is clean, ladies who are cooking are clean, for the general rules and wellbeing of the learners, that hygiene is very important, they check how the food is stored. The committee try and help to provide so that we buy necessary equipments, the nutrition committee is responsible for the feeding scheme part of it.

The Grade R practitioners are responsible to see that the programmes that are part of the curriculum programmes are implemented and the HOD as well as me as the principal monitor and see also that those programmes like physical education, physical activities, HIV/AIDS that those programmes are implemented.

6. Do you have policies that guide the implementation of health programmes for Grade R at your school? If yes do you think they are effectively implemented?

Participant 4: Yes we have HIV/AIDS policy, the learners receive education on issues like not to handle people who are bleeding we talk to them, we educate them on what to do with open wounds, basic first aid we treat with them. Then we also emphasise the need of healthy food to build the immune system to help fight also this pandemic of AIDS. Then we have got health and safety policy. The health and safety committee is responsible there and we also teach learners about safety, what areas are out of bounce for them. Also in health and safety we teach them evacuation drills as well as drills when there is fire in school. Then there is a policy on nutrition. The committee there also see to it that this policy is implemented. Then the HOD of foundation phase, the principal, myself are also playing a role to see that these policies are implemented, and then we are also guided by white paper on early childhood development that is talking about certain models, financing, and curriculum and developments that are integrated for the Grade R.

Some are implemented some are not because of the challenges and the lack of resources some of the programmes cannot be implemented well. For example physical activities, we don't have things outside playing area, the sand pit, the swings and see-saw and the areas where there is grass, where they can play. So in some instance policies are not implemented well because of certain challenges.

7. Does the SMT monitor and evaluate health programmes for Grade R at your school and how do they do it?

Participant 4: Yes the SMT is mainly a part of giving support, giving advice, it is also their duty to keep the practitioners motivated, and then the SMT and the SGB are busy at the moment planning certain things to improve the conditions and resources. We are planning to pave certain areas to minimise the dust. We are addressing parents during parents meetings, for example learners only receive one fruit per week, so we advise parents to provide snack, we ask them to provide learners with fruit so they have a fruit at least for everyday.

We are also busy planning to install jungle gym and sand pit, swings and all the necessary equipments that can be there for physical activities, so in collaboration with the SGB the SMT tries to provide everything that is needed. We also have learning and teaching support material. The SMT mainly through the HOD foundation phase, the HOD is checking the schedule coverage with the practitioners if the practitioners cover the schedules and if they do health programmes with learners. They also monitor the work that was done by learners. The HOD then write the report that comes to the principal which is part of monitoring and if necessary we will call the practitioner and give her advises and try and help where we can.

8. From which programmes do Grade R learners benefit most? Why?

Participant 4: They benefit most from feeding scheme because most of them come to school hungry and in the morning they get instant porridge, power mix and that give them necessary energy to concentrate and do their work. They also get lunch with different menus for different days. So I think they benefit most from the feeding scheme. They also a lot from the first aid, there is a first aid kit available in their classrooms, and the practitioner can help them with minor injuries and if there is major injuries we take them to the clinic. They also benefit a lot from dental health because most of them don't have toothbrushes, so when they

visit the dentist, the HOD mostly accompany them on trips and there they receive education, teaching how to brush teeth and they also receive toothbrushes and toothpaste. They benefit a lot from dental health programme.

9. Are there programmes that Grade R learners are not benefiting from? Why?

Physical activities, they don't benefit because of the challenges we are have got, that we don't have necessary resources as mentioned that we don't have the see-saw and all those other equipments needed for physical activities. They don't benefit on physical activities because of lack of space and equipmentstoperform physical activities.

10. Which programmes do you think can be added that will best benefit the Grade R learners?

Participant 4: I think we have most of the health programmes, only if we can improve the conditions of the existing ones.

11. What support do you get from the SMT to ensure effective implementation of health programmes?

Participant 4: As I have said the SMT is in the management position, so basically what the SMT is doing is to support and to try and see that they get all the necessary resources and equipments so that this health programmes can be implemented, so I will summarise by saying the SMT give advice and motivate, they support and they plan to improve resources so that the programmes can be done effectively.

AUDIT

TRAIL

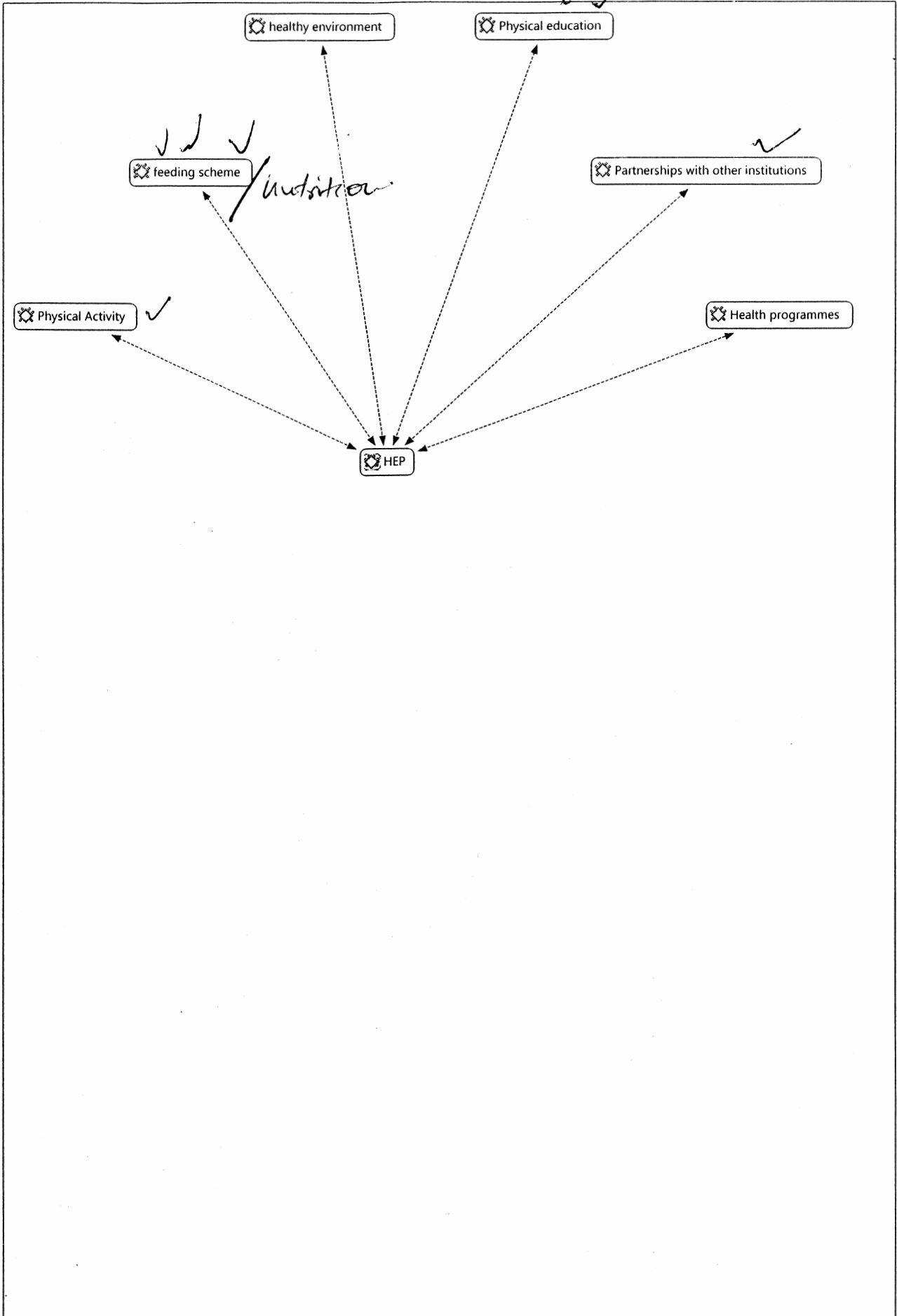
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Edited by: Super
Date/Time: 2012-12-19 09:44:49

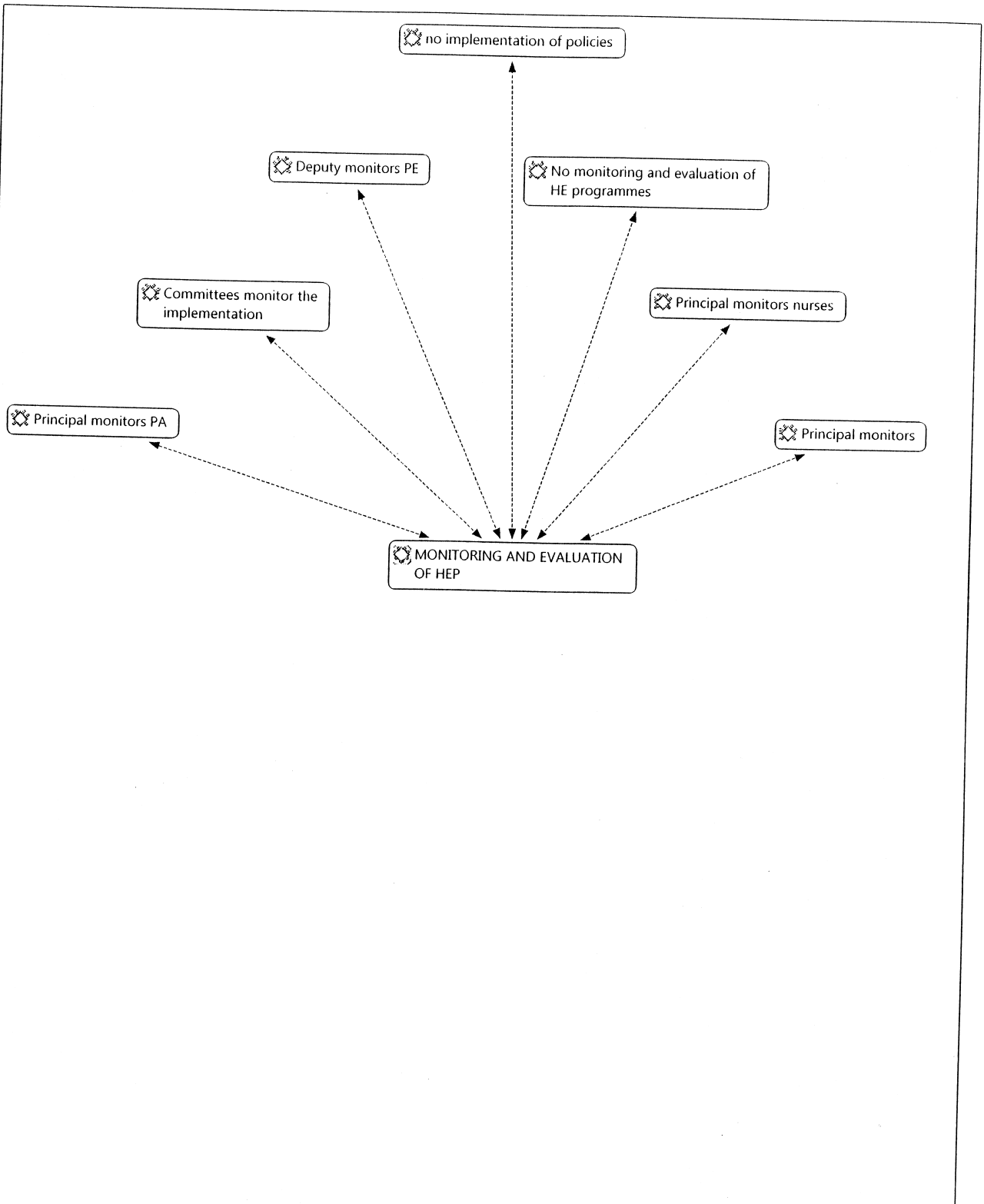
Blocked drains
Bo role in planning
building blocks
buy food for grade R
CHALLENGES
child head families
Clean physical environment
Clear plan - nutrition
Committees monitor the implementation
Department conducts
Deputy monitors PE
dont come to offer support
dont play a role
ELRC
evaluation of HEP
feeding scheme
First aid
Give support
Grade R new
Health and safety policy
Health programmes
healthy environment
HEd
HEd by the practitioner
HEP
HEP CHILDREN BENEFIT MOST
HEP CHILDREN DONT BENEFIT
HEP CHILDREN NOT BENEFITING
HEP TO BE ADDED
HIV/AIDS policy
IMPLEMENTATION OF HEP
Implementation of programmes
Into from wrokshop not used
Learning resources
Listen to practitioners
material for PE
Mental wellness prog
Monitoring
MONITORING AND EVALUATION
NEEDS
no first aid kits
no food during holidays
no help with challenges
no implementation of policies
No maintainance
No monitoring and evaluation of HE programmes

no playing facilities
no policies for grade R
no proper fencing
no role
no role in grade R
No safety
no security
no stationary
No support
No support for PA no money
not enough furniture
not implemented
not involved
Not involved in SMT mmetings about HEP
not part of planning
Nurses initiate
Nutrition
nutrition- clear plan
own playground
parents dont pay
Partnerships when there is a need
Partnerships with other institutions
PE by teachers
Physical Activity
Physical Activity by practitioner
Physical education
Physical education by teacher
Physical environments
Physical environments not clean
Planning
Planning activities
playground not big enough
POLICIES
policies developed
policies implemented
Principal monitors
Principal monitors nurses
Principal monitors PA
PROMOTION OF HE
puzzles
ROLE IN HE
ROLE SMT
safety
sand pit
SMT monitors and evaluates
SMT SUPPORT
take injured learners to the clinic
taps leak
This is a Code
toilets blocked
WORKSHOP

HEP



MONITORING AND EVALUATION OF HEP



MONITORING AND EVALUATION OF HEP

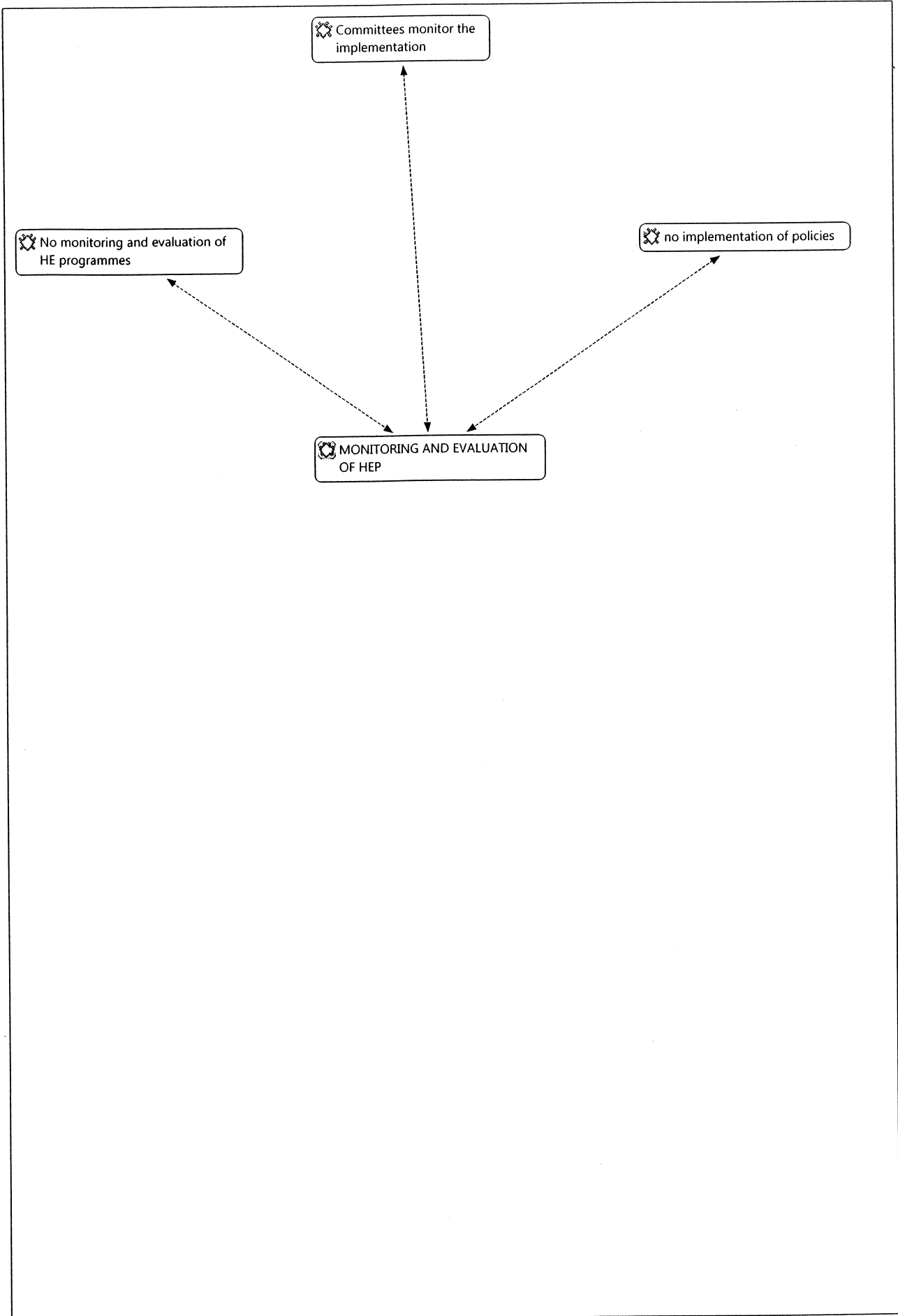
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Author: Super

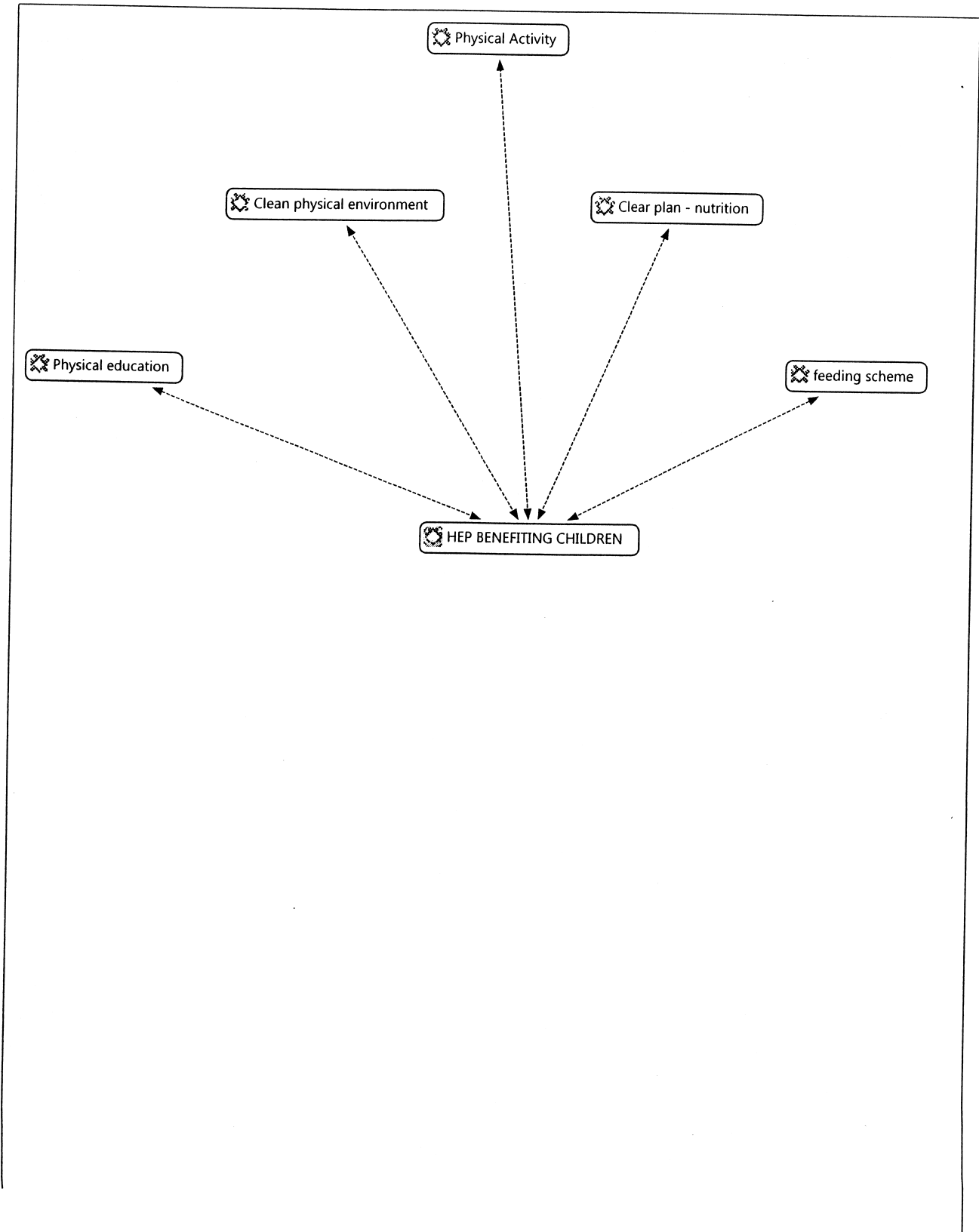
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MONITORING AND EVALUATION OF HEP



HEP BENEFITING CHILDREN



HEP BENEFITING CHILDREN

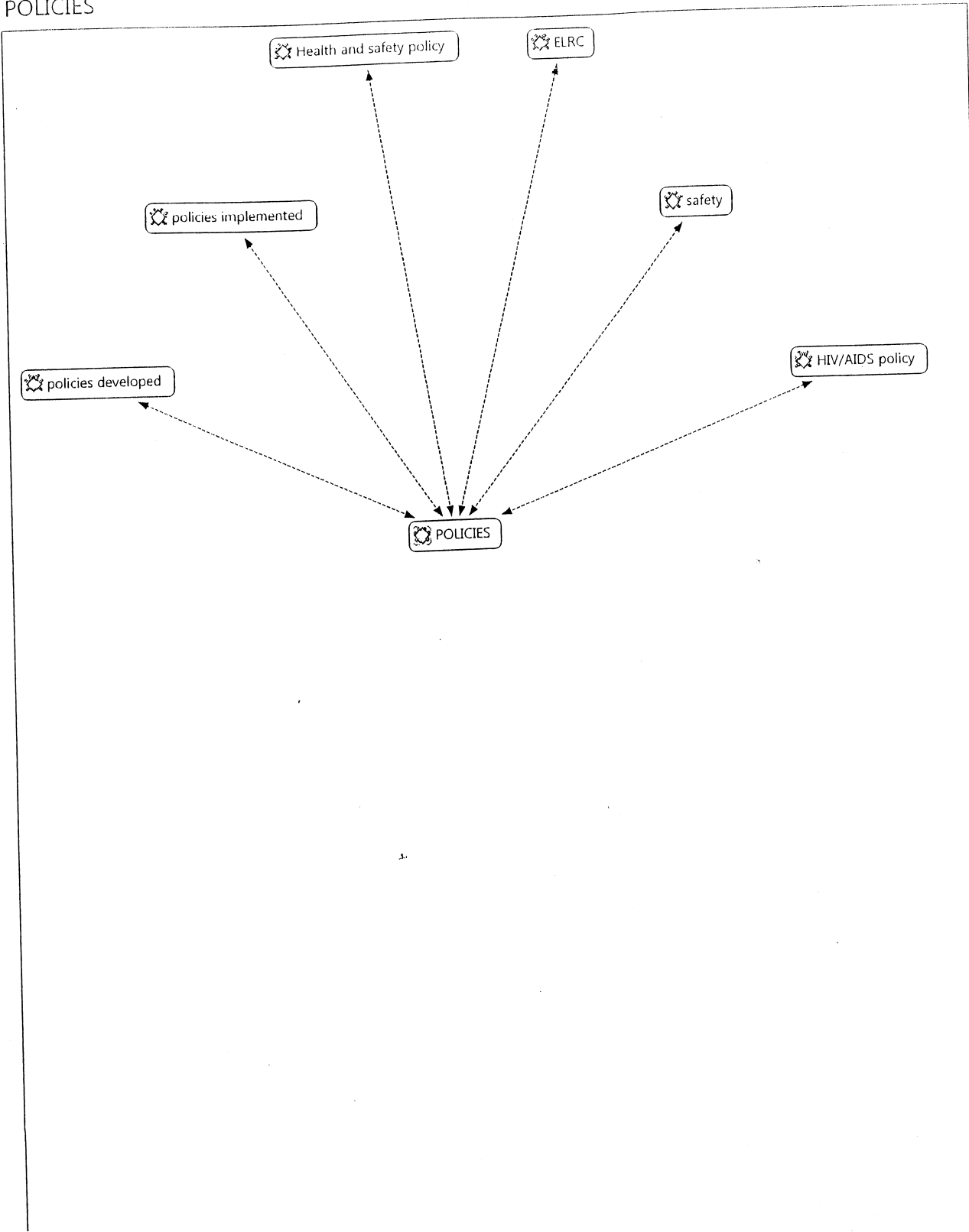
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Author: Super

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POLICIES



POLICIES

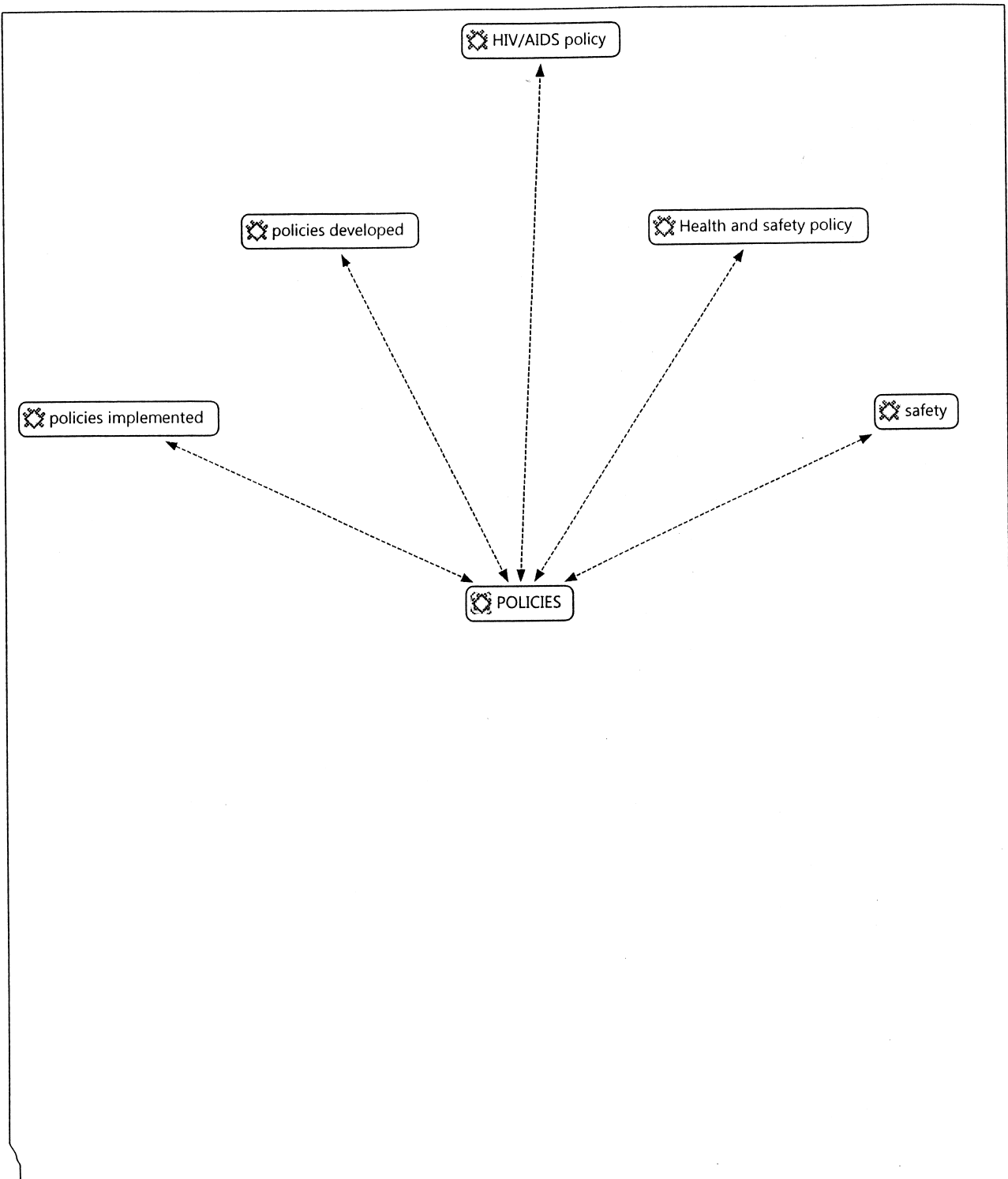
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Author: Super

Date/Time: 2012/12/19 10:22:26 AM

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POLICIES



POLICIES

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Date/Time: 2012/12/19 10:13:52 AM

Nodes: 6...

All objects sorted by creation date

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Edited by: Super
Date/Time: 2012-12-19 11:10:45

Editing period : 208 days
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Last object created: 2012-12-19 10:57:29 (Network View: SUPPORT SMT)

(2012-05-25 15:52:59) HU: Welcome
(2012-05-25 15:55:26) Primary Doc: P 1: welcome.png (1)
(2012-05-25 15:56:17) Quotation: 1:1 welcome.png (370:445)
(2012-05-25 15:56:17) Code: This is a Code (1-0)
(2012-12-18 09:58:06) Primary Doc: P 2: Transcripts.docx (69)
(2012-12-18 09:59:27) Quotation: 2:1 The programmes that are here a.. (8:8)
(2012-12-18 10:00:07) Code: Health programmes (2-0)
(2012-12-18 10:00:07) Quotation: 2:2 programmes (8:8)
(2012-12-18 10:00:21) Quotation: 2:3 feeding scheme (8:8)
(2012-12-18 10:00:48) Quotation: 2:4 According to me, I don't see t.. (10:10)
(2012-12-18 10:01:25) Code: PROMOTION OF HE (1-0)
(2012-12-18 10:59:05) Primary Doc: P 3: responses.docx (2)
(2012-12-19 08:00:11) Quotation: 3:1 The programmes that are here a.. (9:9)
(2012-12-19 08:00:46) Quotation: 3:2 feeding scheme (9:9)
(2012-12-19 08:01:08) Code: feeding scheme (3-0)
(2012-12-19 08:02:06) Quotation: 2:5 feeding scheme (8:8)
(2012-12-19 08:02:56) Quotation: 2:6 don't see them playing any rol.. (10:10)
(2012-12-19 08:02:56) Code: dont play a role (1-0)
(2012-12-19 08:03:23) Quotation: 2:7 R learners have a lot of needs.. (10:10)
(2012-12-19 08:03:40) Code: NEEDS (1-0)
(2012-12-19 08:04:00) Quotation: 2:8 their own playground (10:10)
(2012-12-19 08:04:00) Code: own playground (1-0)
(2012-12-19 08:04:19) Code: Learning resources (1-0)
(2012-12-19 08:04:19) Quotation: 2:9 playing resources (10:10)
(2012-12-19 08:04:39) Quotation: 2:10 puzzles, (10:10)
(2012-12-19 08:04:47) Quotation: 2:11 building blocks (10:10)
(2012-12-19 08:04:57) Quotation: 2:12 sand pit (10:10)
(2012-12-19 08:05:48) Code: sand pit (1-0)
(2012-12-19 08:06:01) Code: building blocks (1-0)
(2012-12-19 08:06:08) Quotation: 2:13 puzzles (10:10)
(2012-12-19 08:06:18) Code: puzzles (1-0)
(2012-12-19 08:06:30) Quotation: 2:14 Yes ma am, we encounter proble.. (12:12)
(2012-12-19 08:06:47) Quotation: 2:15 Yes ma am, we encounter proble.. (12:12)
(2012-12-19 08:06:57) Code: CHALLENGES (4-0)
(2012-12-19 08:07:18) Code: no security (1-0)
(2012-12-19 08:07:18) Quotation: 2:16 security (12:12)
(2012-12-19 08:07:40) Code: no proper fencing (1-0)
(2012-12-19 08:07:40) Quotation: 2:17 proper fencing (12:12)
(2012-12-19 08:08:03) Quotation: 2:18 play ground (12:12)
(2012-12-19 08:08:03) Code: playground not big enough (1-0)
(2012-12-19 08:08:27) Code: no playing facilities (2-0)
(2012-12-19 08:08:27) Quotation: 2:19 playing facilities (12:12)
(2012-12-19 08:08:45) Code: taps leak (1-0)
(2012-12-19 08:08:45) Quotation: 2:20 leaking (12:12)
(2012-12-19 08:09:01) Code: toilets blocked (1-0)
(2012-12-19 08:09:01) Quotation: 2:21 blockage of toilets (12:12)
(2012-12-19 08:09:46) Quotation: 2:22 No maam I don't take part in p.. (14:14)
(2012-12-19 08:12:00) Code: ROLE IN HE (5-0)
(2012-12-19 08:12:18) Code: Bo role in planning (1-0)

(2012-12-19 08:12:18) Quotation: 2:23 take part in planning (14:14)

(2012-12-19 08:12:34) Quotation: 2:24 We have nutrition programmes i.. (16:17)

(2012-12-19 08:12:56) Code: IMPLEMENTATION OF HEP (5-0)

(2012-12-19 08:13:22) Quotation: 2:25 Physical education (17:17)

(2012-12-19 08:13:39) Code: PE by teachers (1-0)

(2012-12-19 08:14:16) Code: HEd by the practitioner (2-0)

(2012-12-19 08:14:16) Quotation: 2:26 are responsible (17:17)

(2012-12-19 08:14:37) Code: SMT monitors and evaluates (1-0)

(2012-12-19 08:14:37) Quotation: 2:27 monitoring and evaluating the .. (17:17)

(2012-12-19 08:15:00) Quotation: 2:28 Participant 1: Yes mam is we d.. (19:19)

(2012-12-19 08:15:11) Code: POLICIES (3-0)

(2012-12-19 08:15:53) Code: policies developed (2-0)

(2012-12-19 08:16:10) Code: not implemented (1-0)

(2012-12-19 08:16:54) Quotation: 2:29 Yes mam is we do have policies.. (19:19)

(2012-12-19 08:17:10) Code: WORKSHOP (1-0)

(2012-12-19 08:17:27) Code: Department conducts (1-0)

(2012-12-19 08:17:45) Code: Info from wrokshop not used (1-0)

(2012-12-19 08:17:56) Quotation: 2:30 he SMT does not monitor Grade .. (21:21)

(2012-12-19 08:18:08) Code: MONITORING AND EVALUATION (3-0)

(2012-12-19 08:18:53) Quotation: 2:31 The SMT does not monitor Grade.. (21:21)

(2012-12-19 08:18:53) Code: No monitoring and evaluation of HE programmes (2-0)

(2012-12-19 08:19:09) Quotation: 2:32 Nutrition because they eat eve.. (23:23)

(2012-12-19 08:20:12) Code: HEP CHILDREN BENEFIT MOST (3-0)~

(2012-12-19 08:20:26) Code: Nutrition (5-0)

(2012-12-19 08:21:10) Quotation: 2:33 Physical activities because of.. (25:26)

(2012-12-19 08:21:39) Code: HEP CHILDREN NOT BENEFITING (1-0)

(2012-12-19 08:21:58) Code: Physical education (4-0)

(2012-12-19 08:22:31) Code: Physical environments (1-0)

(2012-12-19 08:22:53) Quotation: 2:34 First of all if the school can.. (28:29)

(2012-12-19 08:23:11) Code: HEP TO BE ADDED (2-0)

(2012-12-19 08:23:26) Code: First aid (3-0)

(2012-12-19 08:23:48) Code: Mental wellness prog (1-0)

(2012-12-19 08:24:09) Code: Physical Activity (5-0)

(2012-12-19 08:24:32) Quotation: 2:35 The SMT does not support us at.. (31:31)

(2012-12-19 08:24:41) Code: SMT SUPPORT (3-0)

(2012-12-19 08:26:11) Code: No support (2-0)

(2012-12-19 08:26:54) Quotation: 2:36 The SMT does not support us at.. (31:31)

(2012-12-19 08:26:54) Code: Not involved in SMT mmetings about HEP (1-0)

(2012-12-19 08:27:29) Quotation: 2:37 Feeding scheme is the only one.. (35:35)

(2012-12-19 08:27:42) Code: HEP (3-0)

(2012-12-19 08:28:08) Quotation: 2:38 I don't see them playing any r.. (37:37)

(2012-12-19 08:28:26) Code: ROLE SMT (2-0)

(2012-12-19 08:28:54) Code: no role in grade R (1-0)

(2012-12-19 08:29:00) Quotation: 2:39 Yes I do have a problem regard.. (39:39)

(2012-12-19 08:30:12) Quotation: 2:40 :I am not part of planning and.. (41:41)

(2012-12-19 08:30:41) Code: not part of planning (1-0)

(2012-12-19 08:30:53) Code: no role (1-0)

(2012-12-19 08:31:15) Code: not involved (1-0)

(2012-12-19 08:31:49) Quotation: 2:41 In nutrition programme learner.. (43:43)

(2012-12-19 08:38:43) Quotation: 2:42 Even if the school have it, lh.. (45:45)

(2012-12-19 08:39:35) Code: no policies for grade R (1-0)

(2012-12-19 08:40:03) Code: no implementation of policies (1-0)

(2012-12-19 08:40:26) Quotation: 2:43 :Inever saw them I monitoring .. (47:47)

(2012-12-19 08:41:26) Quotation: 2:44 :I only see them benefiting fr.. (49:49)

(2012-12-19 08:42:14) Code: HEd (1-0)

(2012-12-19 08:42:35) Quotation: 2:45 Yes they are many. We don't ha.. (51:51)

(2012-12-19 08:44:41) Code: HEP CHILDREN DONT BENEFIT (1-0)

(2012-12-19 08:45:24) Code: healthy environment (1-0)

(2012-12-19 08:45:40) Code: safety (3-0)

(2012-12-19 08:45:59) Quotation: 2:46 Physical activities to develop (53:56)

(2012-12-19 08:46:53) Code: Clean physical environment (1-0)

(2012-12-19 08:47:08) Quotation: 2:47 Physical activities to develop (53:56)

(2012-12-19 08:47:48) Quotation: 2:48 :I don't get any support from .. (58:58)

(2012-12-19 08:43:36) Code: no help with challenges (1-0)

(2012-12-19 08:49:08) Code: dont come to offer support (1-0)

(2012-12-19 08:49:17) Quotation: 2:49 I have four programmes that I.. (60:63)

(2012-12-19 08:51:46) Code: Partnerships with other institutions (2-0)

(2012-12-19 08:52:50) Quotation: 2:50 Now if I may talk about nutrit.. (61:68)

(2012-12-19 08:53:54) Code: nutrition- clear plan (1-0)

(2012-12-19 08:53:54) Quotation: 2:51 Now if I may talk about nutrit.. (61:61)

(2012-12-19 08:54:41) Quotation: 2:52 In physical education, I am re.. (62:62)

(2012-12-19 08:54:41) Code: Physical education by teacher (3-0)

(2012-12-19 08:55:27) Quotation: 2:53 In healthy living the practiti.. (63:63)

(2012-12-19 08:56:18) Quotation: 2:54 And lastly, they are taught ph.. (66:66)

(2012-12-19 08:56:18) Code: Physical Activity by practitioner (3-0)

(2012-12-19 08:57:30) Quotation: 2:55 The last one is the partnershi.. (68:68)

(2012-12-19 08:57:30) Code: Nurses initiate (1-0)

(2012-12-19 08:57:43) Quotation: 2:56 The role that I play as the sc.. (70:71)

(2012-12-19 08:59:13) Code: Planning (1-0)

(2012-12-19 08:59:24) Code: Monitoring (2-0)~

(2012-12-19 08:59:40) Code: evaluation of HEP (1-0)

(2012-12-19 08:59:50) Code: Give support (1-0)

(2012-12-19 09:00:29) Quotation: 2:57 Participant 3: The challenges .. (73:76)

(2012-12-19 09:01:22) Code: Grade R new (1-0)

(2012-12-19 09:01:39) Code: not enough furniture (1-0)

(2012-12-19 09:02:18) Code: no first aid kits (1-0)

(2012-12-19 09:02:43) Code: no stationary (1-0)

(2012-12-19 09:03:09) Code: parents dont pay (2-0)

(2012-12-19 09:04:43) Code: No safety (1-0)

(2012-12-19 09:05:08) Code: Physical environments not clean (2-0)

(2012-12-19 09:05:49) Code: no food during holidays (1-0)

(2012-12-19 09:06:29) Quotation: 2:58 the planning that is needed to.. (80:84)

(2012-12-19 09:07:09) Code: Planning activities (1-0)

(2012-12-19 09:07:39) Code: Implementation of programmes (1-0)

(2012-12-19 09:08:28) Quotation: 2:59 Participant 3: implementation .. (86:89)

(2012-12-19 09:09:48) Code: Clear plan - nutrition (2-0)

(2012-12-19 09:11:08) Code: Partnerships when there is a need (1-0)

(2012-12-19 09:11:38) Quotation: 2:60 Participant 3: there are a num.. (92:99)

(2012-12-19 09:12:42) Code: Health and safety policy (1-0)

(2012-12-19 09:13:03) Code: HIV/AIDS policy (1-0)

(2012-12-19 09:14:02) Code: ELRC (1-0)

(2012-12-19 09:14:25) Code: policies implemented (1-0)

(2012-12-19 09:15:03) Code: Committees monitor the implementation (2-0)

(2012-12-19 09:15:28) Quotation: 2:61 Participant 3: in terms of mon.. (102:107)

(2012-12-19 09:18:14) Code: Principal monitors (1-0)

(2012-12-19 09:18:52) Code: Deputy monitors PE (1-0)

(2012-12-19 09:21:16) Code: Principal monitors PA (1-0)

(2012-12-19 09:21:40) Code: Principal monitors nurses (1-0)

(2012-12-19 09:22:03) Quotation: 2:62 Participant 3: yes, I will say.. (109:112)

(2012-12-19 09:27:22) Quotation: 2:63 Participant 3: when SMT member.. (114:123)

(2012-12-19 09:28:57) Code: Listen to practitioners (1-0)

(2012-12-19 09:30:06) Code: buy food for grade R (1-0)

(2012-12-19 09:30:28) Code: material for PE (1-0)

(2012-12-19 09:30:51) Code: No support for PA no money (1-0)

(2012-12-19 09:31:18) Code: take injured learners to the clinic (1-0)

(2012-12-19 09:31:44) Quotation: 2:64 Participant 4: Nutrition progra.. (128:128)

(2012-12-19 09:32:32) Quotation: 2:65 monitoring general cleaner to .. (130:130)

(2012-12-19 09:34:09) Quotation: 2:66 The school is an old school, p.. (132:134)

(2012-12-19 09:36:15) Code: No maintenance (1-0)

(2012-12-19 09:37:28) Code: child heade families (1-0)

(2012-12-19 09:37:50) Code: Blocked drains (1-0)

(2012-12-19 09:38:15) Quotation: 2:67 Participant 4: grade R surroun.. (137:137)

(2012-12-19 09:39:04) Quotation: 2:68 nutrition: there are care give.. (139:141)

(2012-12-19 09:42:15) Quotation: 2:70 Participant 4: nutrition: ther.. (139:141)

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(2012-12-19 09:47:29) Code Family: CHALLENGES (29)

(2012-12-19 09:50:46) Network View: CHALLENGES (30)
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(2012-12-19 09:56:58) Network View: HEP (6)
(2012-12-19 09:57:53) Code Family: MONITORING AND EVALUATION OF HEP (7)
(2012-12-19 10:01:48) Network View: MONITORING AND EVALUATION OF HEP (4)
(2012-12-19 10:02:08) Code Family: POLICIES (6)
(2012-12-19 10:14:10) Network View: POLICIES (6)
(2012-12-19 10:16:11) Network View: HEPPro (7)
(2012-12-19 10:16:34) Code Family: NEEDS (27)
(2012-12-19 10:19:14) Network View: NEEDS (28)
(2012-12-19 10:23:16) Code Family: HEP BENEFITING CHILDREN (5)
(2012-12-19 10:29:46) Network View: HEP BENEFITING CHILDREN (6)
(2012-12-19 10:55:11) Code Family: SUPPORT SMT (5)
(2012-12-19 10:57:29) Network View: SUPPORT SMT (6)