The role of the teacher as a promoter of health in schools: conceptualisation and practical implications

TI Mashau

 **orcid.org/ 0000-0002-4212-7857**

Thesis submitted for the degree *Doctor Philosophiae* in *Learner Support* at the North West University

Supervisor: Dr CT Viljoen

Graduation: July 2019

Student number: 11730358

DECLARATION

I declare that: **The role of the teacher as a promoter of health in schools: conceptualisation and practical implications** is my own work and all the sources have been acknowledged. This study has not been submitted for any examination in any university.

Signed: ..... Date:……..

DEDICATION

This thesis is dedicated to:

- All teachers who are passionate about the promotion of health in schools.
- Health promoting schools which strives to be outstanding in their approach.
- My beautiful family.

ACKNOWLEDGEMENTS

The journey was long but worth it. It is befitting to honour all who were by my side during the journey of becoming one of the doctors in health promoting schools (HPS) field. In particular, I would like to thank the following:

- To the Most High God who gave me wisdom and strength to complete this masterpiece for His Glory. I am humbled.
- To the head of my household, my mentor Prof TD Mashau you have been my role model and a pillar of support to me. Throughout this journey, you supported me and never doubted my ability to succeed. Thank you very much for your love, patience and understanding.
- To my supervisor Dr CT Viljoen, thank you for believing in me even when I doubted my capabilities to carry out the task till the end. Your constant reminder that I can make it helped me throughout the project. Most of all your experience, patience and support made the journey worth exploring.
- To the University of South Africa (Unisa) that allowed me space to study through the Academic Qualification Improvement Programme (AQIP) bursary fund. I value the support. This goes to the NWU as well.
- To the Department of Basic Education (DBE), Gauteng Province for giving me permission to conduct research in schools and to the principals who gave me permission to conduct research in schools.
- To the teachers in HPS who so willingly participated in this study. Your dedication, commitment and resilience to promote health in your school made me to believe that it is possible to be health promoters as teaching practitioners.
- To my sister Lucretia who gave me support when I was in the beginning of my undergraduate study. I have made it!
- To my mother, Mrs Mudau Winnie your passion for education made me to realise that I can make it. Well done.
- To Sylvia and my children, Mulanga, Rivhusanae, Ndwela and Adaho, you were always there to give me that moral support and I could see that you were waiting for me to climb the final ladder in education so that you can clap your hands and say well done mama!

ABSTRACT

KEY WORDS: teachers; learners; schools; health; health promotion; health promoting schools; health promoter.

The purpose of the study was to **investigate how teachers conceptualise their roles as promoters of health in the schools.** Schools are good settings for promoting health. Hence, there is a need to equip teachers with knowledge and skills to promote health in schools. The role of teachers as promoters of health in schools is probably the best thing schools ever needed to respond to the emotional, social, physical, and psychological needs of learners. However, teacher professional development in the field of health promotion in schools is lacking.

The DBE in South Africa, in its efforts to prevent learners' health risks and to promote health in schools, has introduced Life Orientation (LO)/Life Skills (LS) as a vehicle to promote health. Hence, Life Orientation/Life Skills teachers are vested with the responsibility to promote health through teaching. Research has indicated not only Life Orientation/Life Skills teachers should be promoters of health in schools. Nevertheless, it should be the whole school development where all members of staff as well the general staff members and stakeholders should endeavour to improve health of learners in schools.

Teachers understanding of the five components of a HPS is still lacking; hence they only understand the activities within the HPS. The study is underpinned by two frameworks, Bronfenbrenner's ecological framework as well as the HPS conceptual framework for understanding how the role of teachers as promoters of health could possibly be. In terms of gaining permission for access in schools the ethical standard such as informed consent, confidentiality and voluntary participation were adhered to.

The research project was positioned in an interpretive research paradigm. The study used the exploratory qualitative research design. Purposive sampling approach was used to select samples of educators who were observed and later participated in the focus group interviews. For empirical research, six schools in the Gauteng Province were purposively selected because between 2006 and 2010 they were part of the HPS pilot schools project in the province and there were 20 participants who participated in the focus group interviews. Data analysis revealed that there is a gap in establishing what could be the role of teachers even when Life Orientation/Life Skills is used in schools.

The results indicated that teachers' understanding of their roles as promoters of health in schools is when they focus on teaching learners about hygiene, nutrition, body development,

and HIV/AIDS. Each school has a feeding scheme program as well as a garden which is used to supplement nutrition. The following eight themes emerged from the study on the role of teachers as promoters of health in schools. They include build partnership with parents and the community to promote health; promote learner health and well-being; responsibility of school health services; to build capacity for teachers and learners; addressing factors which affect teaching and learning; support and sustainability of the promotion of health in schools; leadership and management of health promotion in schools and the need to promote the well-being of teachers.

The study proposed a HPS teachers' framework where teachers will be able to understand that systems and the concepts of HPS were essential for the promotion of health in schools. In conclusion, teachers have the potential to promote health in schools. Therefore, it is essential for teachers to be supported to be promoters of health in schools.

OPSOMMING

SLEUTELWOORDE: onderwysers; leerders; skole; gesondheid; gesondheidsbevordering; gesondheidsbevorderende skole; gesondheidspromoter

Die doel met hierdie studie was om ondersoek in te stel na die wyse waarop onderwysyers hulle rolle as promoters van gesondheid in skole konseptualiseer. Skole word tans gesien as geskikte ruimtes waarbinne gesondheid bevorder kan word. Op grond hiervan bestaan daar ‘n behoefte om onderwysers toe te rus met die nodige kennis en vaardighede om gesondheid te bevorder in skole. Indien die onderwysers sodanig toegerus word, kan skole gesien word as ruimtes waarin die emosionele, sosiale, fisiese en psigologiese behoeftes van die leerders aangespreek word. In teenstelling met hierdie standpunt wil dit egter blyk asof die professionele ontwikkeling van die onderwyser as ‘n promoter van gesondheid in skole, ontoereikend is.

Die pogings van die Departement Basiese Onderwys om leerders se gesondheidsrisiko’s te voorkom, en om gesondheid te bevorder in skole, het gelei tot die instelling van Lewensoriëntering as voertuig om gesondheid te bevorder. Die Lewensoriënteringonderwyser het derhalwe die verantwoordelikheid gekry om gesondheid te bevorder in skole deur hulle onderrig. Navorsing dui daarop dat, nie slegs die Lewensoriënteringonderwyser nie, maar dat die skool as ‘n geheel, lede van die personeel en ander rolspelers, gesondheid van leerders behoort te bevorder in skole.

Navorsing dui verder daarop dat die onderwyser nie oor die nodige kennis beskik rakende gesondheidsbevordring in Gesondheidsbevorderende skole nie. Die gedane navorsing het as onderbou die ekologiese raamwerk van Bronfenbrenner sowel as die konseptuele raamwerk van die Gesondheidsbevorderende Skool. Beide het derhalwe gedien as verklaringsbron van hoedanig die rol van die onderwyser as promotor van gesondheid in skole gesien kan word. .

Die voorgeskrewe stappe om etiese toestemming te verkry tot toegang van die gekose skole – ingeligte toestemming, vertroulikheid en vrywillige deelname – is gedoen. Die navorsingsprojek is gedoen vanuit ‘n Interperatiewe navorsingsparadigma.

Die projek word verder gekenmerk deur ‘n verkennende kwalitatiewe navorsingsontwerp. ‘n Doelgerigte benadering is gevolg om die mees geskikte onderwysers te selekteer as deelnemers van die navorsing. Ses skole in die Gauteng Provinsie is geselekteer om deel te wees van die projek. Al ses die skole was gedurende 2006-2010 deel van ‘n loodsonersoek na Gesondheidsbevorderende skole in die Gauteng Provinsie. Twintig

onderwysers en een skoolhoof het deelgeneem aan semi-gestruktureerde onderhoude in die empiriese deel van die projek.

Uit die data-analise het duidelik geblyk dat daar gapings bestaan in die kennis en vaardighede in wat gesien kan word as die rol van die onderwyser as die promotor van gesondheid in skole. Hierdie tendens is selfs waarneembaar by die Lewensoriënteringsonderwyser. Die resultate dui verder daarop dat die onderwysers, as promotors van gesondheid, hulle rolle sien deur te fokus op die onderrig van basiese higiëne, voeding, 'n verstaan van die ontwikkeling van die liggaam en MIV/Vigs. Elkeen van die skole beskik oor 'n groentetuin waarmee die voeding by die skool ondersteun word.

Verskeie temas het na vore gekom in die navorsing wat dui op die konseptualisering van onderwysers ten opsigte van hulle rolle as promotors van gesondheid in skole. Hierdie temas is: die bou van vennootskappe met ouers en onderwysers om gesondheid te bevorder; die bevordering van gesondheid en welstand van die leerders; 'n besef van die verantwoordelikheid van skoolgesondheidsdienste; die ontwikkeling en bevordering van die kapasiteit/vermoë van onderwysers en leerders; die aanspreek van daardie faktore wat onderrig en leer kan beïnvloed; die ondersteuning en volhoubaarheid van gesondheidsbevordering in skole; die belangrikheid van leierskap en bestuur van gesondheidsbevordering in skole en die behoefte wat bestaan rondom die welstand van die onderwyser.

Die navorsingsprojek stel 'n Gesondheidsbevorende Skoolraamwerk voor wat gebruik kan word deur onderwysers in hulle pogings om die verskillende sisteme en konsepte te verstaan rakende gesondheidsbevordering in skole.

LIST OF ABBREVIATIONS

ACER	Australian Centre for Educational Research
ATP	Annual Teaching Plan
BMI	Body Mass Index
CAPS	Curriculum Assessment Policy Statement
CBO	Community Based Organisation
CDC	US Centre for Disease Control and Prevention
CSTL	Care and Support for Teaching and Learning
DBE	Department of Basic Education
DDBE	District Department of Basic Education
DBST	District Based Support Team
DoH	Department of Health
DDoH	District Department of Health
DSD	Department of Social Development
EFA	Education For All
EMIS	Education Management Information System
ENHPS	European Network of Health Promoting Schools
EPWP	Extended Public Works Programme
ESS	Education Support Services
FP	Foundation Phase
FRESH	Focusing Resources of Effective School Health
GDBE	Gauteng Department of Basic Education
GDE	Gauteng Department of Education
HP	Health Promotion
HPS	Health Promoting Schools
HSRC	Human Science Research Council
IBST	Institution Based Support Team
IECM	Information, Educational and Communication, Materials
ISHP	Integrated School Health Program
IUHPE	International Union for Health Promotion and Education
JICA	Japan International Co-operation Agency
JPTD	Junior Primary Teachers Diploma

LO/LS	Life Orientation/Life Skills
LoLT	Language of Learning and Teaching
LSEN	Learners with Special Education Needs
LTSM	Learning and Teaching Support Material
LURITS	Learner Unit Record Information Tracing System
M&E	Monitoring and Evaluation
MDG	Millennium Development Goals
MoU	Memorandum of Understanding
NCESS	National Committee for Education Support Services
NCSNET	National Commission of Special Needs
NDBE	National Department of Basic Education
NDoH	National Department of Health
NGO	Non-Governmental Organisation
NHMRC	National Health and Medical Research Council
NSHP	National School Health Policy
NSNP	National School Nutrition Programme
PDBE	Provincial Department of Basic Education
PDoH	Provincial Department of Health
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PSNP	Primary School Nutrition Programme
SACE	South African Council of Educators
SAPS	South African Police Service
SASA	South African Schools Act
SBST	School Based Support Team
SGB	School Governing Body
SHE	Schools for Health in Europe
SHN	School Health Nurse
SHP	School Health Policy
SHS	School Health Services
SIAS	Screening, Identification, Assessment and Support
SNA1	Support Needs Assessments 1

SNA2	Support Needs Assessments 2
SNP	School Nutrition Programme
SP	Senior Phase
SPTD	Senior Primary Teachers Diploma
SWOT	Strength, Weakness, Opportunity and Threats
TSTs	Teacher Support Teams
UN	United Nations
UNESCO	United Nations Organisation for Educational, Scientific and Cultural Development
UNICEF	United Nations Children's Fund
WHO	World Health Organization

TABLE OF CONTENTS

DECLARATION ..... **i**
DEDICATION ..... **ii**
ACKNOWLEDGEMENTS ..... **iii**
ABSTRACT ..... **iv**
OPSOMMING ..... **vi**
LIST OF ABBREVIATIONS ..... **viii**
TABLE OF CONTENTS ..... **xi**
LIST OF TABLES ..... **xxii**
LIST OF FIGURES ..... **xxiii**
LIST OF APPENDICES ..... **xxiv**
CHAPTER 1 **1**
INTRODUCTION AND STATEMENT OF THE RESEARCH PROBLEM **1**
1.1 INTRODUCTION **1**
1.2 BACKGROUND TO THE RESEARCH PROBLEM **3**
1.3 SIGNIFICANCE AND MOTIVATION **14**
1.4 PROBLEM STATEMENT **14**
1.5 DEMARCATION OF THE STUDY **14**
1.6 PURPOSE OF THE STUDY **15**
1.7 THEORETICAL FRAMEWORK **15**
1.7.1 Bronfenbrenner's ecological framework 15
1.7.1.1 Microsystem 18
1.7.1.2 Mesosystem 19
1.7.1.3 Exosystem 20
1.7.1.4 Macrosystems 20
1.7.1.5 Chronosystem 21
1.7.2 Bronfenbrenner's framework in education 22
1.8 CONCEPT CLARIFICATION **23**
1.8.1 Teacher 23
1.8.2 Health 24
1.8.3 Health promotion 28
1.8.3.1 Promote social responsibility for health 30

1.8.3.2 Increase investment for health development 30
1.8.3.3 Consolidate and expand partnerships for health.....31
1.8.3.4 Increase community capacity and empower the individual 31
1.8.3.5 Secure an infrastructure for health promotion.....32
1.8.4 The health promoting schools.....32
1.8.5 Health promoter 38
1.8.6 Implication.....39
1.8.7 Conceptualisation 39
1.8.8 Support systems 40
1.9 RESEARCH PARADIGM 40
1.10 RESEARCH DESIGN AND METHODOLOGY 41
1.10.1 Research design.....41
1.10.1.1 Literature review 42
1.10.1.2 Empirical research 42
1.10.1.3 Qualitative research design 42
1.10.2 Research methodology.....43
1.10.2.1 Site selection.....43
1.10.2.2 Participants.....46
1.10.2.3 Methods of data generation 47
1.10.2.3.1 Focus group interviews.....47
1.10.2.3.2 Documents.....47
1.10.2.3.3 Observations.....47
1.10.2.3.4 Data analysis 48
1.11 TRUSTWORTHINESS.....49
1.12 ETHICAL ASPECTS OF THE RESEARCH 50
1.12 STRUCTURE OF THE RESEARCH REPORT.....50
CHAPTER 2 51
HEALTH AND THE PROMOTION OF HEALTH IN SCHOOLS.....51
2.1 INTRODUCTION 51
2.1.1 Exposition of health promotion concept 52
2.1.1.1 The provision of vertical health services in schools 52
2.1.1.2 From vertical health services to integrated school health services 52
2.1.2 The rationale of health promotion 53
2.1.2.1 Equity and rights discourse.....53

2.1.2.2 Efficacy discourse 53
2.2 THE INTERNATIONAL CONTEXT OF HEALTH PROMOTION 54
2.2.1 Towards a common understanding of health promotion 54
2.2.2 The European Network of Health Promoting Schools 55
2.2.3 The World Health Organisation 56
2.2.4 Health promotion in schools 57
2.2.5 Health promoters in schools 58
2.2.6 The role of teachers as promoters of health 58
2.2.7 Health and education 59
2.3 HEALTH PROMOTION IN THE DEVELOPED AND DEVELOPING COUNTRIES 61
2.3.1 United Kingdom/Scotland 63
2.3.2 Australia 64
2.3.3 France 64
2.3.4 New Zealand 64
2.3.5 Hong Kong 64
2.3.6 India 65
2.3.7 Indonesia 65
2.3.8 Developing African countries 65
2.3.9 The need for health promoting schools 67
2.4 CONCEPTUAL FRAMEWORK 71
2.4.1 The health promoting school conceptual framework 71
2.4.1.1 School health policies 74
2.4.1.2 The physical environment of the school 75
2.4.1.3 The school's social environment 75
2.4.1.4 Community links and partnership 75
2.4.1.5 Personal health skills 76
2.4.1.6 School Health Services 77
2.4.2 The Gauteng Province in the South African context on health promotion 78
2.5 SHIFT FROM HEALTH EDUCATION TO HEALTH PROMOTION 79
2.5.1 Health promotion approach 79
2.5.2 Health promotion strategies and practices 80
2.5.3 Education as emancipation for health promotion perspective 80
2.6 SHIFT FROM HEALTH PROMOTION TO HEALTH PROMOTING SCHOOLS 82
2.6.1 The principle of health promoting schools (HPS) 84

2.6.2 Key role players in the HPS 85
2.7 SHIFT TOWARDS HEALTH PROMOTING SCHOOLS IN SOUTH AFRICA 87
2.7.1 The Constitution of South Africa 91
2.7.1.1 Health care, food, water, and social security 92
2.7.1.2 Children 92
2.7.1.3 Right to education 92
2.7.2 Policies in health promotion 94
2.7.3 SIAS Policy document 95
2.7.4 The Integrated School Health Policy (ISHP) 99
2.7.5 Education White Paper 6 100
2.7.6 Education policies and programmes 101
2.7.7 Social Development Policies 102
2.7.8 Current scenario in the implementation of school health in South Africa 102
2.7.9 Barriers in the implementation of HPS 112
2.8 HEALTH PROMOTING SCHOOLS CONCEPTUALISATION IN THE GAUTENG PROVINCE IN SOUTH AFRICA 113
2.8.1 Introduction 113
2.8.2 The nature of HPS schools in Gauteng Province 115
2.8.3 Characteristics of health promoting schools in Gauteng Province and 116
their immediate surroundings 116
2.8.3.1 School funding 117
2.8.3.2 Health services progress 118
2.8.3.3 Matters of concern regarding the school environment 119
2.8.3.4 Existing health promotion activities implemented at schools in Gauteng 120
2.8.3.5 School's health policies 121
2.8.3.6 Health related services rendered at schools 121
2.8.3.7 Collaboration with other stakeholders 123
2.8.3.8 Access of learners to nutritious food 124
2.9 IMPLICATIONS OF HEALTH PROMOTING SCHOOLS IN THE GAUTENG PROVINCE OF SOUTH AFRICA 125
2.9.1 Professional development 125
2.9.2 Resources 125
2.9.3 Collaboration 126
2.9.4 Attitudes, perception and beliefs 127

2.9.5 Vision, management and leadership....127
2.9.6 Whole school development....128
2.10 BENCHMARKS FOR EFFECTIVE SCHOOL HEALTH PROGRAMMES....131
2.10.1 A comprehensive approach....131
2.10.2 Integration....131
2.10.3 Empower learners....131
2.10.4 Supportive school policy framework....131
2.10.5 Teacher training....132
2.10.6 Collaboration with health services....132
2.11 BENEFITS OF HEALTH PROMOTING SCHOOL PROGRAMME....132
2.11.1 Skill acquisition for learners....133
2.11.2 The school's social environment....133
2.11.3 Educational outcomes....134
2.11.4 Health services....134
2.11.5 School based health policies....135
2.11.6 The school's physical environment....135
2.12 CONCLUSION....135
CHAPTER 3 137
THE TEACHER AND THE PROMOTION OF HEALTH IN SCHOOLS....137
3.1 INTRODUCTION....137
3.2 HEALTH PROMOTING SCHOOL MODELS....139
3.2.1 The Australian Health Promoting Schools Model....142
3.2.2 The New Zealand Health Promoting Schools Model....143
3.2.3 The Iceland Health Promoting Schools Model....144
3.2.4 The US Co-ordinated School Health Programme Model....145
3.2.5 The South African Health Promoting School Model....147
3.2.6 A comparison of Health Promoting School models....149
3.3 TEACHER PROFESSIONAL IDENTITIES AS PROMOTERS OF HEALTH....152
3.3.1 Teachers' beliefs and perceptions in health promotion....153
3.3.2 Teachers and the teaching of health promotion....154
3.3.3 Teaching as health promotion in service of the community....156
3.3.4 Health promotion and teachers understanding....157
3.4 TEACHERS PARTICIPATION IN HEALTH PROMOTION IN SCHOOLS....160
3.4.1 Teachers readiness for health promotion....161

3.4.2 Teachers attitude on health promotion.....163
3.4.3 Teachers' professional development and health promotion.....164
3.4.4 Teachers' relation to the school community and health promotion 166
3.4.5 Teachers' predicament in relation to health promotion 167
3.5 HEALTH PROMOTION NEEDS OF TEACHERS 168
3.5.1 Emotional needs of the teachers 168
3.5.2 Need for knowledge and skills about health promotion.....169
3.5.3 Teachers need for support in health promotion 170
3.6 TEACHER EXPERIENCES ABOUT HEALTH PROMOTION IN SCHOOLS.....172
3.6.1 Participation of teachers in health promotion is not clearly stated 173
3.6.2 Teachers confused about the elements of health promotion in school 174
3.6.3 Lack of understanding on health promotion and implementation of policies by teachers 175
3.6.4 Poor management of the health promotion programme by officials.....176
3.6.5 Lack of collaboration between the partnering departments.....177
3.6.6 Lack of synergy between stakeholders affects teachers.....179
3.7 HEALTH PROMOTION STRUCTURES AND PRACTICES 179
3.7.1 Life Orientation/Life Skills 180
3.7.2 Curriculum differentiation.....182
3.7.3 Health promotion and related topics 183
3.7.4 Resources and the promotion of health 184
3.8 THE ECOLOGICAL SYSTEM AND BARRIERS TO LEARNING IN THE HEALTH PROMOTION CONTEXT.....185
3.8.1 The microsystem.....187
3.8.2 The mesosystem.....188
3.8.3 The exosystem.....189
3.8.4 The macrosystem 190
3.8.5 The Chronosystem.....191
3.9 HEALTH PROMOTION AND THE MANIFESTATION OF BARRIERS TO LEARNING 194
3.9.1 Systemic barriers and health promotion.....198
3.9.1.1 Lack of resources.....198
3.9.1.2 Overcrowded classrooms 198
3.9.1.3 Inflexible Curriculum 199

3.9.1.3.1 Curriculum content 200
3.9.1.3.2 Teaching and learning factors 200
3.9.1.3.3 Professional development for teachers 201
3.9.1.4 A quest for relevant pedagogy 201
3.9.1.5 Lack of adequate training 202
3.9.1.6 Teacher readiness for health promotion 203
3.9.1.7 Teacher attitude 203
3.9.2 Societal barriers and health promotion 204
3.9.2.1 Lack of parental involvement 204
3.9.2.2 Substance abuse 205
3.9.2.3 Child abuse 205
3.9.2.4 Violence 206
3.9.2.5 HIV/AIDS prevalence 206
3.9.2.6 Poverty 207
3.9.3 Medical barriers and health promotion 207
3.10 CONCLUSION 208
CHAPTER 4 209
RESEARCH DESIGN AND METHODOLOGY 209
4.1 INTRODUCTION AND ORIENTATION 209
4.2 RESEARCH AIMS AND OBJECTIVES RE-EXAMINED 209
4.3 RESEARCH PARADIGM 210
4.3.1 Paradigms in research 211
4.4 RESEARCH DESIGN 213
4.5 QUALITATIVE RESEARCH 215
4.5.1 Features of qualitative research 215
4.5.2 Different types of qualitative research strategies 216
4.5.3 Phenomenology 218
4.6 POPULATION AND SAMPLING 218
4.7 THE ROLE OF THE RESEARCHER 219
4.8 DATA COLLECTION 220
4.8.1 Data collection methods 220
4.8.1.1 Focus group interviews 220
4.8.1.2 Observations 223
4.8.3.3 Document analysis 225

4.8.2 Data analysis 226
4.9 RIGOUR IN QUALITATIVE RESEARCH 228
4.9.1 Trustworthiness 228
4.9.1.1 Credibility 228
4.9.1.2 Transferability 229
4.9.1.3 Dependability 229
4.9.1.4 Confirmability 230
4.9.1.5 Authenticity 230
4.10 TRIANGULATION 230
4.11 ETHICAL CONSIDERATIONS 230
4.11.1 Permission to conduct research 231
4.11.2 Right to privacy and confidentiality 232
4.11.3 Participants' informed consent 232
4.11.4 Participants' protection from harm 233
4.11.5 Beneficence 233
4.11.6 Anonymity 234
4.11.7 Access and acceptance to the schools 234
4.12 CONCLUSION 235
CHAPTER 5 236
PRESENTATION AND DISCUSSION OF THE FINDINGS: THE ROLE OF THE TEACHER AS A PROMOTER OF HEALTH IN THE GAUTENG PROVINCE OF SOUTH AFRICA 236
5.1 INTRODUCTION 236
5.2 PROFILES OF SCHOOLS AND PARTICIPANTS 236
5.2.1 Profile of participating schools 237
5.2.2 Teachers profile 237
5.2.2.1 Participants' age 237
5.2.2.2 Participants' gender, subject, phase and grade 238
5.2.2.3 Participants' educational qualifications 238
5.2.2.4 Position of participants in school 239
5.3 DATA ANALYSIS 239
5.3.1 Analysis and discussion of findings 242
5.3.1.1 Build partnership with parents and the community to promote health 242
5.3.1.2 Promote learner health and well being 249
5.3.1.3 Responsibility of school health services 263

5.3.1.4 To build capacity for teachers and learners in the promotion of health in schools. 276
5.3.1.5 Addressing factors which affect teaching and learning 282
5.3.1.6 Support and sustainability of the promotion of health in schools 289
5.3.1.7 Leadership and management of health promotion in schools.....300
5.3.1.8 The need to promote health and well-being for teachers.....308
5.4 IMPLICATIONS FOR HEALTH PROMOTION IN SCHOOLS.....314
5.4.1 Implications for teachers.....315
5.4.2 Implications for learners.....317
5.5 CONCLUSION.....319
CHAPTER 6 323
CONCLUSIONS, FRAMEWORK FOR TEACHERS AS PROMOTERS OF HEALTH, LIMITATIONS AND RECOMMENDATIONS.....323
6.1 INTRODUCTION 323
6.2 CONCLUSIONS 323
6.2.1 Conclusions from Chapter 2: Health and the promotion of health in schools.....323
6.2.2 Conclusions from Chapter 3: The teacher and the promotion of health in schools324
6.2.3 Conclusions on Chapter 5: presentation and discussion of the findings: the role of the teacher as a promoter of health in the Gauteng Province of South Africa.....325
6.3 BRONFENBRENNER'S ECOLOGICAL FRAMEWORK AND THE ROLE OF THE TEACHER AS A PROMOTER OF HEALTH IN SCHOOLS.....326
6.3.1 The microsystem.....327
6.3.1.1 Frustrated teachers.....327
6.3.1.2 Lack of training.....328
6.3.1.3 Lack of resources.....328
6.3.1.4 Lack of parental involvement 329
6.3.1.5 Teachers not ready.....329
6.3.1.6 Inflexible curriculum 329
6.3.2 The mesosystem.....330
6.3.2.1 Lack of relationship between school and parents 330
6.3.2.2 Lack of collaboration between home and school 330
6.3.3 The exosystem.....330
6.3.3.1 Lack of commitment by the SMT.....331
6.3.3.2 Dysfunctional SBST 331

6.3.3.3 Lack of support from DBST 331
6.3.3.4 Non-involvement of the SGB 332
6.3.4 The macro system 332
6.3.4.1 Lack of collaboration between the departments 332
6.3.4.2 No leadership and management of HP 333
6.3.4.3 Policies not aligned to curriculum 333
6.3.5 The Chronosystem 334
6.4 A FRAMEWORK FOR THE TEACHER AS A PROMOTER OF HEALTH IN SCHOOLS 334
6.4.1 Proposed framework for teachers as promoters of health in schools 336
6.4.2 The framework structure 336
6.4.2.1 Partnership with the community 337
6.4.2.2 Learners' well-being 337
6.4.2.3 School health services 338
6.4.2.4 Capacity building 338
6.4.2.5 Teaching and learning 338
6.4.2.6 Sustainability of the programme 339
6.4.2.7 Leadership and management of the programme 339
6.4.2.8 Health promotion for staff 340
6.4.3 Relationship between the components of this framework 340
6.4.4 Implementing the integrated health promoting schools (HPS) framework for teachers 344
6.4.4.1 The role of the teacher in implementing the framework 344
6.4.4.2 The role of the school community in implementing the framework 345
6.5 CONTRIBUTIONS OF THE STUDY 346
6.5.1 Theory 347
6.5.2 Policy 347
6.5.3 Practice 347
6.6 LIMITATIONS TO THE STUDY 348
6.7 RECOMMENDATIONS 349
6.7.1 Recommendations for health promotion study 349
6.7.1.1 The National Department of Basic Education (NDBE) 350
6.7.1.2 The National Department of Health (NDoH) 352
6.7.1.3 Provincial Department of Basic Education (PDBE) 353

6.7.1.4 Provincial Department of Health (PDoH) 355
6.7.1.5 District Department of Basic Education (DDBE) 355
6.7.1.6 District Department of Health (DDoH) 356
6.7.1.7 Teacher training institutions 357
6.7.1.8 Schools (School Management Team) 357
6.7.1.9 Teachers 358
6.7.1.10 Policy makers 360
6.7.1.11 Stakeholders (Parents and the community) 360
6.7.2 Recommendations for further research 361
6.7.2.1 The approach to health promoting schools (HPS) 361
6.7.2.2 How stakeholders can play their roles in schools 361
6.7.2.3 Collaboration between the departments 361
6.7.2.4 Better understanding of health promotion concept to all systems levels 361
6.7.2.5 Research on non LO/LS teachers 362
6.7.2.6 Research in other Provinces of South Africa 362
6.8 REFLECTIONS ON THE STUDY 362
6.9 DISSEMINATION OF FINDINGS 363
6.10 FINAL CONCLUSION 363
7. REFERENCES 366
8. APPENDICES 408

LIST OF TABLES

TABLE 1.1: DIFFERENCES IN THE DEFINITION OF HEALTH 25
TABLE 1.2: TRADITIONAL APPROACH TO SCHOOL HEALTH VERSUS THE ENPHS. 36
TABLE 2.1: AN EXAMPLE OF THE FRESH FRAMEWORK IN DEVELOPING COUNTRIES 69
TABLE 2.2: COMPARISON OF HEALTH PROMOTION AND HEALTH PROMOTING SCHOOLS 83
TABLE 2.3: NUMBER OF LEARNERS, TEACHERS AND SCHOOLS IN THE ORDINARY SCHOOL SECTOR, BY PROVINCE, FROM 2013 TO 2015 93
TABLE 2.4: STRENGTHS, WEAKNESSES, OPPORTUNITIES AND THREATS (SWOT) ANALYSIS FOR SCHOOL HEALTH PROGRAMMES 104
TABLE 2.5: ROLES: DEPARTMENTS OF HEALTH AND BASIC EDUCATION AT NATIONAL, PROVINCIAL AND DISTRICT LEVEL 108
TABLE 3.1: INSTRUCTIONAL TIME IN THE FOUNDATION PHASE 181
TABLE 3.2: INSTRUCTIONAL TIME IN THE SENIOR PHASE 182
TABLE 3.3: HEALTH RELATED TOPICS 183
TABLE 4.1: DIFFERENT RESEARCH PARADIGMS 212
TABLE 4.2: DIFFERENT QUALITATIVE RESEARCH STRATEGIES 217
TABLE 5.1: PROFILES OF PARTICIPATING SCHOOLS 237
TABLE 5.2: PARTICIPANTS' AGE 238
TABLE 5.3: PARTICIPANTS' GENDER, SUBJECT, PHASE, AND GRADE 238
TABLE 5.4: PARTICIPANTS' EDUCATIONAL QUALIFICATION 238
TABLE 5.5: POSITION OF PARTICIPANTS IN SCHOOL 239
TABLE 5.6: THEMES AND SUB-THEMES EMERGING FROM THE EMPIRICAL STUDY 240

LIST OF FIGURES

FIGURE 1.1: A MAP OF SOUTH AFRICA DISPLAYING THE LOCATION OF THE NINE PROVINCES. 44
FIGURE 1.2: MAP OF THE GAUTENG PROVINCE 45
FIGURE 1.3: MAP OF TSHWANE DISTRICTS.....46
FIGURE 2.1: HEALTH PROMOTING SCHOOLS FRAMEWORK COMPONENTS 73
FIGURE 2.2: KEY ROLE PLAYERS IN HPS.....86
FIGURE 3.1: THE AUSTRALIAN HEALTH PROMOTING SCHOOLS MODEL 143
FIGURE 3.2: THE NEW ZEALAND HEALTH PROMOTING SCHOOLS MODEL.....144
FIGURE 3.3: THE ICELAND HEALTH PROMOTING SCHOOLS MODEL.....145
FIGURE 3.4: THE US CO-ORDINATED SCHOOL HEALTH PROGRAMME MODEL 147
FIGURE 3.5: THE SOUTH AFRICAN HEALTH PROMOTING SCHOOLS MODEL 148
FIGURE 3.6: THE BRONFENBRENNER'S ECOLOGICAL MODEL 186
FIGURE 3.7: THE MICROSYSTEM.....188
FIGURE 3.8: THE MESOSYSTEM 189
FIGURE 3.9: THE EXOSYSTEM 190
FIGURE 3.10: THE MACROSYSTEM.....191
FIGURE 3.11: THE CHRONOSYSTEM 193
FIGURE 4.1: RESEARCH METHODOLOGY SUMMARY 210
FIGURE 6.1THE ROLE OF THE TEACHER AS A PROMOTER OF HEALTH VIEWED FOM THE BRONFENBRENNER'S ECOLOGICAL MODEL.....333

LIST OF APPENDICES

APPENDIX A: PERMISSION LETTER TO THE GDE 418
APPENDIX B: LETTER FROM GDE 420
APPENDIX C: PERMISSION LETTER FROM THE DISTRICT 421
APPENDIX D: NORTH-WEST UNIVERSITY ETHICS APPROVAL 422
APPENDIX E: EXAMPLE OF FOCUS GROUP INTERVIEW QUESTIONS 423
APPENDIX F: EXAMPLE OF OBSERVATION SCHEDULE 424
APPENDIX G: DOCUMENTS RECEIVED FROM SCHOOLS.....427
APPENDIX H: LANGUAGE CLEARANCE AND EDITING CERTIFICATE 428
APPENDIX I: TURNITIN REPORT 429

CHAPTER 1
INTRODUCTION AND STATEMENT OF THE RESEARCH PROBLEM

1.1 INTRODUCTION

Good health is crucial for effective teaching and learning in schools. However, the lack of the clear role played by teachers to promote health in schools compromise the health of learners in schools. The health promotion in schools framework requires that teachers should move from their current thinking about school health to a more comprehensive perspective as it is seen as a more effective way to address school health matters (St Leger, 2006:28; Terburgh, 2015).

According to Samdal and Rowling (2013:3), the health promotion in school approach began as an initiative by the health sector, and now it is an initiative, which has been taken over and developed by the education sector to achieve optimum health for learners. According to Terburgh (2015), the role of the health promoter in the health promoting schools context is recognised by the Department of Health and Department of Education, teachers, policy makers as well learners themselves.

According to the World Health Organisation (WHO, 1996), the health promoting school is a school that is constantly strengthening its own capacity as a healthy setting for living, learning and working. This is because the changes in health are more prone to occur when they are supported by changes in environments and they are established within the framework of people's everyday lives.

The WHO (1997:5) broadens the definition of health promoting schools as "one in which all members of the school community work together to provide pupils with integrated and positive experiences and structures, which promote and protect their health. This includes both the formal and informal curriculum in health, the creation of a safe and healthy school environment, the provision of appropriate health services, and the involvement of the family and wider community in efforts to promote health." Therefore, health promotion and health promoting schools advocate for the classroom

education as an efficient vehicle for health education directed at developing personal health skills and influencing behaviour and health and a supportive school environment that promotes children's and adolescents' health and social development (Samdal, 2008).

Nevertheless, school health normally follows a top-down approach that count on centralized organizational structures (ISHP, 2012) whereas the Health Promoting Schools (HPS) approach calls for more decentralization and participation so that both the difficulty and context of each individual school are taken into account (Rowling & Jeffreys, 2000). As part of decentralisation and participation, it is asserted that the teacher is the most fundamental change agent in any country and in any school that promotes health (St Leger, 2000:82).

However, little changes will occur unless more attention is directed to what their roles could be in the promotion of health in schools and the understanding of how teachers work and what support they need (Viig & Wold, 2005:83; MacNab, 2013). In addition, some challenges need to be addressed in order to understand their roles in the promotion of health in school (Askell-Wiliams & Cefai, 2014).

Over the past decades, research focused mainly on the promotion of the health of learners in schools because it is at school where learners are in the early years of their development (Mittelmark, Kickbusch & Rootman, 2007; Cohall, Cohall, Dye, Dini, Vaughn & Coots, 2007; Johnson, Sendall & McGuaig, 2014:359) and a good setting where teachers meet learners on a daily basis. However, scant and inadequate literature specifically exists about what the teacher can do to promote health and well-being in schools (Cushman & Clelland, 2012:160).

In addition, it seems as if though the pre-service training of teachers at colleges and universities has not empowered teachers enough to play their role as promoters of health in schools (cf. the most recent work in this regard *"Factors facilitating and constraining the delivery of effective teacher training to promote health and well-being in schools: a survey of current practice and systematic review"* done by (Shepard, Dewhirst & Pickett, 2013).

The purpose of the research was to investigate how teachers conceptualise their roles as promoters of health in the schools. Firstly, the scope of the problem is presented within the context of a literature review where after the central research question is formulated; secondly, key concepts that were used in the research are clarified; thirdly, the research design and methodological matters is discussed; fourthly, ethical issues pertaining to the research were highlighted, and lastly, a tentative structure of the research is presented.

1.2 BACKGROUND TO THE RESEARCH PROBLEM

For any development in schools, teacher participation is crucial. However, there is no special instruction on how to facilitate teacher participation (West, Ainscow & Jacqui, 2005; Viig, Tjomsland & Wold, 2010; Bucharies, Alverne & Fontanele Catrib, 2013:310). The health promotion concept is a relatively new phenomenon altogether in many countries including South Africa, irrespective of the number of years since its inception (Viig, *et al*., 2010; Mashau, 2011:96). In many countries, health promotion in schools is much driven by policy and practice (Samdal & Rowling, 2013:4).

However, to enlighten teachers' perceptions concerning health promotion, research has provided a better understanding of how schools can be more effective in promoting health (Miglioretti, Velasco, Celata & Vecchio, 2012). This was summarised by the WHO through the health promoting school programme introduced more than two decades ago (WHO, 1996; The International Union for Health Promotion and Education (IUHPE), 2005).

One of the leading researchers in the field of health promotion in schools, St Leger (1998), report that teachers in Australia had little understanding and training in many health issues, let alone the challenges of the health promoting schools. Similarly, teachers in South Africa, like in Australia and other countries across the globe, have little understanding and training in many health issues as well (Mashau, 2011:181; Waggie, Laattoe & Filies, 2013:26). Furthermore, St Leger (2004) specifies that professional development for teachers should be increased and be more rigorous to equip teachers with the relevant skills to reach out to learners in schools. This should speak to how teachers conceptualise their roles as promoters of health in schools,

which can inadvertently lead to misplaced practice in the classroom (Van Hout, Foley, Mc Cormack, & Tadiff, 2012:328).

Jourdan, Samdal, Diagne and Carvalho (2008) report that the progress in initial training and education for teachers entering the profession has been slowly all over the world and not much about health promotion in schools has been done thus far. According to Rowling and Jeffreys (2006) and MacNab (2013), the understanding of the concepts health promotion in schools (single topic targeted programmes) and health promoting schools (a settings approach which includes skills, policies, environment, community and support services) is still a very unknown field and this can bring much confusion from country to country, school to school and from teacher to teacher because the concepts can be used interchangeably without synergy.

Likewise, in recent research (Mohammadi, Rowling & Nutbeam, 2010; MacNab, 2013), the participants who consisted of principals and teachers were responsible for running the health promoting school programme. These participants were asked for the clarification of what was meant by the term “health promoting school”. The majority of them responded to say it is a “holistic strategy”; “it’s just a label”; “a programme”; ”students welfare”; “health promotion in schools”; “a school that promote health”; “a strategy”; “safe and happy school”; “schools that promote health”; and “a healthy school.

Internationally, many labels and descriptions describe HPS. To some extent, it is called “whole school approach”, including “healthy schools”, “holistic”, “eco-holistic”, “universal”, “comprehensive”, “environmental”, “multi-dimensional” and “multi systemic” (Weare & Markham, 2005). For school-going children and their teachers, it can mean the absence of diseases (Hjelm, 2010:1) exercise and diet. On the contrary, it can denote a positive lifestyle to some people. In essence, health promotion is a combination of actions focused on the school health policies, physical environment, social environment, community partnerships, integrated health services, and personal health skills.

Many participants perceived the concept as too wide and general because it had multiple of explanations. One implication is that there is still confusion with regard to concepts, and that on its own opens room of doubt as to whether the roles of teachers in the promotion of health in schools is clear (St Leger, 1998).

There is growing agreement among researchers that the health promoting school is a promising framework for health promotion practice in schools (Stewart-Brown, 2006; Viig *et al*., 2010). In essence, research further indicates that many schools and countries are embracing a more holistic and integrated approach to school health as an effective strategy of health promotion in schools (National Health and Medical Research Council, 1996; Tang, Nutbeam, Aldinger, St Leger, Bundy & Hoffman, 2008).

Several studies have shown that there are programmes targeting specific health topics. These include the provision of physical activity in prevention of obesity to school-going children (Bauer & Yang, 2004; Kirk, 2006); teacher's perspectives on their possible role in the prevention of school-based programmes targeting alcohol and cannabis (van Hout, Foley, McCormack & Tardiff, 2012); effective agencies for promoting mental health (Herman *et al*., 2005; Rowling, 2003; Stewart-Brown, 2005) and sex and HIV education (Kirby, Laris & Rolleri, 2007).

Topics such as HIV/AIDS, physical education, nutrition, mental health, smoking, substance misuse, oral hygiene, violence (gangsterism) and suicide are foci that are addressed more often worldwide (Stewart-Brown, 2006). Most importantly, other scholars report that intervention on various issues affecting children in schools may be effective in changing health behaviours (Hargreaves, 1994; Davidson, 2007; Tang *et al*., 2008). However, the gap remains that other health issues were neglected in a way.

Internationally, the health promoting schools, as an all-encompassing framework, is being acknowledged as the most promising in changing students' knowledge and skills towards more optimal functioning (Shung-King, 2013:896; Clelland, Cushman & Hawkins, 2013). In a way, health promoting schools are about creating a supportive setting for the purpose of teaching and learning (Bloch, Toft, Reinbach, Clausen,

Mikkelsen, Poulsen & Jensen, 2014) by optimising the health of school-going children by addressing the health barriers to learning and to enhance the learning potential (Shung-King, 2013:896).

It is not only limited to the traditional health education approach, which addresses the cross-curricular topic of health through subjects such as Physical Education, Social Sciences, Physical Sciences, Home Economics, Life Sciences and Life Orientation (Jourdan, Samdal, Diagne & Carvalho, 2008). It is a shift though; from standalone health education to health promotion across many schools and it placed the responsibility on schools, teachers, and management to foster environments, relationships, and policies that sustains Health Promoting Schools (Taylor, Quinn, Littledyke & Coll, 2012).

Nevertheless, health education has been part of schools for some time (Flaschberger, 2012). It has been viewed as part of health promotion because it aims to improve health literacy (Nutbeam, 1998; Peterson, Cooper & Laid, 2001), yet a growing trend confirms that health education alone was not enough to meet health needs of people, and learners in particular (Denmann, Moon, Parsons & Stears, 2002). Schools have been utilised as institutions that can have an impact on the lives of school-going children for a long time mainly because learners are frequently considered the main target group for implementation of the health promoting school (Tjomsland, 2010:10; Samdal & Rowling, 2013).

The school's influence in promoting health in the lives of school children is a holistic approach, which views health in all dimensions. These dimensions include physical, social, emotional, intellectual, and spiritual (Edlin & Golanty, 2007; Hales, 2009). They are critical elements in learners' academic achievement (Kwatubana & Kheswa, 2014:1713). The WHO describes the school as a priority setting in health promotion since it meets young people during formative years of their development (Mittelmark, Kickbusch & Rootman, 2007).

According to leading theorists, Donald, Lazarus and Lolwana (1997:24) as well as the World Health Organisation (1996), health promotion includes, but means more than promoting physical health. It means promoting all those dimensions of development

including the environment, which together contribute to positive, competent and confident persons.

According to Jourdan, *et al*., (2008); McEnvoy and Welker (2000), the promotion of positive health-related behaviour is necessary to children's health and behaviour since the adult morbidity and mortality is owing to behavioural patterns established during childhood and adolescence.

Schooling is an environment through which communities prepare their young for future life and careers. However, ill health and other challenges still prevent many children from growing into productive, capable citizens who can assist their communities to grow and prosper (ISHP, 2012; Terburgh, 2015). Besides this, it is a common experience for children worldwide as millions and millions of children attend schools either primary or secondary school (Miglioretti, Velasco, Celata & Vecchio, 2012).

Nevertheless, the schooling experience differs depending on many reasons such as the context of the school, type of buildings, the experience of learning, teachers, type of classrooms, nutrition, health, humiliation, bullying and violence encounter in the hands of teachers and fellow learners (UNICEF, 2008). In addition, these conditions can be much worse if teachers are not competent enough to guide learners on how to deal with this state of affairs. Hence, schools would have to provide an ideal setting to enhance learners' health-related behaviours, health and subjective well-being (Bloch, *et al*., 2014:15).

In many countries, there is a great concern about the relationship between poor health and learning and this calls for schools to counteract challenging trends and development in the lives of children (Tang *et al.,* 2008). Learning goes along with teaching, which is mainly done by teachers in schools. Be it public, private or special school, the most important fact is that the school is a workplace for teachers. Hence, the aim of the school health services to optimise health of school-going children by addressing health barriers to learning, and thereby enhance their learning potential (Clelland *et al.,* 2013: 896). This whole process requires supportive settings and the acquisition of individual skills by teachers (Lindström & Nilsson, 1998; Van Niekerk & Prins, 2001:244; Rooth, 2005:9).

Teachers' behaviour and subjective well-being play an important role for the quality of their job and their motivation to get involved in roles with health objectives (Jourdan, *et al*., 2008). In addition, Rosas, Case and Tholstrup (2009) suggest that good health can maximize learning. Similarly Marx, Wooley and Northrop (1998) and Jourdan, *et al*. (2008) also confirm that health and learning are linked together in a way that poor health is a precursor to under achievement while positive health generally enhances the opportunity to performing better in school (Peterson, Cooper & Laird, 2001).

In schools, health promotion can be seen to have key objectives that are meant to complement and overlap each other. These objectives are firstly promoting the health and well-being of all the representatives of the school community, and second maximising a good learning environment suitable for effective teaching and learning. Put differently, learners who are satisfied with their school and who perceive themselves as experiencing good health, will have greater interest and potential to concentrate on learning tasks in school (Marx *et al*., 1998).

Similarly, teachers who are satisfied in their workplace are able to influence the learners and can exert more energy to fulfil their teaching roles in the most possible way (Marx *et al.,* 1998; St Leger, 2006:28). The fundamental role of the school is teaching and learning (South African Schools Act, 1996), which is the third objective of health promotion in schools, to improve learners' skills in caring for themselves as well as others (Kickbusch, 1989:14).

There are strong links between health and education and that is what scientific debates also focus on (Flaschberger, 2012) since they affect each other (Suhrcke & de Paz Nieves, 2011). Therefore, to achieve progress in advancing both educational and health goals, greater attention needs to be given to a more holistic approach in health promotion guidelines (Samdal & Rowling, 2013:7). In addition, more emphasis should be placed on those characteristics of the school environment that may have an impact on both academic achievement and school commitment, as well as an impact on health-related behaviours and subjective well-being.

In its aims towards the Global School Health Initiative, the WHO intends to promote the health of learners, school staff, families, and other members of the community through schools (St Leger, Young, Blanchard & Perry, 2010; DoH, 2011). The main objective of this initiative was to increase the number of health promoting schools, which constantly strengthens their capacity as healthy settings for living, learning and working (Bloch *et al*., 2014:15). This confirms that they were building on the Ottawa Charter, which postulates that health is created and lived by people within the settings of their everyday life; where they learn, work, play and love (WHO, 1986:3).

According to Samdal and Rowling (2013), there are varying degrees as to what needs to be, and can be done, to respond to the call of the international network of health promoting schools. In this case, in Poland and United Kingdom, the national approaches taken from within the networks have a great influence on the direct work with individual school by establishing national networks of health promoting schools. Nordic countries such as Denmark, Iceland, Sweden, Finland and Norway utilise policy strategies to initiate actions in schools through integrating the concept of health promoting schools in relevant policies and the national school curriculum. In each country, the main determinant of success could be the extent to which health education and health promotion have been the core elements in the curriculum (Kickbusch, 2003). For example, in Australia and the Scandinavian countries, health education and health promotion are compulsory curriculum areas (Samdal & Rowling, 2013).

The opposite is the case in the Netherlands. Their health-related issues in schools are mainly dealt with by health professionals to a point where a stronger link between the health sector and education has been encouraged (Leurs, Bessems, Schaalma & de Vries, 2007) and the same applies to South Africa where health issues in schools are attended by school health nurse (South Africa: 2012; Shung-King, 2013:896).

Given the national and international differences when it comes to the implementation of health promotion in schools programmes, teachers could not be held responsible if they could think of school health in terms of curriculum. This is because basically they have little understanding of what could be their role, and how community partnerships

might function since they have little training in health issues (St Leger, 1998; Shung-King, 2013; Kwatubana & Kheswa, 2014:1718).

Despite the growing importance of health promotion in schools, only few studies focus on teachers' understanding of the concept (Chan, 2007; Chan & Kitzman, 2010) and specifically not on the roles they ought to play. When it comes to the role teachers can play in promoting health, many schools are facing an enormous dilemma, basically because they are expected to engage in continuous renewal and change in curriculum and the expectations are demanding for teachers (Rowling & Samdal, 2011; Kwatubana & Kheswa, 2014).

The difficulty can be assumed that teacher training in South Africa is not adequate to be able to respond to the health promotion in schools programme (Kwatubana & Kheswa, 2014) and the way the programme has been organised does not give room for teachers to actively participate in health promotion schools programmes since the health professionals are in the fore front (Kwatubana & Kheswa, 2014). Consequently, before teachers could be fully involved in the health promotion in school, there is a need to analyse and assess skills and attitude and more importantly, their training in relation to health promotion (Davidson, 2007; Marks, 2009). This applies as well to the levels of support, which have been designed from top to bottom (St Leger, 2006:28; Samdal & Rowling, 2013; Mohlabi, Van Aswegen & Mokoena, 2010: 250) from the national, to the provincial and finally to the district level and then given to schools as School Based Support Team (SBST) (Department of Education, 2002a:10). This resulted in a system that is more likely to retain the status quo repeatedly (Jourdan, Pommier, & Quidu, 2010; Jourdan, McNamara, Simar, Geary & Pommier, 2010; Speller *et al.,* 2012; Shepard, Dewhirst, Pickett, Byrne, Speller, Grace, Almond, Hartwell & Roderick, 2013; Macnab, 2013; Waggie, Laattoe & Filies, 2013:26; Macnab, Gagnon & Stewart, 2014; Askell-Wiliams & Cefai, 2014).

The international call for action in schools in terms of health promotion recommends building the capabilities for teachers to further sustain health promotion in schools (Tang *et al.,* 2008; Gugglberger & Dűr, 2011). This is because teachers who have received training in health promotion in schools programmes are more likely to be involved in health promotion activities in schools and personal competence and

motivation have an effect on the amount of health promotion embarked on (Leurs, Bessems, Schaalma & de Vries, 2007).

However, the study by Waggie *et al.,* (2013) report that teachers are not yet synthesised into the health promoting schools model as they did not perceive themselves in a way that they can help solve health problems encountered by learners. The experience of schools has been that the emphasis on health promotion stimulates the development of a good learning environment. Similarly, there is a relationship between health promotion aims and school aims (Tjomsland, Iversen & Wold, 2009; Samdal, Viig & Wold, 2010).

On the African continent, the concept of health promoting schools initiative has been introduced to at least 32 countries, which through decades have struggled to initiate the programmes (Mashau, 2011). Nevertheless, Africa has joined the programme of HPS at a time when there is a high escalation and concern for the health and well-being of school-going children (Mashau, 2011:3). Schools are concerned about the state of health of their learners and, there are diseases, learning difficulties and learning disabilities, which are beyond teachers' understanding of learners, and only known to health practitioners (Mohlabi, Van Aswagen & Mokoena, 2010).

According to various researchers (Fullan, 2007; Kidger, Gunnell, Biddle, Campbell & Donovan, 2010; Young, St Leger & Buijs, 2013), the teacher can be seen as a gatekeeper; the main agent of change within and outside the classroom environment. It literally means that the role of a teacher in the lives of learners cannot be stressed enough to show the need to promote their health since they are consistently encountering challenges one after the other (DoH, 2000a:1).

These complications include drug abuse, poor nutrition, teenage pregnancy, high drop-out rate, HIV/AIDS, psychological problems, depression and suicide, tuberculosis, etc. (Donald, Dawes & Louw, 2000; Department of Education, 2002b; DoH, 2011; Mashau, 2011; ISHP, 2012). Learners spend most of their times in schools where they are in contact with teachers who are able to influence them in one way or the other. Against this background, the school is regarded as a very good setting to promote the health of learners and their well-being (WHO, 2000; Mohlabi *et al*., 2010).

In South Africa, health promotion is at a stage wherein people are not aware or even understand what it entails within their communities and even at schools (Mohlabi *et al*., 2010), let alone a teacher as a promoter of health. According to research done by Mashau (2011:110), Speller *et al.,* (2010) and Waggie *et al.,* (2013), it was clear that even teachers were confused about the concept health, health promotion as well as health promoting schools. On the same note, research conducted in selected Gauteng integrated health service schools by Kwatubana and Kheswa, (2014:1716) was almost impossible since "No one in the school had any information about nurses rendering these services at their schools".

Many professionals would agree that a teacher should focus on a class-based curriculum. However, they may not be cognisant that the teacher, in many instances, should develop appropriate school health policies, enhancing the social environment and linking with relevant community agencies as well as producing better health outcomes for learners (Lawrence, 1998:224).Teachers' confusion with the concept could possibly be because health promotion in schools and health promoting schools are addressed and described differently and interchangeably in various leading documents (Mashau, 2011:83; Nutbeam, 1992; WHO, 1996; Weare & Markham, 2005).

Change in schools largely depends on what teachers do and think (McRae, 1988; Fullan, 2001:115), and if they were driving and owning the change (Fullan, 1993). This really showed that there was a weak link to the teacher's role in health promotion in schools or health promoting schools (Jourdan *et al*., 2008).

Research conducted indicate that teachers' experience was that they were overburdened with responsibilities, teaching their particular subjects in the class, administration, extra-curricular activities, meetings and workshops (Swart & Pettipher, 1999; Engelbrecht & Green, 2001; Macnab, 2013:2; Samdal & Rowling, 2013). According to Schmidt and Datnow (2005), teachers were seen as people who oppose change partially because of the constant overload imposed on them by the Department of Education and other systems, which require their attention and time. In contrast, Fullan (1993:23) notes that "the main problem in public education is not

resistance to change, but the presence of too many innovations, mandated or adopted uncritically and superficially on an *ad hoc* fragmented basis".

Based on the phenomenon of the study, health promotion is a very complicated topic to deal with in the education domain (Miglioretti, 2012). However, it has been found that learners and teachers who were healthy teach and learn better (Marx *et al*., 1998). The focus on teachers gave this topic a tremendous challenge because the programme itself was more focused on the theory; topic-based and focuses on learners rather than focusing on how teachers can contribute in the promotion of health for learners (Mohamed, 2015; Quirke, 2015). Teachers see health promotion as an initiative that is hard to tackle, merely because teachers think it increases their workload (Marx *et al.,* 1998).

Besides teachers' perception on health promotion as more of responsibilities, other obstacles hindered the effectiveness of health promotion globally as Heaton (2014) stated. These obstacles range from lack of skills and knowledge and the concept application by health promoters (WHO, 2006). Lack of dissemination of knowledge contributes to low establishment of the concept as the activities were only planned in the health sector only; and that they were viewed in a negative manner (Macnab, 2014). In addition, Macnab (2014) indicates that other obstacles include slow professionalism and lack of clearly defined responsibilities, especially in the training of health promoters as well as the collaboration between the departments.

The health promoting schools movement is taking place in schools. Hence, there is a need to have health promoters in schools to promote health in schools (Gugglburger & Dür, 2010). However, there are different views concerning the skills and knowledge required for one to qualify as a promoter of health. Moreover, health promoters within the school in the form of teachers are seen as key health promotion since they can bridge the gap that exists among the departments, parents and the community (WHO, 2000; Wyn *et al*., 2000). The difficulty in understanding health promotion concept in schools, as well as the understanding of what could be the role of a teacher as a promoter of health makes it challenging to reach out to learners' health and well-being (Gugglberger & Inchley, 2012; St Leger, 2006). It was this gap, where the researcher

would like to find out what could be the role of the teacher as a promoter of health in schools.

1.3 SIGNIFICANCE AND MOTIVATION

According to McMillan and Schumacher (2006) the significance of a study justify the reasons for the researcher's choice of a particular phenomenon. In addition a rationale increases generalisability of the study and extends the empirical research as it focuses on recent issues. The researcher chose the role of teacher as a promoter of health in schools as an educator. This was prompted by the researcher study which was done on a Master level where she wanted to find out how parents can promote their children health in school. Looking deeper into the health promotion in schools, the researcher became aware of the gap in addressing health needs of learners by teachers in the school. The proposed framework for teachers in the school would provide a model on which teachers could base their actions and interventions to promote health in the school.

1.4 PROBLEM STATEMENT

The literature reviewed has indicated that little was known concerning health promoters in schools since this is the responsibility of the school health services where nurses are in the forefront. Their health promoter role is critical as they need to enable people to take charge of their health (Tjomsland *et al*., 2009). Nevertheless, health promoters' perception of health and health promotion is not distinct. Against the above literature review, the research question that guided the project is as follows:

- How do teachers conceptualise their roles as promoters of health in the schools?

The following sub-questions directed the research endeavour:

- How do teachers perceive health and health promotion in schools?
- How do teachers in their pedagogical practice promote health in the school?
- What could be presented as a possible framework for the teacher as a promoter of health in the school?

1.5 DEMARCATION OF THE STUDY

This study focused on the role of the teacher as a promoter of health in schools in selected districts in the Gauteng Province of South Africa. It was limited to health

promoting schools only. Owing to the limited nature of the investigation in terms of the context covered, the findings may be generalizable only to health promoting schools.

1.6 PURPOSE OF THE STUDY

The primary aim of the research project was to:

- **Investigate how teachers conceptualise their roles as promoters of health in the schools.**

The following secondary aims also gave direction to the research endeavour:

- an exploration of how teachers perceive health and health promotion in schools;
- understanding of how teachers in their pedagogical practice promote health in the school; and
- the presentation of a possible framework for the teacher as a promoter of health in the school.

1.7 THEORETICAL FRAMEWORK

A theoretical framework is a lens used in research through which the results can be interpreted (Maree, 2012:34), as it clarifies the connections between the phenomenon under study by providing insights which will probably lead to the discovery of new connections (Tudge, Mokrova, Hatfield & Karnik, 2009). In a way, the theoretical framework is a set of ideas and concepts that have been organised to tell us about the world, ourselves and other features of reality (Landsberg *et al*., 2005:9). In addition, it also provides an overview of perspectives, research results with reference to the topic.

The theoretical framework also provides the researcher with the necessary platform to plan the study based on existing ideas in the field (Maree, 2012:34). The research aim was to investigate what could be the role of the teacher as a promoters of health in schools. In order to understand the role of the teacher, Bronfenbrenner's (1979) systemic ecological framework has been utilised for the study.

1.7.1 Bronfenbrenner's ecological framework

Bronfenbrenner's ecological framework defines health as an interaction between an individual and the environment (Quirke, 2015). This framework allowed space for a better and complex understanding of both social and physical interactions settings in

the development of a child. Moreover, the framework enables critical role players to become empowered and to identify the strength and needs of the various systems (Hay, 2009) because they contribute directly or indirectly in the promotion of health in schools. This applies to qualitative study because there are questions asked. In this instance, the Bronfenbrenner's ecological theory has been applied in order to investigate the role of teachers as promoters of health in schools.

It has been argued that Bronfenbrenner's ecological framework goes beyond the individual-environment relationship that interacts with each other as the individual develops (Bronfenbrenner & Morris, 2006). According to Donald *et al.,* (2010) and Spilt *et al*., (2011), the proximal interaction can be a long-term relationship between a parent and a learner. In addition, a teacher and a learner can be affected by the person factor and the social context. Against this background, this theoretical framework was deemed relevant in this study ultimately because it give emphasis to the interaction between the individual's development and the systems within the general social context where health is promoted (Donald *et al.,* 2010; Quirke, 2015).

These levels are important in the sense that whatever happens in one system affects and is affected by the other (Landsberg *et al.,* 2005:10; Nel *et al.,* 2013). Therefore, Bronfenbrenner's theory affirms that the ecology of human development involves the scientific study of the progressive, mutual accommodation between active, the growing human being and the changing properties of the immediate settings in which the developing person lives. This process is affected by the relationship between settings and by the larger context in which the settings are embedded (Bronfenbrenner, 1979:21).

The human behaviour, attitude, experiences and motives cannot be understood outside their context (Quirke, 2015). However, the greatest conundrum in education system lies in the understanding of how the levels interact and influence the individual learner (Landsberg *et al.,* 2005:9; Donald *et al.,* 2010). For instance, if the understanding at all levels in the environment is unlikely, there will be challenges that will affect schools and teachers in particular. Hence, the teachers are regarded to be the most valuable resource as the promoters of health in schools (Jourdan, 2016).

Because of the amount of health challenges learners experience in schools, radical change of attitude for teachers is needed (Donald *et al.,* 2010). Owing to the nature of schools where the proposed intervention was suggested, some schools may not have the capacity of promoting health because teachers are ignorant of the initiative (Jourdan, 2011). However, inviting teachers to be involved comes with a challenge that the health promotion initiative might be standardised or just be a preventative practice (Quirke, 2015).

The description of the framework has assisted in the understanding of health in the educational context. To attain a better understanding on the importance of these systems theory in this research, the levels in the environment as they were outlined by Bronfenbrenner (1979) were discussed thoroughly in the sections below. The core principle of the Bronfenbrenner's systems theory is its interrelated nature of contexts (1979), where for instance teachers, school environment, cluster, district, provincial departments, national departments, support services, resources might be substantial in explaining the experiences for teachers to execute their roles as promoters of health. The gap in the collaboration between the departments in a way has affected how teachers promote health in schools.

According to this theory, things that happen in one part of the system can affect other parts, and ultimately, the ecological system as a whole (Donald *et al.,* 2010:37). Therefore, the ecological theory was used to explain how the negative/positive interactions in the five interacting systems influence children in terms of health in schools. The purpose of the study was to investigate how teachers conceptualise their roles as promoters of health in the schools.

It is vital for schools to consider the entire context in which learners exist. However, it has been a common misunderstanding for schools to focus solely on the impact of school programmes on learners rather than the family, school, the community as well as the peers (Henderson & Mapp, 2002; Duerden & Witt, 2010). The changing nature of teachers' job over time challenges how they will give support to learners in school, in this case, the promotion of health.

In this study, the ecosystemic perspective, which has evolved out of the blend of ecological perspective of Bronfenbrenner (1979:21) and the systems theory, was utilised as it affirms the HPS settings approach. In addition, the latter posits that ecology of human development involves the scientific study of the progressive, mutual accommodation between an active, growing human being and the changing properties of the immediate settings in which the developing person lives. This process is affected by relations between the settings, and by the larger context in which the settings are embedded.

Frederick and Clive (2002) describe Bronfenbrenner's ecology theory in terms of five levels that overlaps each other. In addition, these levels are microsystem, the mesosystem, exosystem, macrosystem, and the chronosystem.

1.7.1.1 Microsystem

According to Landsberg *et al.,* (2005:11), a microsystem is defined as the immediate environments where an individual develops. It is characterised by those events and individuals closest to a person's life (Nel *et al.,* 2013). The immediate environment relationship with which the child interacts includes the immediate family, school, neighbourhood, and the day care centre (Donald *et al.,* 2010). The modus operandi among the levels in the environment has an impact on how the child develops (Landsberg, 2011; *Nel et al*., 2013; Ntagungira, 2014). If the environment is enabling, then it is easier and healthier for the child to grow within such environment.

To expand the microsystem further on the school level, there are quite a number of things which are involved in the development of a child. These include the teachers, learners, the principal, curriculum, classroom interaction with peers and teachers, the pedagogy of teaching, the school environment, the condition of the physical classroom, the quantity, and the quality of the interpersonal and intrapersonal relationships, and the learning environment.

Above all this, the teacher is the most important person who interacts with the child face-to-face on a daily basis (Nel *et al.,* 2013). In essence, the micro system support the learner's feeling of belonging in the school setting where Landsberg *et al.* (2011) argue that there could be risk factors within the school, which can affect the

development of a learner. As confirmed by Lerner (2005), these factors could be child-headed families, substance abuse and homelessness.

1.7.1.2 Mesosystem

There is a close relationship between the microsystem and the mesosystem where the systems interact with each other (Nel *et al.,* 2013). In the microsystem, the child appears in one setting which is the home, and it is the home which handles the relationship between home and school and the neighbourhood as well (Landsberg *et al.,* 2011). According to Bronfenbrenner (1979), the church, camp and workplace are part of this system. Therefore, a mesosystem is a set of microsystems associated with one another in a sense that what happens in the immediate environment can influence how children respond at school (Donald *et al.,* 2000; 2002).

This close relationship in the micro and mesosystem helps in scrutinizing how the interaction between the school and the family can highly contribute to learning and teaching (Ntagungira, 2014). This is because the mesosystem expands and the child develops in the territory by forming new relations and joining other settings outside the microsystem settings. If the shift is not handled well owing to the understanding of health promotion in schools among teachers and parents is not well known and therefore it can cause confusion when it comes to assisting children in schools (Mashau, 2011; Bronfenbrenner, 1979: 25).

Cushman and Clelland (2012) note the challenges that can be brought about by other elements in the system. The consistency on how health promotion programmes should be handled in schools by teachers is not well established, which can mean that whatever happens in the national, province, district, and school can affect the manner in which the teachers play their roles as promoters of health in school (Terburgh, 2015). In the mesosystem, learners who have troublesome upbringing owing to unsupportive child-headed families if they do not receive emotional support from their teachers it can escalate to barriers to learning (Lean & Collucci, 2010; Landsberg *et al.,* 2011; Terburgh, 2015; Haider *et al*., 2018).

Similarly, it can also mean that depending on the needs of schools, learners can also experience different successes depending on their teachers' attitude towards the

programme (Hay, 2009). However, if the learners could receive support from their teachers, it can boost their self-esteem and sense of security.

1.7.1.3 Exosystem

According to Bronfenbrenner (1979: 25), the exosystem consists of the structures that have an impact in the child's mesosystem and have the ripple effects on the child although it does not affect the child directly (Landsberg *et al.,* 2011). These structures include the community, the School Governing Body (SGB), health care facilities, employment, and the communication network, which in turn, influence the mesosystem and the microsystem and contains the settings that do not involve the developing person as an active participant (Nel *et al.,* 2013). Swart *et al.* (2004: 11) confirm that the exosystem is where an individual is not directly involved as an active participant. However, it may influence or be influenced by what happens in the environment.

This speaks clearly to the children who are affected by whatever arrangement done in schools, although they are not participating directly (Donald *et al.,* 2010). Teachers and children in schools are affected by several challenges that happen in the exosystem. These things as identified by Yorke (2008:52) include the education system, health services, parents' socio-economic status, community organization, social development, and the resources that are not readily available to schools and the issue of equity when it comes to resource distribution. Many countries have good policies. Nevertheless, they lack implementation strategy (Mohamed, 2015).

1.7.1.4 Macrosystems

According to Swart and Pettipher (2005:11), a macrosystem is defined as the cultural, ideological and institutional contexts in which all the systems are intertwined; one cannot exist without the other. According to Donald *et al*. (2010), attitude, beliefs in the society's system and culture may have an impact or be influenced by other systems. This could include humanity, social justice and democracy. Teachers' attitude and beliefs can have a positive or a negative influence on the promotion of health in school (Leahy *et al*., 2016). Policies that are developed from a national department can have a critical impact on how teachers can be promoters of health in schools because if

they lack the pedagogy where teachers can participate fully, it could create a great confusion.

1.7.1.5 Chronosystem

The fifth system, which is the chronosystem, was later developed and it symbolises change over time, not only in the characteristics of the child as a person, but also the environment which the child lives in (Bronfenbrenner, 1992). This may include the changes over the years in the family structure where one parent can die or divorce and children will be under the care of a guardian or be a child-headed family, the socio-economic status, poverty, unemployment, and the place of residence (Donald *et al.,* 2010; Hay, 2009).

In this case, the chronosystem includes the developmental time frames that link the thread in the relationship between all the levels and how they influence the individual development. Similar to this, the role of teachers as promoters of health in schools will receive attention as to how it covers learners in schools in the midst of curriculum and political changes.

The Bronfenbrenner's eco-systemic theory focuses on the understanding of the role of teachers as promoters of the health basically from the complex interconnected eco systemic point of view in the social context (Donald *et al.,* 2002). It allows the understanding of the role of teachers from a broader perspective not only as Life Orientation teachers and Life Skills. It connects the school, family, community, and the broader society. According to Swartz (2007), the interconnection between the systems can contribute to effective teaching and learning or create barriers to learning for children.

Children are mainly affected basically because human being's development does not happen in vacuum. However, it occurs in ever changing context such as homes, family and schools (Donald *et al*., 2010), which according to Bronfenbrenner is referred to as microsystems. The chronosystem can also be used as a frame of reference to determine the attitude, knowledge and skills of both learners and teachers before health promotion in schools was implemented and after.

1.7.2 Bronfenbrenner's framework in education

Bronfenbrenner's framework is very much relevant in this study because learners do not exist outside their surrounding systems; hence, the education system, the school, teachers as well as the curriculum determine their academic success (Jourdan, 2016; Leahy *et al.,* 2016). Education is central around children and there are systems that contribute to their development as they have already been mentioned above. However, it is much more important in how they interact. Learners in their learning can present a number of dysfunctional elements, which then interferes with teaching and learning.

These elements can be social, emotional, physical, and psychological depending on how the systems in their development integrated. *Nel et al.,* (2013), Donald *et al.,* (2010) and Landsberg *et al.* (2005) noticed that what occurs in one system could affect the child directly or indirectly. The dynamics of relationships perfectly suit the various social and physical levels of interaction in education (Engelbrecht *et al.,* 2003).

Schools have a greater influence in the society (Marx *et al.,* 1998), and the attention concerning intervention programmes in the school level can have a greater impact in the broader societal context where the interaction of different levels can be used (Herman *et al.,* 2004). The perception and experience of the environment is very important as it creates the feeling of happiness, joy and excitement. Hay (2009) argues that people create their perception based on the reality of things as well the experiences to which they have been subjected.

The practice of HPS approach was done in schools and teachers were expected to be involved. Hence, they were adamant about the ambiguity that the programme could bring in the education domain (Mohammed, 2015). However, their perception was not determined by the resources and training they might have gone through (Wevers, 2012). However, its dependence was on whether the training has met their expectation or not (Jourdan *et al*., 2008). Therefore, the researcher considers the teacher as the most valuable asset of the school as it has been mentioned in Marx *et al*. (1998).

In the microsystems, the school is the most important context in which interactions are intensified and the children's experiences influence the development. In a way,

schools need to provide an enabling environment for learning (Bronfenbrenner, 1979). The understanding of the school as an enabling environment for learning is further extended in the mesosystem where the school is perceived as the open system that interacts with the stakeholders in the other systems, and together they contribute to the health and well-being of children, teachers and their communities (Renwick, 2006).

1.8 CONCEPT CLARIFICATION

The following concepts are central to the project's definitions and a description is provided as an effort to create a common understanding.

1.8.1 Teacher

Over the years, the teacher has been defined as someone who promotes learning and provides for a setting suitable to learning and not merely teaches the learners (Bastable, Gramet, Jacobs, & Sopczyk, 2011:13). However, Lawson and Flocke (2009) assert that a teacher is someone who creates a teachable moment unlike to wait for it to happen, but to actively involve learners in the process of education (Bodeinheimer *et al.,* 2002).

Niemann and Monyai (2012:6) view the role of a teacher as the mediator of learning rather than a transmitter of knowledge. This is strengthened by the theory of constructivism, which rather perceives learning as individualised, social and occurs within context. To strengthen this theory, Niemann and Monyai (2012:7) indicate the specific implications for the teacher as a mediator of learning, which implies the following:

- Learners are actively involved;
- Learners should be at the centre of teaching activities;
- Learners should be helped to learn;
- Opportunities for knowledge construction should be created;
- Creating a real world environment;
- Opportunities for reflective practices;
- Opportunities for constructing knowledge through social negotiation; and lastly
- Multiple representations of reality should be allowed.

The aspects mentioned above give a broader perspective of the definition of a teacher as it was explained by a constructivism theory where the teacher constructs meaning in the learning context (Vygotsky, 1931). For the purpose of this study the definition of the teacher as someone who promotes learning and provides a setting suitable to learning will be used.

1.8.2 Health

Health in itself is a complex term (Marx *et al*., 1998), which depends on the context where it is applied (Mashau, 2011). According to WHO (1984), health is defined as the state of complete physical, social and mental well-being and not merely the absence of disease. Over decades ago, health has been defined under the spectacles of medical terms, which mean being free from diseases and ill health as well as the being in good shape. The table below outlines the major differences in the definition of health.

Table 1.1: Differences in the definition of health

Traditional approach to health	World Health Organisation view of health
The absence of disease.	Positive well-being.
Physical well-being.	Physical, mental and social - about the body, mind and the surrounding context.
The concern mainly of doctors.	The concern of everyone. Includes educational approaches e.g. learning knowledge, attitudes and skills. Includes social change.
The goal is a perfect state of health.	The goal is to help people be as healthy as they want to be – health as a resource for living, not an end in itself.
Health is a matter for individuals – it is entirely up to each of us how healthy we are and if we are not it is our own fault.	Health is influenced by our environment and people need to be supported and given opportunities to be healthy.
Health is improved mainly by medical intervention and lifestyle changes by individuals.	Health is improved mainly through health promotion, helping create social and physical environments that support health, and empowering people to take their own decisions to help them to be as healthy as they want to be. It involves action for social change, increasing social equality, and increasing democratic participation.

Source: Gray, Young & Barnekow, 2006

The traditional approach of health and the definition by WHO (1986; 1996; 1999) show a huge gap in the understanding of health concept. The traditional approach of health is very limited to an individual's health whereas the exposition by WHO is much wider. In line with the WHO definition of health, the social context defines health as the capacity of the body to carry the demands made by the social environment. Moreover, this could mean that if the body is unable to carry on the tasks required by the environment; therefore, it is not healthy.

The different views on health have also impacted rather in a negative way on the manner in which people are regarded as healthy. The definition by WHO (1984; 2006:1) is where health is explained as the "state of complete physical, mental and social well-being and not the absence of disease and infirmity" can resemble a limited scope of health as it may recommend that the slightest weakness in one's body can mean that a person is not healthy.

However, health should be seen in a holistic manner in which a number of factors should be seen as the contributors of health, which enables the person to or cannot perform the task at hand (Marx *et al*., 1998). These factors include the physical, emotional, intellectual, spiritual, and the social settings in one's life. To maximise the potential, these factors cannot be emphasised in silos, one over the other. Essentially, health should be seen in a holistic manner, which encompasses all of life. In conjunction, they contribute to a better health of an individual.

Therefore, the complete state of health should be seen as the one where all factors of health are in a state of balance for the purpose of human existence. The balance of health factors was well presented by Lucas and Lloyd (2005):

- **Spiritual health** promotes an awareness that contribute to the identification and empowerment of values, which includes inter alia hope, perseverance, patience, kindness, and compassion. Spirituality focuses on the morals, values and ethics to balance existence in human beings.
- **Mental health** bases the attention on the ability to apply the intellectual effect, the reasoning power of a human being.
- **Emotional health** deals with the ability to express emotion and to manage stress in an appropriate manner. It also takes account of the sense of belonging and being in harmony with the surroundings.
- **Physical health** is mainly the absence of disease in one's life and the ability to complete various tasks at hand.
- **Social health** is determined by the surrounding, which also plays a greater role in determining whether one is healthy, or not.

All in all health can be defined in various contexts and mean different things to that particular context (Marx *et al*., 1998). In a way, there is no simple given definition of health, which can suffice the understanding of what it can mean at that time. According to Renwick (2006), health has been regarded as a very important element of human understanding. However, if all the factors of health were taken into consideration, the meaning and the interpretation can be easier to understand even when the health concept has to be applied in schools by teachers.

The growth and development of the western medicine in modern times, which was characterised by failure of body parts in one's body, would call for medical intervention. The ancient Greeks viewed health as a very important thing, whereas the Indians view health as harmony with self as well as the nature (Karstens, 2010). In contrast, the ancient Chinese believed that health was a reflection of the important body force that was derived from cosmic energy (Edelman & Mandle, 1990). Therefore, it can be concluded that the ancient define health in the view of life and living and the medical model defines health as illness in the body.

The promotion of health in schools places health as the main vehicle to achieve complete health for children as a resource that is created in the context of everyday life (Kickbush, 2003:383; WHO, 1986). In line with the revised Global School Health Initiative by the World Health Organisation (WHO), "health is directly linked to educational achievement, quality of life and economic productivity (WHO, 1998:1) and this is confirmed by (Samdal, *et al*., 2010; Samdal & Rowling, 2013:141). The explanation by Renwick though defines health as resource for everyday life than being the purpose of life (Renwick, 2006).

This implies that health is a social concept since it does not happen in isolation of the context (Kickbusch, 1989). In addition, the health and well-being of individuals is derived from their social context in relationship with other structures (Kickbusch, 1981; Tjomsland, 2010). In conclusion for the purpose of this study the holistic approach to health will be adopted because it is believed that a number of factors contribute to the health of an individual. In this case the health of learners in schools.

1.8.3 Health promotion

The definition of health promotion is certainly derived from the definition of health and it was defined in many different ways (Marx *et al*., 1998). The Ottawa Charter defines "health promotion as a process of enabling people to increase control over, and improve their health" (Donald, et al., 2002:137; WHO, 1986), whereas Green and Kreuter (1991) define health promotion "as any combination of health education and related organisation, economic and environmental supports for behaviour conducive to health and well-being". Meanwhile, Raeburn and Rootman (1998) delineate health promotion as concerned with positive health and well-being; involving the whole of life such as the complex notion of body, mental, social and spiritual states, and the fact that it is a process linked to everyday life and community. The view in this salutogenic approach implies the consolidation of people's health potential and that good health is a means to a prolific and pleasant life (Becker, Glascoff & Felts, 2010; Renwick, 2006).

The concept of health promotion emerged as a broader, settings-based approach, which focuses mainly on changing living conditions to allow people to make precise decisions regarding their health (Denmann *et al.,* 2002; Flaschberger, 2012). Consequently, it involves a shift from practices that are mainly classroom-based health education model to a more all-inclusive, incorporated construct of health promotion (Deschesness, Martin, & Hill, 2003) in the school. The settings-based approach to health promotion was introduced into settings like hospitals and universities, and schools became a focus for health promotion in the broader community (WHO, 1986; Poland, Krupa & McCall, 2009).

The expansion of health promotion therefore consists of actions that guide, motivate and educate individuals to take good decisions to improve and to increase control over their health (WHO, 2006). Most importantly, the goal of health promotion is to reduce the differences in health status and to promote equity in health in order for people to achieve their fullest health potential. The most integral part in this definition is the notion of empowerment, which focuses on health promotion as a commitment to giving power to the individuals so that they have greater control over their health (Quirke, 2015).

In other words, health promotion encourages people to re-think their ways of thinking about health towards a comprehensive attitude of health and well-being (Strydom, 2011). In addition, previously health has been viewed as an individual matter that can only be taken care of by the health professionals. However, in health promotion, the focus has shifted to health as a community responsibility. According to Terburgh (2015), health is seen as a resource for everyday where there is emphasis on the social and personal resources as well as the physical capacity. Consequently, health promotion goes beyond a healthy lifestyle to well-being and not the responsibility of the health sector only.

Health promotion encourages people to make a paradigm shift from previous ways of thinking about health towards a holistic attitude of health and well-being. Previously, according to WHO (2009), the control of factors that determine one's health is essential for individuals to achieve their fullest health potential. Therefore, the determinants of health include an enabling environment, which supports health through the access to information, life skills and opportunities to making healthy choices (UNICEF, 2004; Renwick, 2006; Jourdan *et al*., 2016).

In a way, human rights are fundamental to health promotion and a critical concern for equity and empowerment (The Constitution of the Republic of South Africa, 1996). According to Davies and McDowall (2006:20), it has the following characteristics:

- Health promotion is a process – a means to an end;
- Health promotion is enabling – done by, with and for people, not imposed upon them; and
- Health promotion is directed towards improving control over the determinants of health.

According to WHO (2009), health promotion in schools is not only about motivating children to exercise or to eat healthy food. It is much broader in a sense that it includes the promotion of physical, social, spiritual, mental, and emotional well-being of learners and staff. It is a whole school approach where research indicated that health promotion should be seen both as a means to improve health and as a way of helping learners to succeed in their schooling (Jourdan, 2011).

This study will therefore adopt the definition where health promotion is viewed as a process of enabling people to increase control over and to improve their health.

Nonetheless, since the primary duty of the school is not to improve learners' health, therefore the promotion of health in schools is not the easiest thing to accomplish. It will therefore require consideration of the nature of the school environment and in particular, the manner in which teachers perceive their own role in health and social well-being of learners. According to (Davies & McDowall, 2006:22), in line with the five components of HPS, the development of the 21st century priorities were to:

1.8.3.1 Promote social responsibility for health

According to the DBE (2011), the policy-makers decisively need to commit to social responsibility where public and private sectors should promote health by endorsing policies and practices that do the following:

- Avoid harming the health of individuals;
- Protect the environment and ensure sustainable use of resources;
- Restrict production of and trade in inherently harmful goods and substances such as tobacco and armaments, as well as discourage unhealthy marketing practices;
- Safeguard both the citizen in the marketplace and the individual in the workplace; and
- Include equity-focused health impact assessments as an integral part of policy development.

1.8.3.2 Increase investment for health development

Health is a very important aspect of life expectancy. However, in many countries, current investment in health is inadequate and often ineffective (Ntagungira, 2014). Likely, the best approach to increase investment for health development requires various sectors to collaborate in the accumulation of additional resources for education and housing as well as for the health sector. Research findings have proven that greater investment for health and reorientation of existing investments has the potential to achieve significant progress in human development, health and quality of life (Leahy *et al*., 2016). In line with global health for all, investments for health should

reflect the needs of particular groups such as women, children, older people, and indigenous, poor and marginalised populations.

1.8.3.3 Consolidate and expand partnerships for health

Partnership for health promotion is necessary between the different sectors (Mohamed, 2015; Roux, 2013). This covers all levels of governance and society. The partnership was said to be transparent and accountable and should be based on agreed ethical principles, mutual understanding and respect. Therefore, existing partnerships need to be strengthened and the potential for new partnerships must be explored further. The implications about partnerships are that they offer mutual benefit for health through the sharing of expertise, skills and resources; hence, the WHO guidelines should be adhered to (WHO, 1986).

1.8.3.4 Increase community capacity and empower the individual

The element of empowering the community is very critical. According to Deschesness, Trudeau, and Ke´Be (2010), the intention of HPS is to build capacity of the school by focusing on all stakeholders for the purpose of developing them as partners who then will participate in the development of HPS. In addition, to make it sustainable, their empowerment will bring about the whole school change. However, health promotion should be carried out by and with people, not on or to people (Marx *et al*; 1998). This error can hamper the development of health promotion in schools if it is carried to people; in this case, if it is carried to teachers for implementation purposes. If it is done properly, then it improves both the ability of individuals to take action, and the capacity of groups, organisations or communities to influence the determinants of health.

Road shows and workshops have been used as the way to take health promotion to the communities (Renwick, 2006). But, most importantly, improving the capacity of communities for health promotion requires practical education, leadership training, and access to resources, which seem to be the most obstacles when it comes to promoting health in communities as well (Mohamed, 2015). Again, empowering individuals demands more consistent, reliable access to the decision-making process and the skills and knowledge essential to effect change. Both traditional communication and the new information media support this process. Social, cultural and spiritual resources need to be harnessed in innovative ways.

1.8.3.5 Secure an infrastructure for health promotion

Effective health promotion would not be possible if proper infrastructure is not available and in place. Therefore, to secure an infrastructure for health promotion, new mechanisms for funding it locally, nationally and globally must be found (Marx *et al*., 1998). Motivations to influence the actions of governments, non-governmental organizations, educational institutions, and the private sector are needed to make sure that resource mobilisation for health promotion is maximized should be developed (Jourdan, 2011). The 'settings for health' represent the organisational base of the infrastructure required for health promotion.

The development of new health challenges would also mean that new and diverse networks need to be created to achieve all-inclusive collaboration of sectors (Johnson & Lazarus, 2003). Such collaboration in networks should provide mutual assistance within and among countries and enable exchange of information on which policies have proved to be effective (Terburgh, 2015). The training and practice of local leadership skills should be encouraged for the purpose of supporting health promotion activities. Documentation of experiences in health promotion through research and project reporting should be enhanced to improve planning, implementation and evaluation. All countries should develop the appropriate political, legal, educational, socio-economic environments required to support health promotion.

1.8.4 The health promoting schools

The HPS are defined as those that aim at achieving healthy lifestyles for the total school population by developing supportive environments conducive for the promotion of health (WHO, 1993:1; WHO, 1995). In addition, HPS are defined as those that constantly strengthen their capacity as a healthy setting for living, learning and working (UNESCO, 1998; WHO, 2009). This is done by providing school health education, which enhances learners' understanding of the dynamics that influence their health and enabling them to make healthy choices and to embrace healthy behaviours in their lives (Donald *et al*., 2010).

HPS aim to achieve, "health lifestyles for the total school population by developing supportive environments conducive to the promotion of health. It offers opportunities

for, and requires commitments to, the provision of a safe and health enhancing social and physical environment" (WHO, 1993:3).To achieve that, the health promoting schools' objectives entail the improvement of collaboration of health promoting schools across the school community, and between the school and the external stakeholders; the adoption of both social and physical environment of the school through management structures and the development of policies; as well as the improvement of curriculum and school activities to address the health needs of learners in schools (Denman *et al*., 2002).

In a broader sense, Health Promoting Schools are defined as those that:

- Promote health and learning by utilising all the resources available in schools;
- Involve both health and education stakeholders, including teachers, learners, parents, health providers as well as the community leaders in an effort to make the school a healthy and better place to teach and learn;
- Endeavour to establish a healthy environment, school health education, and school health services along with community projects, promote health promotion programmes for staff, nutrition as well as food safety programmes;
- Again, it creates opportunities for physical education and recreation, counselling programmes, social support and mental health promotion; and
- Drives policies and practices that respect human rights and dignity, and to provide multiple opportunities for success.

Regional networks of health promoting schools have been set up in Europe, Australia, the Western Pacific, and Latin America (Samdal & Rowling, 2013) to stimulate the development of health promotion in schools (Kickbush, 2003). To support the implementation of health promoting school initiative worldwide, the European Network of Health Promoting Schools (ENHPS), which is known as Schools for Health in Europe (SHE), has established a network of health promoting schools in over 37 countries (McDonald & Ziglio, 1994; Samdal, 2008; Schools for Health in Europe (SHE), 2013). There is a significant growth in the health promoting schools programme in many countries and this implies that teachers also have a greater task to tackle in their day-to-day responsibility in school (St Leger, 2006; Frantz, 2015:2). However, it has to be remembered that in many schools, teachers feel overwhelmed with the continuous supply of prevention programmes, especially because some of them are

faced with an overcrowded classrooms, inflexible curriculum and very limited opportunities to implement those programmes (Peters, Kok & Ten Dam, 2009). Unfortunately, they also do not possess skills and abilities required to carry out the task (Miglioretti *et al.,* 2012).

According to Kickbusch (1989), the notion of promoting health in schools emerged out of the settings approach and because of the growing appreciation, the local environment is significant in shaping and reinforcing health in schools (Renwick, 2006; Weare, 2000; Stewart-Brown, 2006) in the sense that this is where learners and staff learn, teach and play. According to Denman *et al*., (2002), the set primary objectives of the health promoting schools are basically to improve the collaboration across the school, the community and the external agencies; to adapt the social and physical environment of the school by developing policies and strengthening the management structures as well as to improve curriculum and the school activities. Irrespective of the set objectives and the potential of HPS, the use of schools as sites for health promoting schools comes up with challenges where current evaluation results in literature shows that there is still as few in number and inconclusive as to how it is implemented globally (Deschesness, Martin & Hill, 2003).

The Health Promoting Schools in its approach tries to improve the health of school staff, families and community members and learners as well; and also works with community leaders to help them understand how the community contributes to, or undermines, health and education (Marx *et al*., 1998).

From the literature, there are components that characterise the health promoting school. According to Booth and Samdal (1997) and Parsons *et al*. (1996), these components are the formal health curriculum, which gives learners the essential knowledge and skills that will allow them to take reasonable choice affecting their emotional, physical, and social health. The components also include the school environment that covers the physical and social health, the health services and policies of the school as well as the school and community interaction.

According to Samdal and Rowling (2013), the HPS focus on the most basic aspects of health. These include taking care of self and others; taking control and making

healthy decisions over life circumstances; initiating conditions that are favourable to health through policies, services and social conditions; creating capacities for peace, shelter, education, food, income, a stable ecosystem, equity, social justice, sustainable development; preventing leading causes of death, disease and disability (WHO, 1996). These also include helminths, tobacco use, HIV/AIDS/STDs, sedentary lifestyle, drugs and alcohol, violence and injuries, unhealthy nutrition as well as influencing health-related behaviours such as knowledge, beliefs, skills, attitudes, values, and support (Terburgh, 2015).

The HPS approach requires rigorous change in how schools and their staff practice school health (Deschesness *et al*., 2003). In addition, this implies moving from classroom-based health education to a more integrated health promotion that focuses on children attitudes and behaviours and their environment (Jourdan, 2011). It is in schools where there is paradigm clash between health and education, and socio-ecological and medical framework as well as between health practitioners and education practitioners.

Every child has the right to be educated in a conducive environment (Bruce, Klein & Keleher, 2012). This is a school characterised by “constantly strengthening capacity as a healthy setting for living, learning and working” (WHO, 1998:2). In particular, the health promoting school aims to achieve healthy lifestyles for the total school population mainly be developing environments, which are supportive to the promotion of health in schools. According to Donald *et al*., (2002), the HPS offers opportunities that requires commitment to the provision of safe and health enhancing social and physical environment (Day & Gu, 2010).

Learners with barriers to learning need to be cared for in an environment where they are shown respect and support by their teachers. However, lack of understanding that HPS aim to support learners’ needs at schools could put teachers in an unlikely position where they are seen to be unwilling to develop a school system, which is in the favour of children (Mohamed, 2015; Terburgh, 2015).
However, the European Network of Health Promoting School (ENHPS) extends their view and dimensions of a HPS and this is displayed on the table below.

Table 1.2: Traditional approach to school health versus the ENPHS.

Traditional, moralistic approach to school health	**Health-promoting school approach - according to the ENHPS**
Focus on individuals e.g. on their health problems, on his or her 'healthy habits' and lifestyles.	A 'settings' approach - focuses on the totality of the school as an organisation in its community, all staff and all pupils. Developing a school health policy.
Focus mainly on physical health. Physical activity seen as linked only to sport.	Focus on mental, emotional and social health as well as physical health. Physical activity seen as beneficial for all, and as being fun and enjoyable.
Health as the absence of disease and problems. Focus on illness, diagnosis and treatment.	Health as positive well-being; focuses on the quality of life, on prevention of health problems and promotion of positive mental, social and physical health.
Health education seen as a value free approach.	Health promotion based on explicit principles e.g. democracy, equity, participation.
Short-term response to events, often 'crisis management'.	Long-term, developmental approach, which starts early, for all children and meets their stage of development, needs and interests.
Concept of health education	
The focus is changing behaviour, developing healthy habits and lifestyles: conformity and obedience.	The focus is on autonomy and decision-making.People decide for themselves how and to what extent they wish to be healthy.
Health education taught as separate lessons.	Health education integrated across the curriculum.
Curriculum aims to teach knowledge.	Curriculum aims to help pupils learn skills and attitudes as well as

	knowledge. The objective is increasing action competence.
Moralising: the teacher decides. Teacher-centred methods, often with lectures on 'good health'. Learners generally passive.	Student participation in decisions. The focus is on learning rather than teaching, and on active methods involving group work, discussion, games, simulations, problem solving, taking action etc.
Emphasis on negative "messages", warnings and inducing fear.	Emphasis on positive methods, the advantages of being healthy, choice and decision-making.
The whole school	
Teachers not part of the process or seen as role models in a moralistic sense.	Teachers' mental, emotional and social health is as important as pupils. Teacher support and training is essential.
Only certain parts of the physical environment of the school seen as related to health e.g. gymnasiums, sanatoriums.	Whole physical environment – classrooms, corridors, playgrounds, toilets, healthy eating, routes to school - seen as affecting health.
Links with the community	
Experts from the community are involved in the school or class.	The school and pupils participate in society and function as partners in dialogue; pupils take action and are taken seriously.
Outside agencies used for referral of children with problems and difficulties.	Outside agencies actively involved with whole schoolwork.
Parents and community ignored or asked to 'support' the school.	Parents and the wider community actively involved e.g. in decision making, and there is a programme of out of school activities.
Evaluation	

Measuring pupils' behaviour related to smoking, alcohol etc.	Measuring pupils' action competence (thinking, commitment and vision).
Action based on 'what has always been done'.	Action based on evidence of what is more likely to work and on evaluation.

Source: Gray, Young & Barnekow, 2006

The ENHPS concept of health is not only focused on individual teachers or experts to be involved. However, the environment plays a huge role with the purpose of empowering all those who are involved in the health of children in schools. Teachers who are not receiving any support from all other stakeholders cannot be passionate to be involved in promoting the health of children (Mohamed, 2015). The development of skills, knowledge and attitude is important for both stakeholders to make informed decisions about their health (Quirke, 2015). The ENHPS is not stagnant. It is a process where evaluation takes place regularly to determine what works and adopt the positive strategies, hence ENPHS has been substituted by SHE.

1.8.5 Health promoter

A health promoter is a person or organisation that helps something to happen, develops, or increases. Conceptually, a promoter is someone who can act as an organiser, agent, sponsor, advocate, supporter, developer, backer or even advertiser (MacMillan Education, 2007). Therefore, a health promoter refers to someone who is in a position to empower people to increase control over, and to improve their situation (Terburgh, 2015).

Basically, a health promoter plans and ensures that policies are implemented within a particular setting. In addition, a health promoter work to ensure that effective practice is accomplished by building capacity, giving support as well as enabling a range of interventions to deliver health improvement programmes. In essence, health promoters are committed to confront inequalities in health and to promote anti-discriminatory practice (Mormot, 2005; AGCAS, 2012).

1.8.6 Implication

Implication is defined as a possible result of an action (Oxford Advanced Learners' Dictionary, 2000). Moreover, Your Dictionary (2013) defines implications as something which inference may be drawn depending on the understanding.

1.8.7 Conceptualisation

Conceptualisation entails arranging and generating an idea, and to formulate it mentally. In addition, conceptualisation is the formulation of an idea about what something should work (McMillan Education, 2007). In this study, it is important to conceptualise how teachers could play their role in schools as promoters of health. Over a number of instances, the definition of a health promoter in a school setting is more focused on trained individuals who work outside school but providing health services in schools. Terburgh (2015) and le Roux (2017) conducted an extensive research regarding health promoters and their roles indicated that a health promoter is someone who provides services to the community by bridging the gap between the health service providers and the community. These health promoters also provide their health services in schools.

In the study by Kwatubana and Kheswa (2014), it was found that teachers were reluctant to participate in the promotion of health because of how they view school health services. St Leger (1998) indicates that teachers were reluctant because they view health promotion as the responsibility of the health department. The same sentiment was shared by Mohlabi *et al*., (2010) that teachers were not participating in the promotion of health in schools. Because children are experiencing health challenges in schools now than before (Fathi *et al*., 2014), it is crucial that teachers should be promoters of health in schools in their capacity as teaching practitioners.

An extensive research in schools has indicated that schools are the perfect setting to promote health of learners, teachers and the community (Mukoma & Flischer, 2004; Jourdan *et al*., 2010a; Preiser, 2014; Tjomsland, 2009). However, if teachers are not participating in the promotion of health in schools, there could be challenges that can affect the rendering of services in schools as well as the sustainability of health promotion in schools. St Leger (1998) found that teachers do not see themselves as

promoters of health in schools; hence, they do not have a relationship with health promoters who visit their school.

It was found that instead of providing the school health service providers who visit their schools by accommodating them, teachers would not provide classrooms for screening (Kwatubana & Kheswa, 2014). According to the DoH (2011), schools are supposed to provide school health nurses with accommodation. Although teachers are worried by health challenges faced by learners in schools, their attitude against those who provide such services in schools will always hamper the development of health promotion in schools. On the other hand, there is a need to understand that teachers do not have any training in terms of providing health in schools. This is conceptualised in terms of their knowledge and skills, which are inadequate to promote health in schools.

Although teachers are not trained to promote health in schools, but on the basis that they spend more time with learners in schools, it is crucial that their role as promoters of health in schools should be investigated.

1.8.8 Support systems

Support systems in a school refers to infrastructure, resources (financial, human) and pedagogical resources available to support teachers and learners to realise the goal of health promotion in school. In addition, the Department of Education (2003:10) and Sweden (2009:11) define support systems as the following:

- Direct learning support for learners who experience barriers to learning;
- On-going support and training for teachers to respond to the learners needs;
- Curriculum development in response to learners different needs; and
- Provision of Learning and Teaching Support Material (LTSM) and equipment to facilitate learning.

1.9 RESEARCH PARADIGM

The study was positioned in an interpretive research paradigm. As such, the researcher realised that observation was fallible and that all theory was revisable (Henning, Van Rensburg & Smit, 2005:19). The research endeavour is also social

constructivist in the sense that the lived experiences and interactions of the teachers, and the engagement of the researcher, were central to the meanings attached.

Ontologically, the interpretive paradigm presupposes multiple realities where individuals (read: teachers as promoters of health in schools) create their own meaning and interpretation of ideas, events, results thereof, etc. Epistemologically, evidence were gathered concerning the role of teachers as promoters of health by engaging as closely as possible with them. Moreover, the "knowledge systems" (Henning, *et al.*, 2005:20) of the teachers were interrogated so that the manner in which they were creating meaning was understood as clearly as possible.

Axiologically, the researcher was aware of the values and bias as well as the value-laden nature of the data to be gathered. The mere fact that the researcher was ever present in the "field" is acknowledged in the sense that, whatever the outcome of the project, it is a product of the interpretation and presentation of the participants as well as the researcher. The interpretive paradigm also presupposes *methodological* considerations. Therefore, the logic that was followed in the research project can be described as inductive from the ground up (read: teachers' perspectives), rather than handed down to them.

1.10 RESEARCH DESIGN AND METHODOLOGY

The aim of this research was to investigate the role of teachers as promoters of health in schools. The research methods and design that were used are discussed briefly. A detailed discussion of the research methodology was given in Chapter Four.

1.10.1 Research design

The research design can be seen as an integral part of the research project. In a sense, it represents the fundamental plan of the project. Various issues need to be addressed when the design of the project is considered. These include the following: strategy, conceptual framework, the topic to be researched, and the tools and data collecting and analysing procedures (Henning *et al.,* 2005:4). The following research design was followed:

1.10.1.1 Literature review

An extensive literature review on health, health promotion, HPS, role of teachers and support structures available for teachers was conducted to provide the theoretical basis for the study. National and International sources were located by means of literature search to obtain the relevant sources.

1.10.1.2 Empirical research

The empirical research was done in six health promoting school in the Tshwane Districts of the Gauteng Province in South Africa. Focus group interviews were conducted with 19 teachers and one principal which brought the number to 20 participants. Throughout the researcher's visit, there were observations that were continuously going on with regard to the actions and events, which were related to health promotion in schools. For the purpose of this study, documents were also analysed.

1.10.1.3 Qualitative research design

The research study was qualitative in nature and the strategy used was phenomenology (De Vos, Strydom, Fouchė & Delport, 2011:270). According to Creswell (1998:15), "… a qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants and conducts the study in a natural setting."

A qualitative exploratory research design was used owing to the fact that very little was known about a group of people or phenomenon (i.e. the teacher as a promoter of health in schools). For the purposes of this study, an exploratory qualitative research design provided a window on how teachers conceptualise and practically act as promoters of health in schools.

According to Leedy and Ormrod (2010), qualitative research will enable the researcher to do the following:

- Gain new insight about the role of teachers as promoters of health in schools;

- Develop new concepts or theoretical perspective about the role of teachers as promoters of health in schools;
- Discover the problems that exist regarding the role of teachers as promoters of health in schools; and
- Provide means through which the researcher can judge the effectiveness of health policies and practices regarding the role of teachers as promoters of health in schools

Emphasis was placed on the examination of the perspectives and experiences of teachers, pertaining to the promotion of health in schools. Their current experiences and perceptions concerning themselves as promoters of health were also explored.

1.10.2 Research methodology

1.10.2.1 Site selection

The sites that were visited include the six HPS in the Gauteng Province of South Africa. The reason why the researcher chose Gauteng Province is because she resides and works in the province.

In addition, the other reason is because of the co-operation between the National DoH and the Government of Japan through the Japan International Co-operation Agency (JICA) to facilitate the implementation of the HPS concept in primary schools in Gauteng Province (JICA) (2007:2) as it was identified as the target area that requires improvement in the area of community health.

These schools are HPS and were declared as such by the Gauteng Education Department in collaboration with the Gauteng DoH and Social Development. Components such as the development of LTSM as well as Information, Educational and Communication Materials (IECM) in the five health programme areas were implemented in the health promoting primary schools with the aim to complement and support the teachers and schools to teach the learners healthy behaviours as well as suggest engagement activities for the school and communities (Sizanang Centre for Research and Development, 2006). Generally, the majority of the surrounding areas of the schools are impoverished, even though the surroundings range from informal settlements to urban settings (Roux, 2013:125). However, this research positioned its

focus in six HPS, which were in different settlements (formal settlement where there are proper houses, informal settlement where there are shacks and it is overcrowded as well as the farm settlements where there are farms around) in the Gauteng Province.

Figure 1.1: A map of South Africa displaying the location of the nine Provinces.



Source: SA-VENUES.com.online

Figure 1.2: Map of the Gauteng Province



Source: SA-VENUES.com.online

The map in Figure 1.2 shows the Gauteng Province where the research in HPS was done. This is the smallest province of 18 176 km square area in South Africa with approximately a population of 14.3 million people in 2017. Urbanisation, migration and search for greener pastures in the Gauteng province has led to the overpopulation of the province where communities are prone to be the breeding ground of a number of social ills, the reason why the pilot project to prevent illness among children in schools was held in this province first (Roux, 2013).

Below is the map where most research took place in schools around the Tshwane Metropolitan with Tshwane South District, Tshwane West District, Tshwane East District. The distance between schools was approximately 15 kilometres apart from each other and that enabled the schools to interact on a number of occasions.

Figure 1.3: Map of Tshwane Districts



Source: https://www.google.co.za/url?

1.10.2.2 Participants

The main motivation for the research project is the people. Therefore, the sampling procedure known as purposive sampling was used (Henning *et al.,* 2005:71-72). The basic assumption of purposive sampling is that people should be part of the project that fit the criteria of desirable participants.

The participants in the project were permanently employed teachers from the six schools declared by the Gauteng DBE as HPS - in the Gauteng Province of South Africa. These teachers had at least been teaching for five years or more. In total, there were six focus group interviews consisting out of twenty participants (N=20). If it was necessary and data saturation was not reached, further focus group interviews were going to be conducted. By inviting the teachers to participate hopefully an

invitational research culture was established that can have a positive effect in terms of participation to the research.

1.10.2.3 Methods of data generation

1.10.2.3.1 Focus group interviews

A focus group interview is a planned, relaxed and naturalistic dialogue among a small group of people on a specific topic (Israel & Galindo-Gonzalez, 2011, Rubin & Rubin, 1995). According to Morse and Niehaus (2009:90), focus groups are very efficient ways to elicit opinions or to develop an initial understanding of an area. Henning *et al.,* (2005:70) describe the dialogue as "wandering together with" the participants. Focus groups were used to explore the participants' opinions and constructions concerning the research problem. The six HPS in the Gauteng Province of South Africa were combined for the purpose of the research project. Six focus group interviews were conducted at the HPS. For the purpose of this research English language was used.

1.10.2.3.2 Documents

Various policy documents that underpin health promotion were analysed. This embraces key legislation and policies as well as international, regional and national initiatives, which govern and influence health promotion in schools. These documents are viewed as entities of data (Henning *et al.,* 2005:98) and were utilised along the other methods of data generation.

1.10.2.3.3 Observations

Observations or "talk-in-interaction" were to assist in the comprehension of the views held by the participants (Henning *et al.,* 2005:90). Observations are done to help the researcher understand and learn more about other perspectives held by the participants (Creswell & Plano, 2011; Creswell, 2014). In the empirical study, observations were made during the focus groups and during informal conversations and interactions with the participants. Further, the observations acted as flexible engagements with teachers for data collection, listing topics of interest and providing space to record notes about new themes that might emerge during observation.

In addition, some time was spent with the teachers in their classes to observe their interactions with learners, fellow teachers and other members of the school community. More qualitative observation schedules act as flexible guidelines for data collection, listing topics of interest and providing space to record notes about new themes that emerge during observation.

1.10.2.3.4 Data analysis

Qualitative data analysis can be described as the process of obtaining meaning from the data acquired during the data collection stage (Holliday, 2002; Silverman, 2005:5-14). It entails a progressive movement of reading, rereading and identifying themes and categories.

Immediately after the focus group interviews the recordings were transcribed. After all focus group interviews had been transcribed the formal thematic analysis began. Creswell (1998:102); Smith, Flowers and Larkin (2009:82-101) as well as Braun and Clark (2013) provide guidelines that were to be followed in the data analysis strategy.

The first stage was to read and re-read the transcriptions of the focus group interviews and to listen to the audio recordings of the teachers of the schools (Leedy & Ormrod, 2010). The main focus here was to search for information that is salient and that could be noted. The second stage was to involve the initial coding. The challenge was to search for key words, phrases and constructions by the teachers concerning their role as a promoter of health in the school. The manner in which the teachers were using body language to share their experiences and constructions about health promotion was also written down.

Stage three was to involve the development of emerging themes. Salient and highlighted phrases were grouped together and were accompanied by the verbatim exploratory comments and excerpts. From this the researcher made interpretations in order to gain an integrated understanding. During stage four, the researcher looked for possible connections across the emergent themes. During this action, themes were clustered together to reflect the nature of which the teacher can be a promoter of health in the school.

The number of times that a particular theme occurred in the responses of the teachers were tabulated. Through this action, the researcher was able to identify the relevant emerging themes. Finally, the findings of the qualitative analysis were discussed by means of a literature control.

1.11 TRUSTWORTHINESS

In qualitative research, it is important to ensure trustworthiness. According to Shenton (2004:64) and Tracy (2010:839) four criteria need to be addressed.

The first criterion is ***credibility***. Credibility seeks to establish whether there is a correspondence between the way researchers portray their viewpoints and the way respondents actually perceived social constructs (Mertens,1998:182). To ensure credibility, the researcher familiarised herself with the participating schools before the data collection process started. The focus group interviews were transcribed, and in using verbatim data transcriptions, a more reliable conclusion was drawn. The raw data (transcriptions of the focus group interviews) were included in the final report in order to provide a trail of evidence (Cohen & Morrison, 2006).

The second criterion is ***transferability***. Transferability refers to whether findings of a study can be applied to other participants or in different contexts and relies on the possibility that data may be representative of the broader population (Babbie & Mouton, 2001). In this study, certain trends in the manner teachers are promoting health in schools may be transferred to other schools in the country.

The third criterion is ***dependability***, which means that if the study were repeated with the same participants and the same methods similar results would be achieved. In order to ascertain this as far as possible, the researcher described the data collection and analysis process in some detail (Shenton, 2004:71).

The final criterion is ***confirmability***, which suggests data interpretation, and findings of the research are not the creation of the researcher and that the data as well as the interpretations can be related to its sources (Mertens, 1998:184; Tracy, 2010:840). In this study, the responses were quoted extensively to rule out possible presuppositions of the researcher.

1.12 ETHICAL ASPECTS OF THE RESEARCH

The research project was conducted according to the ethical requirements of the Research Ethics Committee of the North West University (ethical clearance number: 00183-16-A2) as well as the GDE.

Permission for conducting the research was sought from the GDE and the School Governing Bodies and principals of the respective schools. A consent letter was distributed to the participants.

Further, all aspects of the research project (background, methodology, data generation, data analysis, etc.) were explained to the participants at the outset of the project. Only after all the participants had a clear understanding and grasp of the project as a whole, the research proceeded. Written consent was requested from all the participants. Time was also given to explain to the participants that their participation is voluntary and that they can withdraw from the project at any stage without permission and/or providing reasons for doing so (Creswell, 2014). It was also emphasised that participants could withdraw from the research without any fear of being penalised in any way for doing so.

The researcher also stressed the importance of confidentiality and provided the assurance to the participants that their personal identities and those of their schools, learners and parents were not to be disclosed in any way.

1.12 STRUCTURE OF THE RESEARCH REPORT

Chapter 1: Introduction and statement of the research problem
Chapter 2: Health and the promotion of health in schools
Chapter 3: The teacher and the promotion of health in schools
Chapter 4: Research design and methodology
Chapter 5: Presentation and discussion of the findings: The role of the teacher as a promoter of health in the Gauteng Province of South Africa
Chapter 6: Findings, conclusions, framework for teachers as promoters of health, limitations and recommendations

CHAPTER 2

HEALTH AND THE PROMOTION OF HEALTH IN SCHOOLS

2.1 INTRODUCTION

Schools have become more aware of the need to reconsider their roles from within the school community as well as in the society where they exist (Renwick, 2006). Marx *et al*. (1998) also suggest that the role of the school should be to influence the society. This is done to empower children with knowledge, attitude and skills as future citizens (Ntagungira, 2014) in matters regarding their health. It is important though that knowledge about health and the promotion of health should be understood by those working with and around children in schools.

According to Morton and Lloyd (1994) and Leahy, Burrows, McCauig, Wright and Penny (2016), health has become part of everyday teaching and learning in several primary schools. Moreover, health could have been infused into the national curriculum addressing topics such as drug abuse, tuberculosis, body development, sexually transmitted disease and HIV/AIDS. Schools are seen as settings that can promote health issues through teaching and learning.

However, St Leger (2006) found that schools have limited capacity to influence learners' health status and behaviour. Therefore, other stakeholders within and around the school community are perceived as the possible factors that can play a role in promoting the health of learners in the community (Landsberg *et al*., 2005). The family, society, Department of Education, physical and social environment are regarded as possible role players in the shaping of health of children (Naidoo & Wills, 2010b).

As much as there is a need to consider health and the promotion of health in schools, the question of whether this is reasonable to do in schools by teachers should be addressed. Bearing in mind that health education is marginalised in countries such as United Kingdom (Byrne *et al*., 2012), Australia (Leahy & McCauig, 2014), and New Zealand (Smith & Philpot, 2011), there is no guarantee that what teachers are doing in the classrooms when teaching Life Orientation/Life Skills will be able to liberate children with regard to matters pertaining to health.

This chapter focused on the international context of health promotion as well as the conceptual framework that underpins health promotion in schools. The policies that are significant to promote health in schools and a number of other factors were also explored.

2.1.1 Exposition of health promotion concept

The original health promotion definition states that it is a process of enabling people to increase control over, and to improve their health (WHO, 1986). This concept covered concerns about health in public places, universities, hospitals, as well as schools. The research focus has been on topics such as substance abuse, sexually transmittable diseases and other related diseases, which are caused by physical infirmities and nutrition (Nyamwaya, 2003). According to WHO (1999), health promotion includes the holistic well-being of individuals such as mental, physical, social, and spiritual health.

On a global level, health promotion experienced some obstacles where health promoters lack knowledge, skill and the concept application (WHO, 2006). According to MacNab (2009), the lack of knowledge has contributed to the fact that health promotion is not well known in the sector, particularly in Africa.

2.1.1.1 The provision of vertical health services in schools

The background of health promotion in South Africa has its own history before 1994, which was characterised by racial, socio-economic and geographic inequity with inconsistent modes of delivery across all areas (Price, 1986; Coovadia, Jewkes & Barron, 2009; Shung-King, 2013). According to Abrahams and Wigton (1997), the school health services functioned as a vertical programme with little collaboration with other district health services. The lack of non-standardised delivery mode prompted the development of the first National School Health Policy (NSHP) in 2003 (National DoH, 2003), which highlighted the integration of school health services.

2.1.1.2 From vertical health services to integrated school health services

However, many challenges marred the development of the 2003 National School Health Policy and its implementation. This was revealed in the evaluation six years

later in 2009 (Shung-King, 2012; Shung-King, 2014). The challenges compelled the Minister of Health to place the school health in the PHC restructuring, which resulted in the revised ISHP in 2012 (ISHP, 2012).

Among the failures of the 2003 School Health Policy, the three significant catastrophes that characterised the 2003 policy were low service provision coverage across the districts; low and inequitable nurse ratio to schools as well as the absence of referral services, which respond to the challenges identified during the screening process. The district coverage from the 2009 data evaluation confirmed that in some sub-districts, coverage was lower than 10% (Shung-King, 2012; Shung-King, 2014).

2.1.2 The rationale of health promotion

The rationale for health promotion is driven by two discourses, namely, equity and right discourse and the efficacy discourse (The Constitution of the Republic of South Africa, 1996; Lindsay, 2007). For the purpose of this study the rationale will be discussed below.

2.1.2.1 Equity and rights discourse

The Constitution of the Republic of South Africa was built on the human rights, which strive to address the inequality of the past (1996). The provision of health services was vertically provided. Hence, there were challenges that the services were not provided in the same way (Shung-King, 2012). The Constitution of South Africa strongly brought hope for the disadvantaged poor, black South Africans as they were receiving weak health care services (Bray, 2000). In particular, most policies address the issues around equity as they try to cover school-going children. UNESCO (2003) confirms that education is a basic human right.

2.1.2.2 Efficacy discourse

The adoption of health promotion concept in schools is said to be the most effective means of combating and promoting health in schools. The efficacy discourse argues that learners who are not healthy cannot benefit from their learning like the counterparts who are healthy. Marx et al., (1998) confirmed that healthy learners learn better.

The efficacy discourse assumes that well implemented health promoting school models have social benefits for all learners in school. The elements of health promoting school provide learners with a conducive environment for learning where they feel loved and cared for. The participation of all stakeholders in the promotion of health gives learners a complete state of health where their social, emotional, physical health is fully accomplished.

2.2 THE INTERNATIONAL CONTEXT OF HEALTH PROMOTION

2.2.1 Towards a common understanding of health promotion

Health promotion originated during an epidemic disease outbreak in the overcrowded industrial area in the United Kingdom. According to Naidoo and Wills (2009), this period was literally known as the social hygiene period where a health movement that focused on the promotion of health was established. In addition, a foundation for health promotion was formed at the first international conference in Ottawa, Canada in 1986. The Ottawa conference presented the charter for action to achieve health for all by 2000 (WHO, 1986). Above all, the conference focused on the needs of industrialised countries. Then again, it considered the needs of other global regions (2009). It was established during the Ottawa Charter Conference that the requirement for health are "peace, shelter, education, food, income a stable eco-system, sustainable resources, social justice, and equity" (WHO, 2000:4; Tones & Tilford, 2001). From the above requirements, five action areas for health were derived. These action areas were discussed thoroughly in section (2.3) below. Furthermore, countries were encouraged to develop strategies and programmes for health promotion (WHO, 2009).

Since the first Ottawa Conference, several international conferences were held in various countries to discuss health promotion. Secondly, the Adelaide Conference was held to discuss health as a critical social goal. The new direction for health was set and that all social entities play a role in the promotion of health (WHO, 1988).

The Third conference was held in Sundsvall, Sweden in 1999, where the supportive environment for health was demonstrated as the context that the human development highly depends on. The Conference theme was a call for the world to make environment supportive to health (WHO, 2009).

The Fourth international conference was held in a developing country of Indonesia, Jakarta where the private sectors were roped in to support health promotion (WHO, 1997). Over and above, the national governments were compelled to adopt the health promotion initiative by developing, promoting and supporting networks for health promotion.

The Fifth Conference was held in Mexico where South Africa pledged to take action on the listed strategies to close the gap (WHO, 2000). The sixth conference in Bangkok established that policies and partnerships should be the focus point to improve health in the global and national development. Furthermore, the Bangkok Charter supports and builds on the strategies and principles that were established by the Ottawa Charter for health promotion in Canada in 1986. The Bangkok Charter further moved to the groups and organisations, which were critical to achieve health (WHO, 2005).

The Seventh International Conference on health promotion on the Closing and Implementation Gap was held in Kenya, Nairobi. Its focus was on the financial crisis that was said to threatening health care systems (WHO, 2015).

The Eighth Conference on health promotion was held in Finland, Helsinki where it built on the actions and evidence inspired by the Alma Ata Declaration on PHC and the Ottawa Charter. The Conference indicated that the core responsibility of the government is to prioritise health and equity as well as to consider the need for effective policy coherence between health and well-being. The Conference clearly stated that to achieve all this it would require the political urge and strategic foresight on health promotion (WHO, 2013).

2.2.2 The European Network of Health Promoting Schools

The European Network of Health Promoting Schools originated in the 1980's where three organisations were merged (Rasmussen, 2005). In its approach, the focus was on the Ottawa Charter and the goal was to increase commitment and the principles of HPS among its key partners, namely, the schools, education departments, health sectors, governments and communities (Rasmussen & Rivett, 2000). A project was launched to determine the potential in the combination of health promotion and education.

According to Burgher *et al*. (2000), the European Network of Health Promoting Schools (ENHPS) was formed by the leading organisations, hundreds of schools and the European countries to create a school environment that encourage a healthy lifestyle. In addition, the three leading organisations developed the idea of integrating health and education where every aspect of the school setting was made to be part of the daily routine. It is assumed that although health education has been part of the schools by focusing on disease prevention and illness, teachers and learners in the ENHPS were working together to make their schools a better place in terms of promoting mental, social and physical health (Burgher *et al*., 2000).

To this far the network has grown to over 43 countries worldwide (WHO, 2008). To monitor the progress in the established HPS programmes, a series of guidelines and were developed (Rasmussen, 2005).

2.2.3 The World Health Organisation

For over 60 years, the WHO has been focusing on global health concerns ranging from AIDS, childhood sicknesses, small pox and family planning. It has been the initiative by the United Nations (UN) after an aftermath, which was brought about by the World War II to start an organisation that focuses on the improvement and maintenance of health worldwide (WHO, 2015). Although there were delays in the commencement of the WHO, the organisation developed the HPS concept and currently, it is responsible for the international conferences on health promotion (WHO, 2015).

The development of HPS has gained momentum since its inception in the United Kingdom (Crosswaite, Currie & Young, 1996). Schools are moving from traditional health education to the promotion of health in schools, which does not only focus on the curriculum but also focuses on the HPS approach (Lynagh *et al*., 2002). Schools are normally grounded on socio-ecological approach where the psychological world is said to be influenced by actions around the family and the school context (Williams & Lawson, 2013).

2.2.4 Health promotion in schools

The promotion of health in schools is alleged to be guided by the five Ottawa Charter principles to promote health (WHO, 2009). The five principles moved beyond the provision of health education to include the socio ecological approach where the settings affect the development of human beings. According to Marx *et al.,* (1998) schools can have a positive influence in the promotion of health in schools as well as the society.

A number of schoolchildren in disadvantaged communities are faced with the health challenges because of socio-ecological disparities, which interferes with learning. In the process of promoting health in schools, it is assumed that children who are hungry, sick, troubled, and depressed cannot function well in the classroom, irrespective of the goodness of the school (Marx *et al*., 1998).

To attend to the learners' health needs, schools either adopt the whole school approach where all stakeholders are involved or start with the activities, which are efficient. Apart from that, schools do the needs assessment to identify the gaps in the school health programmes and make decisions on how to strengthen the existing health related efforts (Marx *et al*., 1998).

According to Marx *et al*., (1998) no matter how much the health promotion program might be promising in schools, the following concerns are real and they need to be attended to. These concerns are:

- The concerns about money, training and facilities
- Concerns about time
- Concern that things were done this way
- Concern that people succeeded in the absence of health promotion
- Concern that it's a school business and not health business
- Concern that nothing is broken, so there is no need to fix anything
- Concern that teachers will not benefit from the programme.

Until such time when teachers will understand the elements of health promotion in schools, the questions above will be a hindrance if they are not addressed.

2.2.5 Health promoters in schools

The definition of a health promoter has been slightly provided in Chapter 1. However, this has to be taken over to understand the health promoter from the international perspective. According to Tzenalis and Sotiriadou (2010), the health promoter's definition has been utilised in different manners with very little meaning given thereof. Beric and Dzeletovic (2003) conducted a study in schools, which indicated that in Canada health promotion was taken as a profession wherein health promoters were trained. However, countries such as Puerto Rico, Cuba, Finland, Haiti, and Yugoslavia, there were no specifications regarding health promotion as a profession. The study has also identified teachers as some of key role players in the promotion of health in schools.

In the United States, health promotion has been offered by nurses in the form of health education where topics such as nutrition, oral health, prevention of sexually transmitted diseases as well as the prevention of smoking was offered (National Association of School Nurses, 2002). In Sweden, health promotion is covered within the entire scope of health and medical care sector (Brobeck, Odencrants, Bergh, & Hildingh *et al*., 2013).

In the United Kingdom, health promotion is a profession on its own where health and education are seen as separate professions (Beric & Dzeletivic, 2003). In South Africa, the rapid growth of HIV/AIDS programmes has seen the increasing development of untrained health workers (Andrews *et al*., 2004). Moreover, the ISHP postulates that school health nurses delivered school health services and they were part of PHC staff (ISHP, 2012).

Obviously, literature did not provide the clear definitions on the health promoters and the roles they need to play in schools. Discrepancies concerning promoters of health did not give way as to how teachers can promote health in schools.

2.2.6 The role of teachers as promoters of health

Teachers are vital in the promotion of health in schools because they understand the challenges learners face at school under their care (Whitley *et al*., 2013). According to Flaschberger (2012), school health promotion has been declared very effective

provided the teachers and all school staff contribute to the promotion of health in schools. There is a plethora of empirical evidence indicating that teachers who have been trained in health promotion are likely to be involved in the promotion of health in schools (Mohamed, 2015; Viig *et al*., 2010).

Nevertheless, there is a lack of efficacy among teachers irrespective of the training they went through. According to Whitley *et al*. (2013), once-off workshops in mental health and bullying are no longer enough as they do not provide the most required need to support learners in schools. However, Williams and Lawson (2013) indicated that rather health promotion and mental health need to be integrated into the teachers' curricula.

2.2.7 Health and education

Health and education are inseparable (Marx *et al*., 1998). However, within the health promoting school, it is clear that education is for health rather than about health (Ackerman, 1997). This is because school health services that are run by health professionals take the lead. Mohamed (2015) indicates that the health sector alone cannot deal with the health of children in schools.

According to New Zealand Health Promoting Schools National Strategic Framework (2011), there is a massive agreement by organisations that schools can make substantial contribution to children's health and well-being by improving their academic achievement through teachers. These include WHO, UNICEF, UNESCO, CDC, ENHPS, and IUHPE.

The significant body of evidence demonstrates that education is critical in achieving better health for children in schools (Leahy *et al*., 2016). There is a positive association between health and education (Bundy, 2011; Marx *et al.,* 1998). In fact, education is one of the prerequisites for health (WHO, 1986) because learning cannot occur if learners' mental, physical, emotional, and social health is not taken care of in schools.

The two momentous conferences helped to create the building blocks for HPS and its partnership between health and education. These conferences were the First International Conference on Health Promotion held in Ottawa, Canada in 1986 and it

adopted the Ottawa Charter for Health Promotion and the WHO International Conference on PHC held in Alma Ata, Kazakhstan in 1978, which at the end adopted the Declaration of Alma Ata.

The Alma Ata Declaration also urged the governments to use education as a vehicle to prevent, promote and to control health issues (New Zealand Health Promoting Schools National Strategic Framework, 2011). Hence, health and education are closely linked in the sense that learners with poor vision or hearing often would have learning difficulties. Learners who are tired and malnourished often have concentration skills while learners with poor resistance to infections are often absent from schools. In addition, learners with mental health problems or substance abuse are often robbed of the capacity to learn (Landsberg *et al*., 2011). Moreover, good health and educational achievements are not ends in themselves, but rather means which provide people with an opportunity to lead better lives.

It is known that schools have a limited capacity to promote children's health. This implies the human resources such as school health nurse (Kwatubana & Kheswa, 2014; Mohamed, 2015) and teachers who are supposed to work with children on a daily basis. Irrespective of the limited capacity in terms of resources, schools need to increase their capacity by way of training teachers to promote health (Leahy *et al*., 2016).

At the same time, the support services with regard to curriculum places a great amount of pressure on teachers as they need time to apply health promotion in schools and resources to do that (Renwick, 2006). In other words, health promotion in schools calls for a greater chunk in the curriculum revision to accommodate all determinants of heath, and not only Life Orientation to be used as a tool to promote health (Leahy *et al*., 2016).

The interdependence between health and education plays a greater role in the fact that good health contributes to educational outcomes by eliminating barriers to learning (Lean & Colucci, 2010; Mohamed, 2015). Therefore, it is vital to understand the goals of health and education in the promotion of health in schools. Different sectors have different goals in the promotion of learner's health in school. However,

there is a need for role players to understand one another's context and functions (Anderson, 2005). There is a concern that there is a lack of concerted efforts in addressing health issues between the DoH and the DBE (Mohlabi *et al*., 2010).

2.3 HEALTH PROMOTION IN THE DEVELOPED AND DEVELOPING COUNTRIES

Health promotion is a radical movement that stimulated the world and societies to change their perceptions on health rapidly. It has gathered momentum in the 1980s where the medicalisation of health was challenged and it stressed the socio-economic aspects of health (Downie, Fyfe & Tannahill, 1990). Unlike the past centuries, the 21st century has come with more challenges for schoolchildren than before. As a result, the poorest and most disadvantaged children living in low-income countries are affected the most (World Bank, 2011:1).

According to Chamusri (2008:22), "poverty deprives millions of children worldwide of housing, food, health care, and education". In addition, children in rural communities suffer greatly not because if they are not receiving poor service delivery; they are not reached at all. In a way, this hampers their chance to succeed in schools (WHO, 1997). Moreover, there is a great deal of evidence that substantiates the effectiveness of HPS in a global context (Stewart-Brown, 2006; Inchley, *et al*., 2007; Tang *et al*., 2008; St Leger *et al*., 2009; MacNab, 2013; MacNab *et al*., 2014; Stewart, 2014).

The international trends on the understanding of Health Promotion according to New Zealand Health Promoting Schools National Strategic Framework (2011) agreed on few aspects, which implied that HPS is the effective means to improve health and the educational outcomes. However, there is a lack of understanding on how health and education interact and impact each other. The health community sees the six aspects of health promotion as separate to the curriculum whereas the schools include the aspects in the curriculum and through their pedagogy. In addition, there is a great move on the view of health as in the 1980's where health promotion and prevention was just imparting knowledge to empowering learners in taking part of their own health even though many HPS are still informational. Nevertheless, changes in participants beliefs and values is important and not just to do it; there is no description of what the whole school approach is and how and why it works; the evidence based practice and outcomes in the whole school approach is promoted (Quirke, 2015).

Nevertheless, the majority of research and evaluations focused on single topic or programmes. Research indicates that HPS is a valuable programme. However, the implementation of the programme fails in many instances. The Ottawa Charter describes many aspects, which can be implemented in the HPS, but it does not clearly describe how it can be implemented in a school context. HPS aims to improve outcomes for all; yet there is no research where indigenous knowledge and approaches have been integrated into HPS framework especially in developing countries and in Africa precisely. Finally, there is a need for governmental departments to collaborate for HPS to be successful (Jourdan *et al*., 2010b).

Many HPS are administered through single departments or the NGO. Regardless of the HPS concept development being international in its nature, Mukoma and Flischer (2004), in their findings, reported that there were no evaluations in Africa. Nevertheless, there have been reports from a number of low and middle-income countries on the success of HPS programmes (MacNab *et al*., 2010; MacNab & Kangasaki, 2012). It is believed that worldwide, HPS has the potential to impact positively to over one billion children (Mohamed, 2015; Kwan *et al*., 2005) merely by creating a conducive environment for learning.

According to Lee *et al*., (2006), children are viewed as the segment of the population identified to be most at-risk and have a great potential to improve. Internationally, health promotion has been the vehicle to promote health in schools as well.

The HPS concept has been adopted both by developing and developed countries in an attempt improve health of children in schools (WHO, 1996). In developed countries, the concept has been used effectively to improve the health of children and the community at large. The creation of health programmes in schools that caters for basic needs and health matters is very crucial (Samdal, 2008). This can be in a form of health programmes, which addresses physical, emotional, psychological, spiritual, and intellectual needs of schools (Roux, 2013; Karstens, 2010).

Different countries address health challenges according to their needs. Some address nutrition issues because children are not getting healthy and enough food to eat, like

in Rwanda (Ntagungira, 2014), and in America and Europe obesity is a problem (Langford, Bonell, Jones, & Campbell, 2015); and some focus on the misuse of drugs and teenage pregnancy. However, the majority of developing countries focus on many health issues such as poor hygiene, poverty and risk of communicable diseases. In South Africa the focus is on hygiene, nutrition and communicable diseases.

The interpretation of health concept with regard to HPS is wide though. According to Konu and Rimpela (2002), the wellness concept is used in USA in a school setting, within the programme that focuses on the implementation of health promotion and health education. Nevertheless, in Asian countries, the multilevel approach of HPS has been applied. In sequence, the school health policies were implemented in 1996 in China, in India in 1997 and in Indonesia in 1998 respectively.

The course for implementing HPS in Asia was influenced by the population size, low socio-economic status and low education levels. For instance, in China, the high population rate in a way contributed to the spread of Helminthes infection (Long-Shan, Bao-Jun, Jin-Xiang, Li-Ping, Sen-Hai & Jones, 2000).

To illustrate the development of health promotion, few developed and developing countries were randomly chosen to display their status in health promotion. In the study, developed countries included are the United Kingdom/Scotland, Australia, France, and New Zealand whereas the developing countries included countries such as Hong Kong, India, Indonesia as well as the African countries.

2.3.1 United Kingdom/Scotland

According to Samdal and Rowling (2013), HPS in Scotland was established in 2002 where it was located within the education sector and health and education departments as well as the national health promotion agency supported it. However, the efforts to sustain the relationship between health and education were not easy (Gugglberger, 2011).

The Scotland National Framework, ‘Being well-doing well’ provided a vision for HPS with key values, aims and characteristics upon which local authorities in partnership with the Health Board were given an opportunity to develop their own frameworks. In

Scotland, the health and well-being of learners has been the responsibility of all staff and it has gained recognition in the curriculum.

2.3.2 Australia

In Australia, HPS has emerged as a comprehensive framework to improve and to empower health status of learners in schools (St Leger, 1998). It was believed that the success of the programme lies in the understanding of teachers with regard to their roles. Hence, St Leger (1998) calls for teachers to be proactive unlike to prevent diseases, which may befall learners. In Australia, this is done by a collaboration of framework, which matters the most in the lives of learners.

2.3.3 France

According to the French Ministry of Education (FME) (2011; 2014), health education has not been treated as a separate subject to be taught in the classroom as such but it has been treated as a citizenship education. The promotion of health in school for learners does not require special teachers such as LO/LS teachers who can be promoting health in schools, but it has been taken as an everyday activity, which all teachers were involved.

Health education is integral to the education of individuals and the citizens as a whole (FME, 2001). Nevertheless, in practice, a number of schools in France set a low priority on health education.

2.3.4 New Zealand

In New Zealand, the HPS aim is to improve and protect the public health by improving people's health and to minimise health risk among school-going children (New Zealand Health Promoting Schools National Strategic Framework, 2011). According to Cushman (2008), health and education impact on each other and they are inextricably linked with the purpose to increase equity in New Zealand.

2.3.5 Hong Kong

The school health promotion has enhanced positive results for teachers and learners as well. Evidence from school research confirms that health promotion for learners has been very effective. In Hong Kong, there are strategies that have been put in place

to address the key areas for health promotion (Lee, Tsang, Lee, To & To, 2001). These areas include, among others, the rigorous training of teachers in health promotion and health education in health promotion, resources and funding, the policy making ensuring that school managers were in the forefront to lead the programme, and the formation of healthy alliance as well. According Lee *et al*. (2001), these strategies provided an opportunity for teachers to address challenges in school on a wider basis.

2.3.6 India

In India, health and education form the basis of the most sectors to develop the nation. However, according to WHO (1999), India experienced a lack of basic school facilities such as drinking water facilities and sanitation as well as inadequate school health services were identified. According to WHO (1999), with the multiple challenges in health, the only strategy to address these issues was to infuse health into the school curriculum.

2.3.7 Indonesia

The high population rate focused on the improvement of health through schools, and this was coordinated by the school health coordinating committee, which includes the Ministry of Education, Religious, Public Health, and the Interior. Each ministry has been allocated its responsibilities by the school health coordinating committee to develop HPS. According to WHO (1999), in Indonesia, the national strategies and approach applied includes community participation, training of personnel, counselling services, curriculum development and other special programmes, which promote health and education.

2.3.8 Developing African countries

It is indisputable that Africa, compared to other continents, has many health challenges which if not well addressed can overburden the potential of HPS in the near future. Nevertheless, there are many motives why the continent must persevere in the HPS initiative. These motives are good health, which in turn can improve education in Africa (WHO Regional Office for Africa (AFRO), 2013).

In Africa, the HPS programme came at the right time when many children experienced health challenges that not only affect their physical bodies, but also affect their learning

as well. However, the main obstacle is that these challenges are limited by resources no matter how enormous they can be (MacNab, Stewart & Gagnon, 2014:246). According to Marmot (2005) and Currie *et al*. (2012), this calls for the whole world to stand up and address the determinants of health in a way that African countries can benefit greatly.

Besides malnutrition and other communicable diseases that face Africa, there is also an increasingly lifestyle-related disease like diabetes and obesity (Mbanya, Motala, Sobngwi, Assah & Enoru, 2010). Hence, Lee (2009) indicated the need to begin promoting healthy lifestyle and healthy behaviour for children. Pridmore (2000) conducted a study that analysed HPS in Nepal, Zambia and Botswana**.** She found that children participation has improved, and the main challenge though was that the attitude of adults proved to be the barrier to health promoting school development. In particular, the role of teachers as role models was emphasised even though it was not happening because of their understanding of the health concept in education (Gordon & Turner, 2001).

Again a research conducted in Africa has proven that intervention of single topic can be utilised as entry level for HPS (Macnab *et al*., 2014:252) since the cost would be low and possibly using local resources. However, as a way to extend the intervention in Africa, WHO Regional Office for Africa (2013) established the following objectives and the guiding principles:

- The evidence based practice;
- The human gender and gender equity;
- The equity in health to ensure access, availability and affordability of health promotion services;
- The ownership of programmes by individuals and communities through participation;
- The collaboration of stakeholders to promote health; and
- The accountability and responsibility among government departments.

2.3.9 The need for health promoting schools

The concern about children's health in schools has been on the global agenda for as long as schools have been in existence (Jourdan, 2011). It has taken many years of shaping and developing the best possible practices and the policies that can cater for the needs of children with barriers in schools. Barriers to learning are complex in nature, ultimately because they can be a result of an interaction between multiple systems and they have an impact on learning (Landsberg *et al*., 2011:19). Mohamed (2015) distinguishes that HPS is a settings approach even though schools' approach is in a more discreet activities.

Despite the call to improve the schools' approach to an integrated approach, the concern around children's health in school continues to rise unabatedly. In addition, this calls for concern to look at the other avenues in which children can be catered for in schools. The HPS approach offers a systematised and a holistic comprehensive framework to address barriers to learning. However, they are not seen as individual problems but as a contribution from the environment as well and in this case the school environment (Ntagungira, 2014).

There is growing evidence that has been acknowledged by the World Health Organisation (WHO, 1996) that health promotion and the preventative health practices are effective. They improve the overall health and well-being, addressing the health inequities, coordinating the best use of resources, enhancing the economic productivity, and to reduce the high rate of chronic disease and injury (McQueen & Jones, 2007; WHO, 2008; Harper & Oldenburg, 2009; Mohamed, 2015). In essence, the HPS approach is based on inter-sectoral collaboration by departments, and the participation by various stakeholders in all levels of health and education (Lazarus, 2006).

In a way, HPS entail a multi-disciplinary and multi-dimensional framework, which on the other hand contrast from its equivalent Focusing Resources of Effective School Health (FRESH) framework, which addresses school health matters from a narrow point of view of distributing resources (Ntagungira, 2014). The FRESH framework as a common structure for school health was established by UNESCO, UNICEF, WHO and the World Bank at the Education for All World Forum in Dakar in 2000, after

realising that ill-health among school children around the world was undermining the determinations towards the realization of education for all. According to Bundy (2011), many developing countries have adopted the FRESH framework and the example of this framework is shown below in Table 2.1 and how countries tackle specific challenges within their schools.

Table 2.1: An example of the FRESH framework in developing countries

Country	FRESH or HPS Initiative Components	Key interventions
Kenya	Policy	School health policy written jointly by the Ministries of Education, Health and Agriculture.
	Environment	UNICEF framework on safe and clean school grounds (Child Friendly Schools (CFS) approach adopted.
	Education	HIV prevention; hygiene education.
	Services	Deworming; safe drinking water; school feeding.
Zambia	Policy	School health policy written jointly by the Ministries of Education and Health and signed by the Ministry of Community Development and Social Services.
	Environment	Ministry of Education adapted HPS framework for certification process of schools with clean and safe grounds.
	Education	Infectious disease prevention; HIV prevention; hygiene education; violence prevention.
	Services	Deworming; micronutrients.
Nigeria	Policy	Ministry of Education-developed policy and tools in collaboration with Ministry of health.
	Environment	National-level environmental risk awareness.
	Education	School and community education on sanitation and hygiene.
	Services	Safe water and sanitation provided at schools; communities involved in installation of ventilation improved toilets.
Mauritius	Policy	Collaborative policy developed between the Ministry of Education and the Ministry of Health.

	Environment	Promotion of healthy school environment.
	Education	Physical and social education, including sexuality education and behavioural topics such as bullying and aggression.
	Services	In-school medical check-ups.
Barbados	Policy	Ministry of Education and Ministry of Health collaboration on health promotion policy and program.
	Environment	Promotion of safe and healthy school environments.
	Education	Physical education; family life education; infectious and non-infectious disease prevention education; HIV prevention and stigma reduction; nutrition education.
	Services	School feeding.

Source: Bundy, 2011

This common structure for school health was actually conceptualised after realising that universal education cannot be attained when the health needs of children in schools is not met. Secondly, a core group of cost-effective activities can be implemented in all schools together to ensure that the needs are met and to deliver on the promise of education for all. According to Ntagungira (2014:27), this framework supports the notion that policies and good practice ensure that children are healthy and able to learn and therefore, they are essential components of an effective education system.

Likewise, Tang, Nutbeam, Aldinger, St Leger, Bundy, and Hoffmann (2009) indicate that the survey among FRESH partners displays that it is a good framework in that it served as school health advocacy in governments. The difference though is that when behavioural outcomes are managed with this framework, they are not always continual over time (Stewart-Brown, 2006), as they pose high challenges in ensuring consistency in the implementation of more effective approaches.

Not a single approach is suitable to address barriers to learning faced by children in schools, excerpt for a comprehensive approach that calls for the whole school

participation (Marx *et al*., 1998). In support of the above, Tang *et al*., (2009) concur that the FRESH framework, no matter how good it maybe, has little impact on the emerging health issues for the reason that it does not holistically attend to the social determinants of health which has implications on the academic outcome of learners. In a way, ISHP therefore could possibly focus on children's health issues in a comprehensive manner.

In a way, the health-promoting schools approach has features that separate it from other frameworks such as FRESH. In addition, Tjomsland, Larsen, Viig, and Wold (2009), and Kickbusch (2003) indicate that the HPS framework acknowledges that the health and well-being of children and staff are not only subjective to the individual choices, but they are also influenced by the context in which they learn, work and play. Tjomsland *et al*., (2009) further assert that HPS is a multidimensional approach that endeavours to build supportive physical and social school environments that promote learners capacity to make healthy choices and to develop positive attitudes and relationships through life skills.

To comprehend the international perspective in health promotion, the next section focused on the conceptual framework designed by the Ottawa Charter (1986).

2.4 CONCEPTUAL FRAMEWORK

Apart from the theoretical framework, which is the lens of this study, the conceptual framework has been used to define the relationship between the phenomenon under study and the factors that contribute to its functioning. Conceptual frameworks are maps that are constructed to define the causal relationship between a problem and the factors contributing to it (Bentley, Effrors, Palar & Keller, 2008). The HPS conceptual framework will be discussed below.

2.4.1 The health promoting school conceptual framework

The HPS conceptual framework is the basis that has informed the promotion of health in schools. Health promotion and HPS has been used simultaneously to define the promotion of health in schools. Although HPS is the framework of which schools can promote health. In fact, the principle of health promoting school is very much similar to the principles of health promotion (Ottawa Charter, 1996).

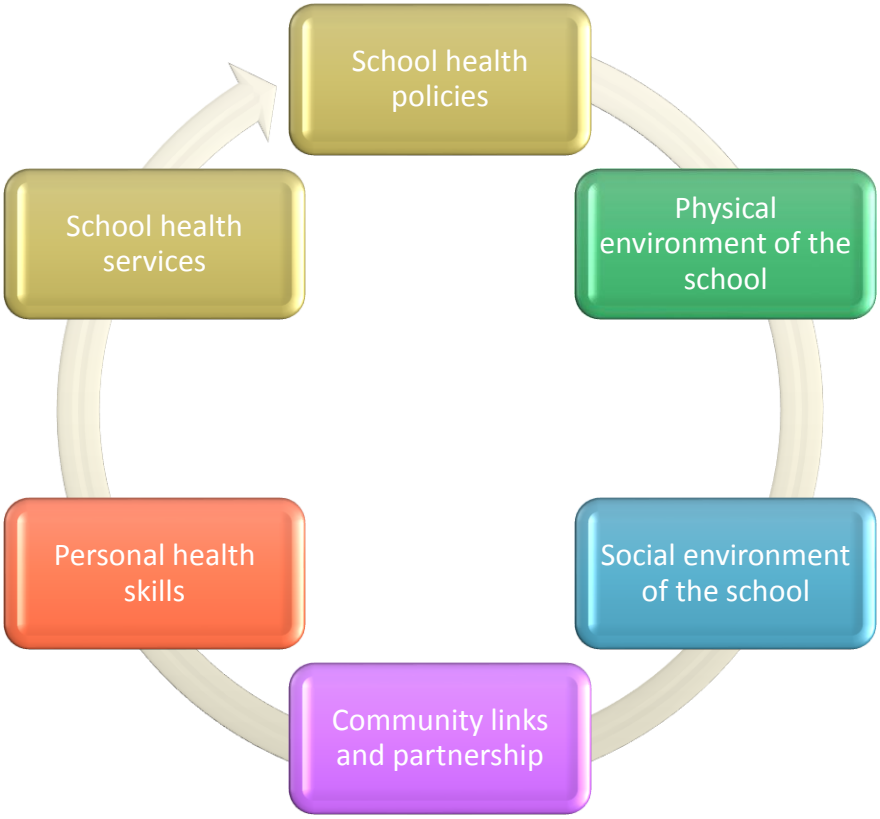
According to Simovska (2012), HPS combine efforts from health and education sectors to improve both health and education outcomes. In other words, the purpose of health promotion in schools was constructed as a social process of individual and community empowerment (WHO, 1986). On this note, the Ottawa Charter (WHO, 1995) outlined a set of five priority action areas that which the HPS framework should cover.

However, these set of guidelines were redefined to fit the school setting. These six areas are:

- *Building public policy* (WHO, 1986) was changed to the *school health policies* component of the framework (WHO, 1996);
- The *creative supportive environments* (WHO, 1986), was then divided into two separate entities. That is the *physical environment of the school* and *social environment of the school* (WHO, 1996);
- *Strengthening community action* (WHO, 1986) has been revised to the *community section* (WHO,1996);
- *Develop personal skills* (WHO,1986) was changed to *personal skills element* (WHO, 1996); and
- To *re-orient health services* (WHO, 1986) was *altered to health services* (WHO, 1996).

The six components of the HPS framework as it is aligned in the Ottawa Charter for Health Promoting Schools (1995) will be described in detail in the following section as it has been indicated in Figure 2.1.

Figure 2.1: Health promoting schools framework components



Source: Ottawa Charter, 1995

The HPS conceptual framework considers the settings where health should occur. In other words, it is a settings approach where the health of the entire school community is encouraged on a daily basis in the classrooms and at school, unlike to target individual learner with the health problems. A number of researches done confirm that schools are ideal setting within which the health needs of learners can be addressed (Rowling & Samdal, 2011; St Leger, 1998; Jourdan *et al*., 2008; DoH, 2011; Leahy *et al*., 2016).

Schools in their nature are educational institutions where learners are taught (Jourdan *et al*., 2010b; Quirke, 2015). However, from the settings approach developed the HPS concept (Stewart-Brown, 2006), which aims to promote the health needs of the school community. There is a need for serious adaptation for schools if they are willing to take the health needs of their children completely (Swart & Pettipher, 1999; Engelbrecht & Green, 2001; Landsberg *et al*., 2005). The environment plays a greater part in the creation of healthy lifestyle; hence, the home and the school should try to communicate the same message, which promotes health (Terburgh, 2015).

According to Denman *et al.,* (2002) and the DoH (2011), the primary objectives of the health promotion in schools calls for collaboration across school community and external stakeholders, the development of the social and physical environment of the school through policy development and the management structures as well as the improvement of curriculum, teaching and learning. The HPS framework focuses on the empowerment of the community with the purpose to support the community in becoming empowered and to increase control of their own health (Naidoo & Wills, 2009). In the following section, the six HPS components will be discussed in detail.

2.4.1.1 School health policies

School health policies are defined as the directions that guide the school's actions and resource allocation towards areas, which promote health (DoH, 2011; ISHP, 2012). The policy also develops a coherent and interdisciplinary health education curriculum, which embraces the social and ecological dimensions of health (WHO, 1991). Similarly, the HPS framework emphasises that school health policies should be documented and approved practices that have an impact on the school's actions in promoting the health and well-being of learners, staff, the families, and the wider community as well. In South Africa the Integrated School Health Policy (2012) is used to promote health in schools.

According to WHO (1996), the directions offered by the policy ensures healthy food, upholds equity principles by ensuring that all learners have equal access on resources, totally smoke free and prohibits alcohol and substance abuse. School health policy also includes formal procedures in response to the challenges in learners' health.

These formal procedures can include first aid, sun protection, health screening, and closure in case of emergency that might hamper the lives of learners (St Leger, 1998). Other policies on safety plan for the implementation in the case of natural disasters and on the control of HIV/AIDS are also embraced (WHO, 1996). Therefore, the school health policy should be aligned with the policies, which underpin health promotion and guides teachers on the procedures to promote the health of children at school.

2.4.1.2 The physical environment of the school

For the promotion of health in schools to occur, there is a need to be concerned with the physical environment (Donald *et al.,* 2010) because the improvement of the environment is very important for teaching and learning. It is very important in the sense that it must provide an enabling environment suitable for learning (WHO, 1991; DoH, 2011). According to WHO (1996), the physical environment of the school refers to among others; the buildings, grounds, and equipment meant for school activities and the other area in school. It requires the school to be safe, clean, sustainable, and secure (Marx *et al.,* 1998). Therefore, barriers to learning that occurs within the environment need to be prevented (Landsberg *et al.,* 2005). A number of schools in South Africa lacks proper classrooms where children can learn. It has reached a point where some learners are taught in dilapidated classrooms or overcrowded classrooms (Sizanang Centre for Research and Development, 2006).

2.4.1.3 The school's social environment

The social environment of the school means, among others, a good relationship between teachers and learners, teachers and teachers, teachers and the parents and the wider community (WHO, 1991). This relationship is crucial in the sense that broken relations between learners and teachers, or parents and teachers, including the wider community can hamper the progress of the HPS programme (Donald *et al.,* 2010). This can include knowledge, attitude and the behaviour of the district officials, province and the national coordinators of school health. The school's social environment should create an environment of support and care, trust, and friendliness that motivates learners to attend school and to be fully involved in their learning (WHO, 1996).

In simple terms, the school's social environment ensures inclusivity in its nature. That means that disadvantaged learners from their communities need to be catered for by the school. Many children from the disadvantaged communities lack support from their community or family members and therefore, they need support from school and other stakeholders (Donald *et al*., 2002).

2.4.1.4 Community links and partnership

As it is clearly stated, the community links are the responsibility of the school to foster family and the community involvement (WHO, 1996). The school should have

collaborations with other stakeholders such as the families, organisations, communities, and the key people who support the health and well-being of learners and the staff in school through its capacity to influence the wider community (Marx *et al*., 1998). According to WHO (1991), the school can connect with the community by encouraging active participation, mutuality and collaboration. Parents are the close important partners. According to WHO (1996), a health promoting school should involve and consult parents on matters concerning their children.

2.4.1.5 Personal health skills

Personal health skills are necessary for learners to build their knowledge, attitude, understanding, and behaviour regarding Life Orientation/ Life Skills, meaning that, it can be offered in an informal or formal curriculum (Renwick, 2006). The curriculum should be designed to cater for health issues affecting learners in an integrated manner to improve the learners' theoretical understanding of health and how to go about it in practice (Leahy *et al.,* 2016).

The development of personal health skills provides vast opportunities for individuals in the school community setting to enhance their capacity by empowering and enabling them to perform competently for health in the society where they are (WHO, 1991). As much as there is a need to develop personal health skills within the HPS, there are challenges.

These challenges according to the DoH (2000:17) include

- The capacity building for service providers to provide cutting edge Health promotion and Life Skills education support to learning contexts;
- The development of compulsory implementation of health education for and life skills for learning;
- Capacity development for teachers and other staff members to promote their health and the health and well-being of learners;
- The capacity development of parents and the broader community to promote the health and well-being of families and the wider community; and
- Peer education training for learners to support and implement health promotion and prevention strategies.

According to the DoH (2000:23), the content of Life Skills education is defined by the demands and the needs within the context of the Life Orientation and other learning areas. In most cases, the national and provincial priorities can take the lead in driving the health promoting school programme and most importantly, teachers need to be thoroughly trained for their roles as promoters of health in schools.

2.4.1.6 School Health Services

According to the DoH (2011), the School Health Services (SHS) provide access to primary health care (PHC) and provide health-promotion services by acting in a coordinating role, and to make use of skills and capacity in different sectors of the society, including the community, learners, teachers and the Non-Governmental Organisation (NGO) (Landsberg, 2011:41; Leahy *et al*., 2016). The PHC services in both provincially and nationally must be accessible to both learners and teachers.

According to the ISHP (2012:9) and Terburgh (2015), “school health services are currently delivered by designated School Health Nurses (SHN) who form part of the PHC staff component” (Mohlabi *et al*., 2010; Shung-King, 2014; Kwatubana & Kheswa, 2014). Through the ISHP (2012) and the Policy on Screening, Identification, Assessment and Support (SIAS) (SIAS, 2014) policy document, the SHN provides screening on all Foundation Phase learners on the following:

- Conduct vision, speech and basic hearing screening;
- Measurement of height, weight and Body Mass Index (BMI). Appropriate nutritional interventions must be planned accordingly;
- Check for fine and gross loco-motor problems;
- Conduct oral health screening;
- Screen for chronic illness or long-term health conditions - this includes both communicable diseases (such as TB and HIV/AIDS) as well as non-communicable diseases; and
- Perform a basic mental health and/or psychosocial risk assessment.

Fundamentally, HPS can be defined as an education context that strives to develop its capacity for healthy teaching and learning, working and living in close partnership with the local community (Roux, 2011; CBO, 2013; DoH, 2015). The focus is on the whole school development and not only on teaching and learning in the classroom

(Mohamed, 2015, Jourdan *et al*., 2016). The implication is that it should reflect the socio-ecological approach to health and it also emphasises the significance of the settings for HPS (Simovska, 2016).

2.4.2 The Gauteng Province in the South African context on health promotion

The HPS Project in the Gauteng Province was the initiative by the DoH, Japan International Co-operation Agency (JICA) as well as the Gauteng DBE. Based on the democratic South African context, which seeks to address the inequalities created by the past, the research aimed to develop a framework of which teachers can use as promoters of health in schools (Sizanang Centre for Research and Development, 2006).

In South Africa, the school health services are driven by the DoH in the domain of the DBE and require the DSD to address the social challenges of learners in schools (Shung-King, 2013:896; ISHP, 2012).

The Gauteng Province joined the HPS initiative since its inception in South Africa in 2006. Owing to the prevalence of health challenges in the Province, primary schools in the disadvantaged communities were selected as pilot schools by the national DoH as well as the national DBE with the support of JICA (Sizanang Centre for Research and Development, 2006). Gauteng Province is the smallest, richest and the highest populated province, which is more vulnerable to the communicable diseases.

There are challenges of overcrowded communities where there is an outbreak of diseases, which has affected school-going children (Landsberg *et al*., 2005, Donald *et al*., 2002; 2010). Socio-pathological conditions such as teenage pregnancy, HIV/AIDS, Helminthes, Anaemia, as well as many disease which affect learning calls for intervention by various sectors to intervene by promoting health in schools (Sizanang Centre for Research and Development, 2006).

In Gauteng Province, through Life Skills in the Foundation Phase and Life Orientation in the Intermediate and Senior Phase health issues are addressed in part but not the whole since teachers understanding of the HPS concept is not clear, and that they are not able to attend to areas that are demarcated for school health nurses.

According to Renwick (2006), health promotion is not only covered in the classroom through formal curriculum. However, the informal curriculum can also be used to promote heath in schools (Samdal & Rowling, 2011). A school health nurse who is designated to a number of schools to screen and identify sickness incurred by schoolchildren handles school health services (ISHP, 2012; Kwatubana & Kheswa, 2014; SIAS Policy, 2014).

Research discovered that the ratio of schools against the number of school health nurses does not tally and that there is a lack of resources to cater for schools (Mohlabi *et al*., 2010; Kwatubana & Kheswa, 2014; ISHP, 2012). Now that health promotion is done in schools where it is the teachers' territory, the involvement of teachers is not clearly defined. Hence, this study sought to find out how teachers conceptualise their roles, how they perceive health and the promotion of health in their schools. The clarification of the concepts was done thoroughly in Chapter 1. Hence, this section focused on how schools contextualise health and health promotion.

2.5 SHIFT FROM HEALTH EDUCATION TO HEALTH PROMOTION

Health promotion emerged from health education because of the fact health practitioners became more aware of the need for positive health approaches to health education (Samdal & Rowling, 2013). This is done by enhancing health and creating capacity unlike to focus on disease prevention so that health education can develop its full potential when it is supported by structures (Kickbusch, 1986). The school context allows the school to link health and education for the purpose of promoting health in school (Leahy *et al*., 2016) by incorporating health within the curriculum.

2.5.1 Health promotion approach

A study by Leibson *et al.,* (2001) and Stewart-Brown (2006) has highlighted the importance of adopting the preventative child-centred approach where health issues that have an impact on children and the community as such are addressed within schools. As it has already been indicated in section 2.2.2, the health promotion approach is in line with the Ottawa Charter for Health Promotion guiding principles (WHO, 1986). The health promotion approach encourages the whole school community social change where an ecological model on health focuses on the

systems perspective as well as the whole school development and change focus (Dooris, 2009; Pearsons, 2002).

Several studies have also noted that the school environment is an ideal setting to promote the health needs of children (St Leger, 1998; St Leger, 2000; Mukoma & Flischer, 2004; Leahy *et al*., 2016; Jourdan *et al*., 2016). Schools find it hard to incorporate health in schools. Hence, the Schools for Health in Europe (SHE) emphasises the need for schools to adapt towards a more health promoting environment (Quirke, 2015).

2.5.2 Health promotion strategies and practices

In order to promote health, there are a number of strategies and approaches, which are used, and these are meant to enhance the health of communities. These strategies include the following:

- The awareness to increase the public and individual's knowledge regarding the matter to be promoted;
- The development of the appropriate resources to enable individuals to access information and facilities, which will augment their health;
- Empowering individuals and communities to strive for changes which prevent illness and to promote more opportunities for health to be advanced;
- Providing knowledge and skills to people of all ages in order to promote their own health; and
- The health of others and to develop policies to prevent health endangering behaviours (Jourdan *et al*., 2008).

2.5.3 Education as emancipation for health promotion perspective

Health is found in everything done in schools: ranging from prevention of diseases; inclusion of learners with various learning difficulties and to overall school approach to health (Jourdan, 2011). School health policies guide teachers on how to give support regarding different health issues in school. In South Africa, the ISHP (2012), SIAS Policy (DBE, 2014) and Education White Paper 6 (2001) have been adopted to guide the health programmes. In addition, it takes the health promotion perspectives, which give individuals more control over their own health as well as resources to improve it

(Ottawa Charter, 1986). This perspective does not only focus on individual per se, but it focuses on communities and their interactions among individuals and their surrounding setting.

The educational system should liberate its learners by providing HPS education, which gives two fundamental objectives of which the first one is to enable learners through its curriculum to acquire skills in order to make reasonable choices about their health (DoH, 2011; Jourdan, 2011), and in the second place is to give support so that all learners would succeed. This applies to all learners in the school and not only those who are at-risk, orphaned, vulnerable, and having learning difficulties or learning disabilities (Jukes, Simmons & Bundy, 2008). It is the responsibility of the school to work closely with families by watching over the health of learners in their care and to enable them to develop their personalities through teaching about health issues.

According to Jourdan (2011), this is done to enable them to acquire knowledge and to develop critical skills, which will enable them to adopt behaviours that will sustain their future health. Therefore, learners' health cannot be left in the hands of the health professionals alone, but should involve all stakeholders in school. That is teachers, school health nurses, social workers, school administration and the NGO's.

To avoid misunderstanding, all stakeholders should contribute according to their roles (Mohamed, 2015), which obviously the health and social work would then give advice as experts and advice concerning health challenges faced in the duration of the programme. In addition, the main educational task would then be the responsibility provided by teachers, parents, school management teams, and administrators who then will analyse the need of the school by initiating and sustaining the project (DBE, 2014).

It has to be understood though that while the stakeholders are establishing their roles by collaborating their services, partnership among them will not occur naturally as it will come about long relationship, which will probably lead to a common culture in schools. That specifically means that roles for all stakeholders need to be strategically stated (Mohamed, 2015).

2.6 SHIFT FROM HEALTH PROMOTION TO HEALTH PROMOTING SCHOOLS

The shift from health promotion to HPS in the early 80's has seen schoolchildren taking part as agents of change and sustainability (Freire, 1972). Learning has become more interactive and realistic in the sense that it ensures their own health and that of others in their community. This shift has seen learning as more interactive process for learners by linking action and reflection through negotiations (Simovska, 2005). The learners' involvement could not be possible without the teachers though, St Leger (2004) notes that professional development for teachers and evaluations played a role.

The major change brought by the shift from informational to transformational change needed a better approach on how to approach health and education regarding the healthy schools issues. According to Tones (2005), the action competencies, which is the ability to act and bring about positive change with regard health, is an essential element to promote health in schools.

Although research has proved the effectiveness of HPS, there remains an understanding internationally where health promotion is seen as the prevention and control of illness as opposed to health promotion as achieving the positive outcomes such as wellness. Table 2.2 indicates the vast difference between health promotion and health promoting school for addressing health issues in school.

Table 2.2: Comparison of health promotion and health promoting schools

	Health promotion in schools	Health promoting schools
Definition	The process of enabling people to increase control over and to improve their health.	A school that has an organised set of policies, procedures, activities and structures designed to protect and promote the health and well-being of students, staff, and the wider school community members.
Focus	Seeks to create organisational change and thus supportive environments that allow for behaviour change and comprehensive school intervention strategies.	Seeks to create organisational health, quality of school relationships, with attention to empowerment and equity.
Activities	Implementation of health policies; provision of products and services conducive to health; mobilisation of community resources 'Healthy choices, easy choices.	Curriculum, teaching and learning; school organisation, ethos and environment; and partnerships and services.

Source: Renwick 2006:64

2.6.1 The principle of health promoting schools (HPS)

The principle of HPS was based on the understanding that learning must be transformational rather than informational (New Zealand Health Promoting Schools National Strategic Framework, 2011) as teachers would prefer to pass information to the learners who are assumed not to be well informed. The principle pursues to improve the health and well-being of community members wherever they are. In a school setting, the HPS principle included the enhancement of student's learning outcomes by promoting their health and well-being; involves learners' participation and empowerment; provides a safe and supportive environment and addresses the health and well-being of the school community.

In other words, HPS mediates people and their environment to make reasonable personal health choices for better life in the future (Mohamed, 2015). The settings approach therefore takes into account the whole school approach which moves beyond individual focus in the classroom (Quirke, 2015) or for that matter a distinct health promotion intervention which focuses on the outbreak of disease to the whole school approach (Weare & Markham, 2005). It occurs through the complex dynamic changes in the system within the school and in collaboration with all stakeholders (Samdal & Rowling, 2011).

HPS principle is practiced in many countries that are members of the United Nations (UN). The practice includes settings such as workplaces, schools, hospitals, villages and towns. Therefore, HPS principle includes the following:

- Addressing health challenges;
- Building the capacity of people through education;
- Emphasizes collaboration between departments and their communities;
- Integrating all levels of support;
- Apprehensive of the healthy lifestyle;
- Put emphasis on positive aspects of health; and
- Working with people to improve their lives (DoH, 2011).

HPS is a multifaceted in a sense that it includes various elements moving from a medical model to an eco-systemic approach, which covers all settings. It is also multi sectoral since it subscribes to the values and principles of the Ottawa Charter (Parsons

& Stears, 2002). Research confirms that HPS has been effective in a number of countries such as Europe, UK, Norway, Western Pacific, Australia, China as well Latin America (St Leger, 1999; Mukoma & Flischer, 2004; Stewart-Brown, 2006; Tang *et al*., 2009; Samdal & Rowling, 2013 & Macnab *et al*., 2014).

Research relating to HPS in a number of studies dealt with specific health topics such as mental illness, hygiene, obesity, hand washing, and HIV/AIDS (Tang *et al*., 2009). According to several researchers (St Leger, 1999; Mukoma & Flischer, 2004; & Langford *et al*., 2014), HPS focus on behaviour change rather than focusing overall school approach. From the WHO (1986, 1987, 1988, & 1999) approach to HPS, the guidelines are flexible to any setting and for any stakeholder. However, Rowling (1996) and St Leger (2004) noticed that although the HPS framework is flexible to work with in any setting, the bureaucratic structures in both the health and education sectors make it almost impossible to accomplish.

2.6.2 Key role players in the HPS

For the growth of HPS, St Leger (1998) identified three crucial groups, which are teachers, education system administration, and public health promotion policy makers and possibly unmentioned key role players who are sometimes not taken into consideration are researchers, parents and funders. The Figure 2.2 below shows the key role players in the HPS.

Figure 2.2: Key role players in HPS



The six key role players in HPS as indicated in Figure 2.2 above are teachers, researchers, funders, parents/community, health professionals, and education professionals. They are crucial for the existence and sustainability of the HPS programme in schools (Mohamed, 2015). In their own way, they contribute to the success of HPS as they interact and overlap with each other. For the purpose of this research, the importance of key role players should be outlined from the theoretical framework starting from health and education departments to the teachers. To do so, the literature has indicated that the national DBE should have clear defined policies with clear goals and objectives, which enhance positive teaching and learning at school (Mohamed, 2015).

With the prevalence of communicable disease within communities, the national DBE will have to design policies, which respond to the elimination of socio-economic barriers among learners and their families. Of course, programmes such as these will also need funding, which basically can be from the departments that have initiated the programme or from the NGO's. In this case, the GDE was funded by the JICA (Sizanang Centre for Research and Development, 2006).

Based on who is funding the project, often teachers reflect that policies are dumped on them from the National Department (St Leger, 1998; Quirke, 2015) and that affect the implementation of HPS in schools. Instead teachers need to be mobilised and there should be a clear link between school health services, parents, the researcher, and the teachers. With its influence, the National DBE should advocate for the resources to the relevant departments as well as to build capacity for all stakeholders.

The DoH needs to work alongside the DBE to ensure that their practice achieve the education goals. In other words, schools should not be taken as the clients of the DoH but work together in a collaborative manner. It has to be understood that HPS should be a whole school approach (St Leger, 1998), where the commitment and support by the principal can make a difference (Mohlabi *et al*., 2010). Mohamed (2015) indicated that if the principal does not understand or support the initiative, the success of the programme is not guaranteed. Similarly, Renwick (2006) indicated that teachers were overburdened already with the curriculum so without the support by the principals teachers could be demoralised.

Research by St Leger (1998; 2000) has proven that teachers are very interested in the HPS concept. Moreover, they need support in terms of resources, professional development, financial and consultation support as well as to build their self-efficacy in terms of giving them space to design their own policies in schools and that enables them to shape their HPS initiative in school. Although health promotion is the agenda of the health sector in order to promote the health of learners in school, its argument has to be more educational focused (Quirke, 2015).

2.7 SHIFT TOWARDS HEALTH PROMOTING SCHOOLS IN SOUTH AFRICA

The South African government showed its concern and commitment about the health of children since the inception of the democratic dispensation in 1994. It has undertaken several national level policy initiatives to promote the health and well-being of young people (South Africa, 1997; South Africa, 2001; South Africa, 2011; Coulson, 1999). At national level, the *National Action Plan for Children* shows commitments to improve the health of the youth (National Programme of Action Steering Committee, 1996.) The government also participated in the signing of the *World Summit*

Declaration and the ratification of the convention on the Rights of the Child at international level (UNICEF, 2002; ISHP, 2012).

South Africa has pledged to put children first by giving their needs the highest priority (ISHP, 2012). According to the DBE (2010), 12 million learners were enrolled in public schools in South Africa in 2010, this number was likely to rise as the transformation, and strengthening of the education system enables it to retain more learners for longer. In such instances where there could be overcrowding and outbreak of diseases in schools, the health sector's aim of providing health services in schools by providing PHC, which focuses on the prevention of and promoting health care is amicable (DoH, 2000b).

The same applies to the road map document Schooling 2025 and Action plan to 2014 for the South African education sector, which includes provision of public health and poverty reduction interventions for learners through the Care and Support for Teaching and Learning (CSTL) (DBE, 2009; ISHP, 2012). For the sake of sustainability, it is crucial that teachers of a particular school are fully involved in the promotion of health in schools basically because involvement of external factors in schools can at any time discontinue their engagement owing to other commitments within their field (Mukoma & Flischer, 2004; Shung-King, 2013).

The current school health programme in South Africa has not yet moved forward in strides from the challenges it is facing (Mohlabi, *et al.,* 2010; Frantz, 2015). These challenges range from low service provision coverage across most districts, as measured by coverage of Grade 1 health assessments; secondly, the challenge is the suboptimal and inequitable nurse to school ratios and the absence of referral services to respond to problems identified through the screening assessments (Shung-King, 2013:896). Moreover, provinces like the Western Cape and Gauteng are taking the lead (University of Western Cape, 2006; Mohlabi *et al.,* 2010). It can be said that owing to lack of understanding and collaboration between the DoH and the DBE, there is a collapse of school health services in most areas (Mohlabi *et al.,* 2010; DoH, 2011).

The majority of teachers in South Africa never formally went through any pre-service or in-service training, which can enable them to help promote the health of learners in

schools (Kwatubana & Kheswa, 2014:1718; Byrne *et al*., 2012). Bearing in mind that the ISHS is a joint venture between the DoH, the DBE and the DSD. It is crucial that in schools teachers must play a huge role as promoters of health because of the time they spent with children in schools educating them and also because of the challenges faced by children, which can have a critical impact in their learning (Shung-King, 2013; Kwatubana & Kheswa, 2014).

The school curriculum in South Africa offers health promotion through Life Orientation as a subject, which equips learners with basic life skills to move from adolescence and into adulthood (Engelbrecht & Green, 2001; Department of Education, 2003). In the ISHP, the health issues affecting children in school is still in the hands of few professionals, such as nurses, doctors, psychologists and Life Orientation teachers in particular (De Jong, 2000; Roux, 2013; Macnab, 2013; Waggie, Laattoe & Filies, 2013:26; Macnab, Gagnon & Stewart, 2014; Askell-Wiliams & Cefai, 2014).

Unlikely, the development and implementation of school health services was found to have challenges six years later when the policy was evaluated (Shung-King, 2012). However, these challenges motivated the Minister of Health to embrace school health services in the Primary Health Care Unit (PHCU) and this has resulted in the revision of the ISHP (2012). According to Shung-King, Orgill and Slemming (2014:60), the ISHP was jointly endorsed by the Ministers of DoH and DBE with the high level of political priority, which is highly presented by the policy.

Reconsidering the health of children in schools is not only a matter of priority in South Africa, it is a global initiative as well (Mohamed, 2015). The recent global review of school health services commissioned by the World Bank clearly designate that the dual role of school health services in contributing to both health and education position of children has been recognised worldwide (Bundy, 2011). It is questionable though that school health services are very much compound in nature.

According to Shung-King *et al*. (2014:60), the difficulty lies in the fact that they are offered across a wide spectrum of age groups, encompass many different kinds of interventions and require integral inter-sectoral collaboration. In addition, Shung-King *et al*. (2014) indicated that in South Africa, since 1994, health promotion has been guided by policies that are directed towards the provision of healthier and enabling

school environment. Therefore, it is of great importance to understand the policy background and the range of intervention programmes that are geared for health promotion (Department of Education, 2000).

One of such programme is the National School Nutrition Programme (NSNP) (Department of Education, 1994), which made provision for nutritious meals for learners in disadvantaged primary and high schools with the purpose of alleviating hunger in schools. These schools are Quintile 1 to 4. According to the South African Schools Act (SASA) (1996), quintile schools are schools, which are found in disadvantaged communities where poverty and unemployment are rife. Hence, they are no fee paying school where the government render all the services as they are section 21 schools (they do not pay school fees). The enrolment varied depending on the community where the school is situated. It was through the NSNP programme rendered in quintile 1 and 3 schools where changes in the general health development and the academic performance of learners was observed as it promotes punctuality, concentration in the class and above all, there was regular attendance for learners in schools (Sizanang Centre for Research and Development, 2006).

Likewise, the National Policy on HIV/AIDS (1996), which focuses on providing suitable information and education on matters related to sexuality, basically by providing suitable instruments for the prevention of HIV/AIDS was established. More of this intervention towards the development of inclusive communities is well established in the Education White Paper 6 (2001) and to standardise the progress of such intervention programmes the National Strategy on Screening, Identification and Support (2014). It was recognised to directly respond to the needs of learners at-risk and the most vulnerable learners by enabling schools to provide proper interventions and support by means of the District Based Support Team (DBST) and the School Based Support Teams (SBST). Moreover, by far the Curriculum Assessment Policy Statement (CAPS) (DBE, 2012) through Life Skills and Life Orientation enables learners to gain knowledge on health issues.

Conversely, taking pride in the single programme intervention policies is not good enough as they cannot solve the majority of problems learners face in schools (Renwick, 2006; Leahy *et al*., 2016; Mohamed, 2015). This is because they provide a

narrow approach since they target a single risk factor such as nutrition, sexuality and HIV/AIDS. Bearing in mind that the health promotion concept in education is more theory driven, the conceptual framework, the scope and its contribution needs more clarity (Roux 2013:107).

Ordinarily the contribution of school health services as reviewed by the World Bank mean; assuring that children attends school at the right age by addressing health barriers which can hinder them from attending the school; helping children to remain in school until they finish; reducing absenteeism due to ill health and to contribute to educational performance by minimising barriers to learning (Bundy, 2011).

In most cases, the understanding of health promotion in schools is often viewed from the health sector perspective. Moreover, the DoH and the Department of Education committed to the course of an integrated policy to address the bio-psychosocial needs of schools (Lazarus, 2006) and with the positive view that there is a connection between health and educational performance for children in schools (Department of Education, 2000; ISHP, 2012). The positive view of health in education has become the agenda of schools more than before. This supports the 2015 agenda of the Millennium Development Goals to ensure better health and education for children as well as the World Education Forum agenda of Education for All (EFA).

In South Africa, the HPS framework is embedded in the ISHP Programme located within a legislative and policy background (ISHP, 2012). In the next section, the legislative documents and policies are discussed in detail.

2.7.1 The Constitution of South Africa

Young people of school-going age in South Africa are obliged by the South African Constitution to attend school and this is reiterated in the South African Schools Act (Section 36(a) Act 84 of 1996). On a positive note, the revised Constitution of the Republic of South Africa (1996), in Section 28 and 29 of the Bill of Rights in Chapter 2 focuses on the protection of people and most importantly, focus on education, among others. This brought hope on the people of South Africa since the apartheid system of segregation against blacks was weak on the health care, food, water, social security, children, and education (Bray, 2000:1). In particular, the Bill of Rights

includes the following rights, which cover most of the aspects of health of children as well. These rights are as follows:

2.7.1.1 Health care, food, water, and social security

Everyone has the right to have access to health care services, including reproductive health care; sufficient food and water; and social security, including, if they are unable to support themselves and their dependants, appropriate social assistance (Constitution of the Republic of South Africa, 1996).

2.7.1.2 Children

Every child has the right to a name and a nationality from birth; family care or parental care, or to appropriate alternative care when removed from the family environment; basic nutrition, shelter, basic health care services and social services; be protected from maltreatment, neglect, abuse or degradation; be protected from exploitative labour practices (Constitution of the Republic of South Africa, 1996). This implies that children are not to be required or permitted to perform work or provide services that are inappropriate for a person of that child's age; or place at-risk the child's well-being, education, physical or mental health or spiritual, moral, or social development. In a way, the child's best interests are of paramount importance in every matter concerning the child's well-being (Asmal & James, 2002).

2.7.1.3 Right to education

Everyone has the right to a basic education, including adult basic education; and to further education, which the state, through reasonable measures, must make progressively available and accessible to everyone (Constitution of the Republic of South Africa, 1996).

It is likely that the enrolment of children in schools increases every year. Therefore, the school health services should be concerned about the health and well-being of children in schools. In 2015, the school enrolment was 12 814 473 in ordinary public school (School Realities, 2015). The table below indicates the increase in the number of children from 2013 to 2015. The number of learners has increased nationally by 2.8% while the number of teachers has decreased by 2.1% and 0.1% respectively. However, KwaZulu-Natal has dropped in learners, teachers and schools similarly

(School Realities, 2015). It is estimated that by 2020, the school enrolment would be between 14 and 17 million in South Africa (The Healthy School Programme in South Africa, 2013:3; Flischer & Reddy, 1995).

Table 2.3: Number of learners, teachers and schools in the ordinary school sector, by province, from 2013 to 2015

Provinces	Learners			Teachers			Schools		
	2013	2014	2015	2013	2014	2015	2013	2014	2015
Eastern Cape	1 938 078	1 946 885	1 953 397	66 007	64 258	64 256	5 733	5 732	5 727
Free State	664 508	672 290	682 704	24 475	24 552	23 661	1 396	1 376	1 332
Gauteng	2 129 526	2 191 475	2 262 319	74 823	77 265	79 354	2 649	2 721	2 780
KwaZulu-Natal	2 866 570	2 901 697	2 881 518	96 057	95 560	86 493	6 156	6 151	6 137
Limpopo	1 714 832	1 720 585	1 753 734	57 108	57 256	55 930	4 067	4 076	4 045
Mpumalanga	1 052 807	1 057 788	1 079 280	34 936	35 000	35 153	1 885	1 867	1 862
Northern Cape	282 631	289 004	290 139	8 972	9 182	9 162	573	577	581
North-West	788 261	800 316	813 873	26 194	26 086	25 126	1 606	1 570	1 544
Western Cape	1 052 435	1 075 396	1 097 509	36 451	35 931	36 958	1 655	1 671	1 683
South Africa	**11 825 140**	**12 655 436**	**12 814 473**	**400 548**	**389 159**	**416 093**	**16 915**	**25 741**	**25 691**

Source: DBE, 2010; School Realities 2014

The increase in the annual enrolment calls for the government and its departments to collaborate to cater for the needs of children, especially the ones that are experiencing barriers to learning in schools. The Constitutional obligations and the policies which promote health in schools need to be taken into consideration (DoH, 2011). Hopefully, the DoH has taken the lead to deliver school health services, which included services on health assessments where school children are screened for sight and hearing, health education and health promotion, preventative intervention such as the vaccinations, immunisations and deworming as well as the environmental health assessments of schools (Education White Paper 6, 2001; DBE, 2014).

To broaden the scope of school health services, the two most important integrally linked initiatives likely to boost the potential of school health was added.

In addition, these are:

- The DBE initiative of Care and Support for Teaching and Learning (CSTL) which was adopted in 2008; and
- The HPS introduced in South Africa in 1990.

Furthermore, to top up to the commitment of providing integrated care for learners in schools, the DBE came up with a five-year plan (2012-2016), focusing on addressing the prevention of HIV, STIs and TB (DBE, 2010) in schools. To keep up with the international developments and to strengthen the school health, the DBE has also extended its mandate through a number of policy initiatives, which were beyond educational framework for the purpose of learner support. Through the adoption of the CSTL, learners' well-being was addressed over nine key areas of intervention.

Apart from the Constitution of South Africa, there are other legislative frameworks. These frameworks are mainly documents that are based on the law, ruling and governing a particular philosophy. These frameworks played a major role in the implementation of ISHP in South Africa. These frameworks are The Children's Act (Act No. 38 of 2005) as amended; the South African Schools Act (Act No.84 of 1999) as amended in 2007; the National Health Act (Act No 63 of 2003); as we as the Mental Health Care Act (Act No. 17 of 2002). The next section will present the policies that are based in the health promotion.

2.7.2 Policies in health promotion

There are policies that govern the promotion of health in schools. According to the study by Ntagungira (2014), a number of education and health polices only exist in policy, but in practice none is applied in schools. More often, schools use the policies from the provincial or national department or develop their own policies to cater for their school needs since policies cannot be a one-size-fits-all. Different schools are in different communities and their problems are not the same (Mohamed, 2015). It is said that school health policies are written documents that state the aims the school is striving towards within their health promoting effort (Samdal & Rowling, 2013).

Teachers lack the skill to implement their school policies and this also compromises their will to reach their health goals in schools. The abilities of teachers to design and to interpret policies in schools allow the teachers to build their own self-efficacy in terms of the ability to draft their own policy, which respond to the challenges of their school community. HPS policy is the basis for the promotion of health in schools and it serves as the guiding principle to direct all activities in school (Samdal *et al*., 2010).

However, it requires a collective and collegial approach in developing and implementing policies (St Leger, 2000). This has been demonstrated by the collaboration between the national DoH and the national DBE in the development of the ISHP (ISHP, 2012). The latter guides the approach of health in schools in an integrated manner where all stakeholders are involved for the common goal of achieving health and education.

Various policies guide HPS in South Africa. Moreover, the ISHP (ISHP, 2012), SIAS (2014), Education White Paper 6 (2001) Life Orientation/Life Skills policy (2012) are used in line with other policies to guide teachers in the application of policies in the classroom. The focus of these policies is more directed to learner support where teachers are supposed to give support to a particular learner in consultation with the parent.

Instead of supporting learners in the classroom, teachers mostly focus on the administration of completing SN1 form (for the learner outset support for learners with disabilities). In addition, teachers focus on learners who were identified during the teaching and learning process as having the need for support (via Profile learner) and SN2 form (for learners who have not benefitted from the support from the teacher and they need more support from the SBST (DBE, 2014) as a means of support.

Although policies give directives for the activities in schools regarding health issues, the health and education goals operate in opposite directions although the purpose is to promote health (Viig *et al*., 2010; Mohamed, 2015). Depending on particular countries, health is not taken seriously or it is given low priority (Jourdan *et al*., 2008) Depending on the general political organisation and goals of education system subject to individual country, there are different ways to tackle health issues in schools. In most cases, teachers are not aware of their role in HPS (Jourdan *et al*., 2008). For the purpose of strengthening health in schools, the following policies were discussed.

2.7.3 SIAS Policy document

The SIAS policy is considered in this study because it is closely aligned to the ISHP to construct a continuous “system of early identification and effective intervention to minimise learning breakdown and potential dropout” (DBE, 2014). The importance of

the SIAS policy should be seen as a means to ensure the transformation of education towards an inclusive education, which is aligned to the Education White Paper 6 (2001). In its purpose, it covers the modus operandi and the set of official forms to be utilised by teachers, SBST and DBST in the course of screening, identifying and assessing health challenges experienced by learners in schools (DBE, 2014).

It has been stated in the SIAS (p, 5) policy document that it has been structured in a way that teachers can understand the support needs of learners and maximise support as well as the support from all levels in the education system. In its principle of support, the SIAS (p, 7) policy indicated that support of learners should no longer focus on the diagnosis and remediation of deficits in individual learner by a specialist staff (Psychologist) but to adopt the holistic approach where all barriers are attended to simultaneously.

The report by the NCSNET/NCESS found the inadequacy in the processes applied in terms of identification and placement and they made the following recommendations:

- To discontinue the use of standardised tests for the placement of learners in specialised learning contexts;
- The procedure used for the placement of learners who require higher levels of support should be reviewed as matter of urgency; and
- The new procedure should be based on the principle that assessment should focus on determining the optimum support learners require, and how and where they would assess it.

(Department of Education,1997:126).

In addition, the SIAS policy clarified the fact that the nature and extent of support can only be determined by evaluating the following:

- The existing resources or support available to the learner and the school;
- The additional support that is still required; and
- What is available within the province or district that could reasonably be made available at school level through a range of means (SIAS, 2014:8).

Above all, it lies with the teacher in the classroom who is supposed to gather information and identify learners who were at-risk as well as to develop classroom

based interventions for the learners who have been identified (DBE, 2014). Furthermore, it has been stated that the teacher can consult the SBST for support and if need be, the DBST can further provide support in terms of inviting specialised services such as the services of the psychologist, speech therapist, physiotherapist, and occupational therapy for further assessments.

It is known that teachers assess their learners on a regular basis DBE (2012). Moreover, a number of teachers fail to meet the national outcomes requirements as defined by the Department of Education (1998). Assessment is an essential part of the education process for all (Wevers, 2012) Therefore, SIAS policy can be a great tool to assess learners as the policy has stated the role of teachers and practitioners are stated as follows:

- The teacher's role in an inclusive environment is crucial. A conceptual understanding of inclusion and the diverse needs of learners, including those with disabilities, is required.
- Learning programmes and materials as well as assessment procedures must be made accessible to all learners, and must accommodate the diversity of learning needs in order to facilitate learners' achievement to the fullest.
- The Learner Profile document will serve primarily as a tool for teachers to plan interventions and support on a day-to-day basis for all learners as part of the teaching and learning process.
- Teachers must take care not to label learners who are identified for additional support, thereby promoting exclusionary practices.
- The uncovering of barriers to learning must be based on sound observation, interviews and consultation, reflection, formative actions, previous records and should be grounded in the curriculum.
- The procedures outlined in the Guidelines for Responding to Diversity in the Classroom will assist teachers to plan support for individual learners who experience barriers to learning.
- The support will include differentiation of content, adjustment of classroom methodologies and classroom environment, and applying the necessary accommodations in assessment and examinations.

Once the teacher has exhausted all strategies, he/she will consult with the SBST.

The SIAS process clearly outlines how the process of screening, identifying and assessing learners for eligibility to receive additional support in special schools or specialised sites is to be replaced by structures that acknowledge the central role played by teachers, school-level support teams and parents (Education White Paper 6, 2001:7).

It is against this background that a change in attitudes, behaviour, teaching methods, curricula, and environments is needed to meet the needs of all learners. Maximising the participation of all learners in the culture and curriculum of schools, and uncovering and minimising barriers to learning, are the central objectives of screening, identification and assessment.

The teacher and all who are directly involved with the learner on a daily basis are expected to apply the SIAS process. The teacher must assume the role of case manager to drive the support process. Information gained from external assessments should serve only to enhance the understanding of the interventions needed and should not be central in decision-making around support. The knowledge and wishes of the parents/caregivers must carry the ultimate weight in any decision-making process.

The final ratification, monitoring and quality assurance of the support programmes will be the responsibility of the DBST. The SIAS process (including the Learning Profile) is a tool for early intervention. It is designed specifically to help practitioners to assess needs at an earlier stage, and then work with families, alongside of other practitioners and service providers, to meet those needs (DBE, 2014:33).

The form of support that requires the teachers to identify barriers to learning in the classroom would seem to be impractical because of the teachers' lack of knowledge and skills to accurately identify barriers to learning without any discrimination (Ntsanwisi, 2007). In the same vein, Adelman and Taylor (2002) share the lack of common understanding when it comes to the definition of what constitute barriers to learning and learning difficulties.

2.7.4 The Integrated School Health Policy (ISHP)

The ISHP is also one pillar that supports the promotion of health in school since it is integrated in its approach with the DoH and the DBE. Its aim focuses on building and strengthening the existing school health services in schools (ISHP, 2012), but with some changes compared to the 2003 School Health Policy (SHP). In its initiative, the ISHP aims to:

- Strengthen the collaboration between DoH, DBE and the DSD for the purpose of serving all learners in all schools;
- Provide all learners in all phases of their schooling with school health services;
- Provide more comprehensive schools health services package that do not only focus on barriers to; learning but to other factors which can have an effect in the learning of learners;
- Place more emphasis on the provision of health services as opposed to screening and referral in schools;
- Implement a more systematic approach where the most disadvantaged schools was the target and further to all learners; and
- To be implemented within the Care and Support for Teaching and Learning Framework being utilised by the DBE.

In its principles, the rights of children are central since active participation is encouraged for their development (Viig *et al*., 2010). This has to focus on the learners who are in disadvantaged schools to all learners in all schools. The key objectives are set to be achieved by strategies such as health promotion and health education, essential school health service package, coordination and partnership, capacity building, and community participation (ISHP, 2012:11). In its target, learners experiencing barriers to learning are also included. However, teachers are not specified as active participants. Nevertheless, they are seen as beneficiaries.

The ISHP (2012:12) clearly indicates that its focus is on school-going age children, although the school community; including teachers, school management, school administrators and auxiliary staff including parents and other caregivers are mentioned to benefit from the programme. The SHS as specified in the ISHP are said to be provided in minimum in all schools.

2.7.5 Education White Paper 6

Education White Paper 6 is a policy that was designed to redress the inequalities of the past in terms of the education system. The policy aims to challenge the critical suppositions of the past regarding teaching and learning where vulnerable and marginalised learners were discriminated (Oswald, 2010). To achieve effective teaching and learning, the Education White Paper 6 (2001) stated the following goals for teachers:

- To support inclusion;
- Advocacy and to raise awareness;
- To embrace diversity;
- To change of perceptions and attitude;
- To address the needs of all learners;
- To accept people who are facing challenges;
- To accept people who are different; and
- Stop discrimination.

In addition, the Education White Paper 6 (2001) gave clarity on how inclusive education should be implemented in schools. The following should be followed:

- All learners are able to learn provided they are given support;
- Enabling the education structures, systems and the learning methods to meet the needs of all;
- Acknowledging and respecting learners differences;
- Acknowledging that learning occurs within the systems;
- Changing the attitudes, teaching methods, curriculum and the settings to accommodate needs of all learners; and
- Maximising participation and minimising barriers to learning.

Furthermore, Education White Paper 6 (2001) emphasises the importance of human resources development for teachers as they are regarded as the link to achieve inclusive education goals. The policy stresses the collaboration of sectors at all levels to make inclusive education a reality in schools. Over and above, the management and governance of the developmental programmes are critical to speed up the implementation of inclusive education in schools. However, the overall plan to achieve the goals of inclusive education in terms of catering for all learners in schools is

unfolding slowly. Hence, all the processes within the system of education to attend to the needs of learners in schools are delayed.

Health policies and programmes are critical for the development of ISHP (2012). Hence, health promotion in schools is provided using a number of policies and programmes. These programmes and policies are as follows:

- The HPS Initiative;
- The Youth and Adolescent Health Policy;
- National Strategic Plan on HIV, STIs and TB: 2012-2016;
- Regular treatment of School-going Children for Soil Transmitted Helminth Infections and Bilharzia Policy and Implementation Guidelines;
- Child and Adolescent Mental Health Policy Guidelines;
- Immunisation Policy; and
- Integrated Nutrition Programme.

Health policies are good in themselves. However, they have to be supported by education policies and programmes, which will ensure that children's health in schools was taken care of in many dimensions (Ntagungira, 2015. These policies and programmes are as listed below.

2.7.6 Education policies and programmes

The Education policies and programmes within the DBE are mainly focused on the establishment of healthier and enabling school setting. Many of the sentiments within the education policies were shared with the health policies. Above all, the policies that govern health promotion in education imply:

- DBE Integrated Strategy on HIV, STIs and TB, 2012-2016;
- National School Nutrition Programme (NSNP);
- National Strategy on Screening, Identification and Support (SIAS);
- Education White Paper 6: Special Needs Education - Building an Inclusive education and training system;
- Schooling 2025 and Action plan to 2014;
- Care and Support for Teaching and Learning (CSTL); and
- Whole School Evaluation

2.7.7 Social Development Policies

In addition to the education and health policies, there are also DSD policies and programmes, which support health promotion in schools.

- Child Support Grant;
- The National Action Committee for Children Affected and Infected by HIV and AIDS (NACCA);
- The National Integrated Plan on Early Childhood Development (ECD); and
- The National Strategy for Prevention of Child Abuse, Neglect, and Exploitation.

In one way or the other, the policies that cater for the health of children in schools take the central stage. Hence, these policies are so interwoven to give the maximum support for the programmes.

2.7.8 Current scenario in the implementation of school health in South Africa

In South Africa, the implementation of the School Health Policy is at different levels in the nine provinces, with other province ahead and others slowly (Mohamed, 2015). Nevertheless, since 2003, the implementation process has been slow, with low coverage at sub-district level (DoH, 2011; ISHP, 2012). Even though in some provinces there is confusion in the application of the concept based on how the HPS programme was presented in schools, health promotion in schools is used interchangeably with HPS although their definitions are slightly different. The concept of school health programme has been more based as a component of the PHC package (ISHP, 2012).

The school health services in most parts of the country were attributed to a range of factors, which according to DoH (2011) include:

- Managerial variation in the value attached to school health services;
- Inequitable distribution of resources in both urban and rural settings;
- The challenge of integrating previously vertical and fragmented services into comprehensive PHC services;
- Competition for limited resources;
- The demand for curative services (*aimed at short term survival*) outweighs the preventive and promotive services (*aimed at long term improvement in health and quality of life*); and

- Poor data management of comprehensive programmes impacting on reporting school health services.

Currently, the school health services are delivered by designated School Health Nurses who form part of the PHC staffing (Kwatubana & Kheswa, 2014; ISHP, 2012). According to DoH (2011), the 2010 Report on the Review of the School Health Policy implementation showed that nurses have expressed the following views on issues that impact on the provision of quality services:

- Insufficient staff and infrequent visits to schools, this limits their ability to give children the time and attention that they need;
- Lack or insufficient basic equipment such as weighing scales;
- Lack of a conducive environment in classrooms for screening and examining children properly, including mental health assessment due to lack of privacy;
- Referral systems are not always available to respond to identified health needs;
- Follow-up are rarely conducted, as nurses generally visit schools once a year; and
- Unavailability of transport, poor roads and infrastructure curtails access to reach areas.

In general, the implementation process of school health was moving at a slow pace to an extent that there was a need for improvement with regard to the number of school health nurses to provinces, which can result in total disparities (Kwatubana & Kheswa, 2014). Owing to a shortage of school health nurses, some of them are recalled to relieve where there is a shortage (Department of Education, 2000). Not only the shortage of school health nurse is a problem, the supportive supervision by line managers is minimal (DoH, 2011).

The principle of HPS and the Constitution of South Africa, where the school environment is supposed to be conducive is found to be generally dilapidated in both rural and urban areas. According to DoH (2011), there is no place for privacy for screening of learners. Kwatubana and Kheswa (2014:1717) found out that “there were no teachers involved in the process of the implementation of the ISHP in the participating schools”. In addition, it was reported that in some schools there was poor sanitation owing to lack of water.

Bearing in mind that schools are places where society's main concerns on health converge, the schools' health programme needs to be revisited. The school health programmes as presented and summarised by the DoH (2011) was analysed in the Table 2.4 below.

Table 2.4: Strengths, Weaknesses, Opportunities and Threats (SWOT) Analysis for school health programmes

STRENGTHS	**WEAKNESSES**
• Political support for SHS. • Availability of policy guidelines. • Availability of SHS focal person at the National Office.	• Weak intersectoral collaboration – school health still perceived as a DOH responsibility. • Poor supervisory support visits mechanisms - supervisors engaged in several programmatic responsibilities, school health is not prioritised. • Provincial Autonomy - National office has no control over the provincial activities including indicators and targets. • Lack of resources: o Human: Non availability of school health nurses at implementation level o Equipment o Financial o Transport
OPPORTUNITIES	**THREATS**
• Collaboration with the DBE is possible. • Schools have the potential/ capacity to be accredited HPS.	• Lack of resources: o Human: school health nurses o Equipment o Financial – budget for school health services o Transport

• Provincial School Health coordinators • School Health weeks provide an opportunity to improve learner coverage. • Intra sectoral collaboration is possible – business unusual. • Community partnership. • Donor support.	• Poor information management – unavailability of readily accessible data on public primary schools and total number of learners. This includes poor data management from the implementation site to the national office. • Poor referral system to address the learner health needs identified- e.g. non-availability of social workers • Non-coterminous districts for the Departments of Health and Basic Education.

Source: DoH, 2011

The analysis of school health programmes as summarised by the DoH (2011) presented the following elements:

- **Strengths**

The health promotion programme in South Africa drew its strength from the fact that there is a political support where education is seen from the Constitution of the Republic South Africa as a basic human right (1996). Moreover, a number of policies support the Constitution and policy guidelines, which strives to promote the health of learners in schools. Policies such as the National Policy on HIV/AIDS (1996); Education White Paper 6 (2001); National Strategy on Screening, Identification and Support (2014); National School Nutrition Programme (1994); South Africa (2012) as well as the Integrated Strategy on HIV, STIs and TB 2012-2016 (2012) are utilised to promote health in schools. Above all, for the purpose of coordination, there is also a School Health Services (SHS) focal person in the national office.

- **Weaknesses**

Apart from the strengths that the school health programmes have, there are weaknesses that can hamper the progress of school health programmes. International

evidence has proven that the success of school health programme lies in the collaboration between the sectors (ISHP, 2012). However, it has been found that there is a weak collaboration between the DoH, DBE as well as the DSD, basically because school health is perceived as the responsibility of the DoH. According to the ISHP, through the PHCU, the professional nurse is responsible for coordinating the implementation of ISHP (2012). In addition to the SIAS policy (2014), the professional nurse also ensures the referral and follow-up when required. Kwatubana and Kheswa (2014) found that there is weak collaboration between the sectors because teachers were oblivious of what the school health nurses were doing in their schools. Poor supervision was also seen as a weakness where not all stakeholders took school health seriously where the national office has no authority over what is happening in the province. Over and above, the ISHP raised a number concerns where resources such as human, equipment, financial as well as transport were lacking (ISHP, 2012).

- **Opportunities**

The school health programmes have the better opportunity to improve, irrespective of what has been mentioned as the weakness in the collaboration of sectors merely because there is a possibility to collaborate with the DBE. Through proper implementation strategies, it has been found that schools have a potential to be accredited as HPS provided there are provincial coordinators who can provide schools with leadership.

- **Threats**

According to the ISHP (2012), three things can threaten the school health programmes. Firstly, these things include lack of resources where many schools are left unattended to; secondly, information about the school health program is not readily available starting from the implementation site to the national office; and thirdly, although it has been indicated as part of the responsibility for the professional nurse to attended to the referral of learners (ISHP, 2012), still it has been found that the referral system is poor because social workers were not available to offer their services.

The Bronfenbrenner's ecological systems theory is composed of levels that overlap, where failure to one system can mean failure to the other levels (Ntagungira, 2014). The analysis of school health programmes has been said to be dependent on the roles of DoH as well as the DBE from the national, provincial and district level as it has been presented in Table 2.5.

Table 2.5: Roles: Departments of Health and Basic Education at National, Provincial and District level

LEVELS	HEALTH	EDUCATION
NATIONAL	• Provide strategic direction in the implementation of school health programme • Coordinate the implementation of the school health policy • Facilitate the integration of health programmes impacting on learners in schools • Standardization of implementation of school health services • Development of orientation manual for school health services • Advocate for the necessary human resources • Resource mobilisation for the implementation of the school health policy • Conduct capacity building of both health professionals and teachers. • Monitoring and evaluation • Identify researchable areas for school health	• Mobilize teachers and the school community on the implementation of school health programmes in the school setting • Facilitate linkages between school health nurse and teachers • Advocate with relevant local Government on water supply and sanitation in schools • Avail appropriate environment for screening of learners • Collaborate with DOH in capacity building of both teachers and health professionals • Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package.
PROVINCIAL	• Appoint a school health focal point.	• To ensure that there is school health focal point

LEVELS	HEALTH	EDUCATION
	• Develop implementation plan for school health programme taking into account the need to cover all school and all learners as outlined in the school health policy • Integrate health services within the PHC approach • Collaborate with Basic Education in the development of a schedule for school health activities • Systematically collect data on school health services • Adapt the national school health policy to suit their local setting • Adaptation and translation into local languages of school health materials • Appoint school health nurses • Conduct capacity building of both health professionals and teachers • Conduct supportive supervision • Resource mobilization for the implementation of the school health policy at local level • Establish a school health steering committee with relevant stakeholders	• Provide total number of schools and learners upon the enrolment at beginning of school calendar • Collaborate with Health in the development of a schedule for school health activities • Mobilise teachers, learners, parents, school governing bodies, and the community on the implementation of school health programmes in the school setting • Facilitate linkages between teachers and school health nurse • Advocate with relevant local Government on water supply and sanitation in schools • Avail appropriate environment for screening of learners • Conduct capacity building of both teachers on Health Promotion and Education and first aid • Participate in the steering committee

LEVELS	HEALTH	EDUCATION
	• Convene school health meetings at the provincial level with relevant role players	• Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package
DISTRICT	• To ensure that there is school health focal point • Develop implementation plan which fits into the district integrated development plan, with clear objectives and indicators • Establish a school health steering committee with relevant stakeholders • Convene school health steering committee meetings at the district level with relevant role players • Strengthen existing system: communication, transport, equipment and proper referral system • Conduct joint supportive supervision (health and education) • To systematically collect data on school health services	• To ensure that there is school health focal point • Provide total number of schools and learners upon the enrolment at beginning of school calendar • Collaborate with Health in the develop a schedule for school health activities • Mobilize teachers, learners, parents, school governing bodies, and the community on the implementation of school health programmes in the school setting • Facilitate linkages between teachers and school health nurse • Advocate with relevant local Government on

LEVELS	HEALTH	EDUCATION
	• Conduct capacity building of both health professionals and teachers • To integrate health services within the PHC approach • Establish linkages with communities and local leaders • Collaborate with Basic Education in the development of a schedule for school health activities • Appoint school health teams	water supply and sanitation in schools • Avail appropriate environment for screening of learners • Conduct capacity building of both teachers on Health Promotion and Education and first aid • Participate in the steering committee • Provide for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package • Avail first aid kits, scales, and measuring tapes in schools

Source: from DoH, 2011

The roles that can be played by teachers as promoters of health in schools can be highly influenced by the roles, which have been played by the departments from the national, provincial as well as the district level (Shung-King, 2013). It is clear from the table above that the roles are outlined from the top-bottom approach where the national departments provides the strategic direction and mobilise resources whereas the provincial departments are responsible for adapting the policies to suit their local

settings hence the approaches vary according to the needs of each province in South Africa.

Lastly, the districts ensure that implementation occurs down to schools. According to Kwatubana and Kheswa (2014), it has been found that poor administration has a serious impact on how health promotion is implemented in schools. The ISHP has indicated lack of both human, equipment, financial, and transport resources, which has an impact on the delivery of school health services (ISHP, 2012), and as such, many children were not reached.

2.7.9 Barriers in the implementation of HPS

The critical element about the implementation of HPS is that it is very much based on theory and not practice (Mohamed, 2015), where each country and schools have to apply it according to their context (Samdal & Rowling, 2013). Lack of accountability and poor administration has been the contributing factors in the failure of implementation in schools (Kwatubana & Kheswa, 2014; Mohlabi *et al*., 2010; Newmann, King & Rigdon, 1997). That clearly says that there is a gap between discourse and practice since very little information about implementation in schools is available (St Leger & Nutbeam, 2000).

There is a gap between what is acknowledged as intervention and what children and their families actually need (Kwatubana, 2014). There is a noticeable change on the physical environment of the schools but community partnership is rather disappointing (Marshall *et al*., 2000; Deschesness *et al*., 2003; Kwatubana, 2014). Most of the literature dealing with community partnership aims to exhaust resources from the community and not actually working with the community (Deschesness *et al*., 2003).

Mostly teachers see their relationship with parents as being one-sided as teachers want parents to support them in their educational role (Clelland *et al*., 2013). The possible supposition indicates lack of evidence concerning successful implementation owing to the complexity and difficulty to implement in a meaningful way and lack of evidence, which proves success of the programme in schools (St Leger, 1999). If it is available, it is still in its infancy. It can be argued though that more information in HPS speaks more to the theory of HPS and lack implementation in schools.

Lack of resources for providing teacher professional development, coordination and integrated participation with all stakeholders can undermine the efforts to implement HPS in schools (Mohamed, 2015). For schools to prosper, they need funding from the department or support from the NGO's. However, lack of support can compromise teacher effectiveness in terms of implementation. According to Leeder (1997), the financial support and commitment from policy makers is critical for successful health promotion intervention. Ziglio *et al*., (2000) subscribe to the notion that such commitment in many countries is until lukewarm.

Nevertheless, HPS programmes in schools and in the community are quick fixes mentality, which turns out to be one time intervention of low quality, which produces few lasting changes (McEvoy & Welker, 2000). Marx *et al*., (1998) and St Leger (1998) concur that it is vital though to develop appropriate support in the form of resources, proper training and commitment. Above all, Mohamed (2015) and Kwatubana (2014) added the lack of understanding of the HPS concept; teachers experiencing challenges in their normal course of work; the need for support and lack of leadership and commitment from principals as some of the barriers in the implementation of HPS. One contributing factor could be the dearth of scientific literature on HPS in South Africa as there are limited numbers of published studies (Mohamed, 2015).

2.8 HEALTH PROMOTING SCHOOLS CONCEPTUALISATION IN THE GAUTENG PROVINCE IN SOUTH AFRICA

2.8.1 Introduction

The HPS programme in Gauteng Province started by appointing an Assistant Director in the DBE to assume the responsibility of the concept implementation (Roux, 2013). The HPS concept is still very much confused with the traditional health education and physical education in schools. Likewise, it is tied with Life Skills or Life Orientation subjects. Sometimes the concepts are utilised in a much closer meaning whereas there is a huge difference. In principle, health education, health promotion, learner assessment, identification and screening as well as immunisation are integrated within the ISHP document (ISHP, 2012).

The confusion is also aggravated by the fact that although the development and implementation of HPS has been a strategic objective for the DBE under the Health Promotion Directorate. Accordingly, the DoH takes the lead by providing health services, which can only be supplied by school health nurses (ISHP, 2012) irrespective of the written guidelines for the development and implementation of the HPS concept (Motlatla, 2007:61). In support of the initiative, the ISHP allocates school health teams, which visit schools (ISHP, 2012). Many teachers in schools are not aware if they are to be involved in HPS or not (Kwatubana & Kheswa, 2014).

It is expected that at school level, there must be HPS committee established to cater for the needs of children. This committee can be in a form of collaboration between school health team and the School Based Support Teams (SBST) for the purpose of sustainability. However, literally, this is not possible since the SBST does not have skills and the capacity, which according to Stofile and Green (2007), the cultural ethos of collaboration for the purpose of promoting health in schools has not yet been conceptualised, and this applies to schools in the Gauteng districts as well.

Currently, there is a provincial committee in the Gauteng provinces as well as the sub-committees in the districts, which deal with the health promotion in schools. The district structure is also known as the DBST. According to JICA (2007), collaboration between health, education, social development departments was still problematic in a way, although there is an ISHP policy in place (ISHP, 2012).

In line with the focus in this research, the HPS in the Gauteng Province boasts of 14 primary schools that are considered pilot schools for the programme. The initiative of HPS in the Gauteng Province was done in collaboration with JICA where these schools are specifically involved in projects relating to school safety, life skills regarding HIV/AIDS and teenage pregnancy, nutrition and physical activity as well as tobacco control and substance abuse. It cannot be ruled out that majority of schools in the Gauteng Province are not yet considered to be HPS, although activities pertaining to HPS programme as per the SIAS document and the ISHP are taking place in all schools in the province.

These activities include screening, identification of barriers to learning, deworming, and the Human Papilloma Virus vaccine known as HPV, which is given to 10 year old, which prevent the virus that causes cancer to girl children in schools. However, it is round about 66% of Gauteng schools which at least have access to school health services. According to Motlatla (2007), there is a plan in action where other schools were rolled in to become HPS as well.

Almost a decade later, more than 60% of schools in Gauteng are becoming health conscious in how their learners must learn in schools. The difficulty though is in finding the schools progress in line with the ISHP. Success and failures in the program are shared from within the HPS directorate in the Province (Mohlabi *et al.,* 2010). The cycle of health services provided in schools through the collaboration and coordination of the three joint departments in the province is met with serious challenges, which can hamper the progress.

According to JICA (2006), these challenges are lack of transport in various districts and short-staffed with school health nurses (ISHP, 2012; Kwatubana & Kheswa, 2014; Motlatla, 2007:62). Some of the challenges include lack of professional development for teachers, unclear roles for stakeholders, lack of Learning, Teaching and Support Materials (LTSM) to address health issues in schools.

According to Roux (2013), the implementation of the HPS concept in the Gauteng Province has been progressing very well because of the funding by the JICA, which also surveyed the schools to see the possibility of implementation. In the other eight provinces, it was reported that the progress was very slow (Mohamed, 2015) and has been hampered by lack of funds and resources geared towards the project (Mohlabi *et al*., 2010). In addition, Mohlabi *et al*., 2010) indicated that the Western Cape, North West Province as well as KwaZulu-Natal were reported to be successful with the implementation of the program. The nature of schools in Gauteng Province was discussed below.

2.8.2 The nature of HPS schools in Gauteng Province

In order to comprehend the development of schools with regard to HPS in Gauteng Province, the nature of these schools was examined thoroughly. This was done by

looking at the factors underpinning health promotion philosophy and which has been adapted in line with five health promotion components. According to WHO (1996), these components cover the development of healthy school policies; access to appropriate services; the development of personal skills of members of the school community; the development of the school as a supportive environment for the development of healthy attitude and practices as well as the community action that seeks to involve the schools and the broader community. Although this was not followed categorically, according to Sizanang Centre for Research and Development (2006), the characteristics of the HPS and the elements, which forms the health component as per the framework for the development of HPS in Gauteng, was be analysed.

2.8.3 Characteristics of health promoting schools in Gauteng Province and their immediate surroundings

The characteristics of the schools are based on the HPS that were declared as such by the GDE. These schools were found in diverse settlements, which are in farm schools such as Cullinan; in the informal settlements, such as Diepsloot and Soshanguve areas. Overall, communities that display poverty and unemployment irrespective of their settings surrounded these schools (Sizanang Centre for Research and Development, 2006:28).

The prevalence of HIV/AIDS related sickness and other communicable diseases, which sometimes can lead to death, was very much common in these areas to such an extent that their grandparents and other caregivers in the community care for some children. Owing to lack of jobs in rural and informal settlement, migration to larger urban areas in the search for employment is very much common (Sizanang Centre for Research and Development, 2006:28) and children are left to fend for themselves.

According to the report by Roux (2013), some school structures were initiated by missionaries who settled in some of these areas more than 100 years ago, whereas some of these schools are still recent, that is less than a decade. Some of these schools were a bit far away from where learners stay, and accessibility to these schools has been highlighted as a concern since learners have to travel long distances

barefoot and using public transport such as buses and trains (Sizanang Centre for Research and Development, 2006:29).

2.8.3.1 School funding

After 1994, the process of transformation took place to improve the schools which were in disadvantaged communities in order to redress the imbalance of the past (South African Schools Act, Act 84 of 1996, section 34 (1). Despite the efforts to address the imbalance the past in schools, inequalities still exist (Mormot, 2005; Bloch, 2009) where schools situated in the rural areas and disadvantaged communities suffer the most and this has called for the critical reform in the education system (Engelbrecht & Green, 2001).

This implies the school funding norms, which was influenced by poor 'quintile indicators' which determine the school budget transfers, where quintile 1 & 3 schools are the poorest schools incurring the highest total expenditure. According to SASA (Act 84 of 1996, section 34 (1), the post-apartheid government was committed to uplift the system of education in redressing the imbalances of the past and inequality in education by developing a system that determines the required amount of funding for each school called quintile. The quintile score was designed by the poverty score of a school, or quintile rank, which is based on the poverty level of the community in which it is situated.

To ensure equality and fairness in how school funding is allocated ISHP (2012), the Human Sciences Research Council (HSRC) (2009) brought about a means to calculate the funding and the score is calculated using national census data; weighted household data on income dependency ration and the level of education of the community. The division goes further into section 20 & 21 schools (Sizanang Centre for Research and Development, 2006:29).

SASA clearly postulates how schools should spend their funds. As such, Section 21 schools as soon as they receive their funding per learner, they are expected to buy their own resources needed for the academic year. Opposite is the case with section 20 schools since they are not yet section 21 and they are not liable to acquire their

own goods and services. However, their supply of goods and services is done by the GDE provided their needs are identified.

According to Sizanang Centre for Research and Development (2006:29), the supply of goods and services to section 20 schools enables the schools to improve the capacity to be in section 21 schools since they do not have access to funds because they are only informed about their budget. The use of funds in both schools can affect the development of the ISHP programme in the province because the lack thereof can hinder the progress, especially because the whole funding is provided by the JICA. The issue of sustainability if schools do not have power in the funding can be insurmountable.

2.8.3.2 Health services progress

Health services as the major part of the HPS is essential for the progress of health and development of children in schools as it has a direct effects on children (ISHP, 2012). According to the SIAS (2014) policy document, this is where screening, identification, assessment, and support take place within the school environment. Likely, the Gauteng Province, the DoH through its directorate, promotes the implementation of the School Health Policy Guidelines with the purpose of promoting the health of children in schools basically early identification and appropriate during schools visits in all districts in Gauteng (Sizanang Centre for Research and Development, 2006:30; Motlatla, 2007:10).

With regard to the progress in Gauteng Province, all the districts have delivered the Phase 1 of school health services, which covers screening on hearing and vision assessment regardless of encounters and referral to the specialist. According to Sizanang Centre for Research and Development (2006:31), in 2005, both phases of school health services were provided to 117 228 learners from 613 primary schools, and a total of 16 347 learners with deficiencies were identified and referred properly.

Phase 2 has been rolling out in schools and it has covered elements in Phase 1 as well as oral health assessments. However, in both phases, teachers' role is not well defined since health professionals provide health services (Kwatubana & Kheswa, 2014). On top of that the health professionals also provide health education on topics

such as eye care, how to preserve hearing, teenage sexuality and other topics which might have been identified by school (DBE, 2014). To top-up, the DoH (2009) strengthens the knowledge by distributing health guidelines booklets.

2.8.3.3 Matters of concern regarding the school environment

With regard to the progress of HPS programme in schools in the Gauteng Province, the following matters of concern with regard to the schools environment were highlighted. According to Sizanang Centre for Research and Development (2006:34), these matters include the environment around schools, which exposes learners to possible child abuse. There were a number of cases where children would come to school beaten by their parents or even show signs of sexual abuse. Some of these cases often go unreported.

Besides many children facing abuse in their households, there were also signs of negligence identified by teachers in their classrooms, where children would come to school untidy and the homework not done. According to Roux (2013), in a number of times, teachers find themselves in a state where they do not have any other measures to help children to understand that littering is not good and that they have to take care of their school environment.

Basically, littering occurs in schools where the society environment is filthy and the majority of parents are unemployed (Donald *et al*., 2010). In some instances, schools experience vandalism of school properties by the community with the expectation that the DBE would replace whatever has been stolen (Sizanang Centre for Research and Development, 2006). In some schools, owing to the relationship the schools have with the members of the society, they do not experience the challenges of vandalism since members of the community feels that they have the responsibility to look after the school even when the school staff are not around during school holidays.

Schools in the informal settlement experience serious challenges of littering as well as the lack of water owing to the theft of the thermostat of the borehole. According to Roux (2013), it was reported that this has an effect in the hygiene of learners as well as the staff because it can probably take three to four weeks without water and teaching and learning has to proceed without the basic need, which is water. The

teaching of washing hands before and after eating was then disrupted merely because there is no water, and gardening that is seen as the supplement of the nutrition programme in schools, was also affected because of lack of water.

According to Roux (2013), the other matter of concern was the issue around safety for people and the school resources, which were reported to be volatile since they have been burgled several times. In some schools, it was reported that there were no scholar patrols that can help other learners when they cross street to and from the school. This was also aggravated in some schools by the fact that the security guards who were supposed to safeguard the school did not have any specific training as they were hired directly from the community. Through the HPS, some schools were able to design their own means of safety for their learners. This was done by creating a separate gate for learners apart from the gate, which is mainly used by teachers and guests of the school.

2.8.3.4 Existing health promotion activities implemented at schools in Gauteng

As part of health promotion initiatives in the Gauteng schools, the following activities were being implemented. According to Sizanang Centre for Research and Development (2006:36), these activities include HIV/AIDS programmes, vegetable gardens and nutrition programmes, physical activities, sanitation, personal hygiene as well as the visits by school health nurses. Little is known as to how teachers can have an influence regarding these activities (Kwatubana, 2014).

Curriculum Assessment Policy Statement (CAPS) (2012) clearly postulates that teachers are dealing with health and the health promotion by means of Life Orientation or Life Skills. Moreover, in other instances, the garden is also used for subjects such as Maths where children in the Foundation Phase learn how to count and to differentiate the vegetables in the garden and where learners learn about different types of herbs.

It is of great concern though, that synergy between activities by school health nurses and teachers were not clear (Kwatubana & Kheswa, 2014). Apart from what teachers learned from the JICA and other stakeholders, there is less initiation of activities since teachers follow or wait for directives from the province.

2.8.3.5 School's health policies

Owing to the fact that schools are found in diverse environment, it also grants them an opportunity to design their own school health policies, but that is almost impossible because teachers are finding it hard to even understand the HPS concept (Mohamed, 2015). In Gauteng, most schools have implemented the GDE's health-related policies. Some of these schools are using and have developed their own health promotion policies that were said to be aligned with the GDE's policies.

According to Moolla, Lazarus and Reddy (2007), various schools have implemented policies such as HIV/AIDS, health and safety, school health nutrition and a policy for learners with barriers to learning. Although the progress on policies has been achieved in a number of schools, the difficulty lies with the teachers who find it hard to implement these policies in school (Mohamed, 2015). However, it was indicated that through rigorous review and support for teachers implementation burden could be reduced (Swart & Reddy, 1999; Sizanang Centre for Research and Development, 2006:37).

In the HPS, policies are fundamental for the implementation of health practices. There are important policies that are very much linked to the HPS. These are the ISHP, which offers more details on the nature of the programme and the policies, which are linked to it as well as the SIAS policy document, which then gives teachers a better understanding on how to work with all the support systems, which then help with the development of a child. This starts from the teacher who is in contact with the learner on a daily basis to the SBST, through to the DBST to the provincial directorate.

2.8.3.6 Health related services rendered at schools

Professional health practitioners such as doctors, nurses, psychologist, and therapist, who by then were designated to work with a number of schools offered school health services in schools (Kheswa & Kwatubana, 2014; Marx *et al*., 1998). In line with the ISHP (2012:14) school health package, most HPS have received services from school health nurses. These services were outlined in the DoH (2009) and the SIAS (2014) policy document. It can be said that these services were crucial for the promotion of health for schoolchildren.

Besides the professional health services offered in schools, teachers were heavily involved in ensuring that there are sustained gardens in schools of which the seed was offered by BMW as well as the Department of Agricultural, Forestry and Fishery (Roux, 2013). Most often, teachers supplement the School Nutrition Programme (SNP) by adding vegetables on the feeding scheme meals offered to children every day at school and even to give food to the neediest children to take with home. On top of that, owing to the nature of teachers' profession who are then immediate source of contact with learners, they find themselves rendering services that are supposed to be done by health professionals (Mohamed, 2015).

Services include having to counsel children with emotional problems and to take care of children whose parents are not responding to the call from school to pick up a sick child. To some extent, it was reported that sometimes teachers even go beyond their call of duty by taking children to the doctors, especially when they realise that the referral process is going to take long (Terburgh, 2015). The other challenge is that the relationship between the school health nurses and the teachers is not well defined, hence when the health professionals approach the school, it is because they have to complete their duties as per the requirements by the ISHP or probably there is an outbreak within the province where they have to vaccinate all learners. In some cases, school health nurses find it hard to be accommodated in schools (Kheswa & Kwatubana, 2014). Teachers find it very difficult again to work with children with chronic illness because of their lack of knowledge and skills.

It is proper though, that the health services rendered in schools affect teaching and learning in the sense that the health professionals approach the schools anytime they want, which sometimes disrupt the school programme for that day (Kwatubana & Kheswa, 2014; Mohamed, 2015; Leahy *et al*., 2016). Although teachers would try to help here and there, there seems to be minimal intervention by teachers even though they face children with barriers to learning in their classrooms. Hence, there is a need for support and training (DBE, 2014).

Besides the intervention by the DoH in schools, learners who have problems that are beyond health and school professionals were referred to social workers who then continue to further understand their challenges. In most cases, extrinsic barriers tend

to interfere with learning (Landsberg *et al*., 2005; Donald *et al*., 2002), and this is where the social workers extend their services to the homes of children in order to find solution for their problems. In Gauteng, it was reported that social workers visit HPS predominantly to check on learners under foster care (Sizanang Centre for Research and Development, 2006). Some of the schools have remedial teachers in place.

2.8.3.7 Collaboration with other stakeholders

HPS cannot be accomplished by schools alone (Kickbusch, 2003; Mohamed, 2015). Hence, the collaboration between all stakeholders is very important for its success (WHO, 1996). It is known that besides the collaboration with the JICA, schools were involved within their communities regarding their health with other Non-Profit Organisations (NPO) as well. Churches and businesses within the community played a huge role in some schools by offering social services such as counselling to the needy. Some schools would open their school halls for churches and community activities, and vice versa and some churches would offer their facilities for Grade R learners (Sizanang Centre for Research and Development, 2006:38).

Alongside the community as stakeholders, the NPOs involved in schools include Food Gardens for South Africa and Soweto Mountain of Hope. In many other ways, schools would receive other services from the municipalities, political parties as well as mines. However, no matter how much parental involvement has been researched about is still a matter of concern in schools, and this has been confirmed by Van Wyk (2010) and Mashau (2011) that it is often weak. It is limited to the payment of school fees and fundraising as well as the participation of parents in the School Governing Body (SGB).

Research found that parental involvement is not clear hence parents would visit schools only when they were invited (Mashau, 2011; Mohamed, 2015). In some of these schools, some parents were involved in the food gardens, cleaning the ablution facilities and some parents would prepare meals for the learners (Sizanang Centre for Research and Development, 2006:38). It was reported that stakeholders from the Department of Basic Education, health as well as the social development were active, but when years go by the collaboration started to deteriorate and schools were left alone to carry on with the project with the trivial knowledge they have gained.

2.8.3.8 Access of learners to nutritious food

Bearing in mind of the diversity of schools under research, the majority of learners in these schools received their one and only meal per day at school because of the nutrition programme in schools. According to Ross (2010), Sawaya (2006) and Leahy *et al*., (2016), there is no education which can be offered to hungry children. Sizanang Centre for Research and Development (2006:38) conducted a study that indicated that it was only few schools where learners were able to bring their own healthy food to school whereas other schools have tuck shops and most of them allow hawkers who sell food during break. The items sold by the hawkers were not regulated since they sell fast and junk food such as bunny chow, chips, atchaar, sweets, and popcorn.

This was confirmed by Sizanang Centre for Research and Development (2006:39), that hawkers do not sell healthy food, apart from one or two traders who sell porridge and meat. The quintiles of the schools grant the schools an opportunity to be part of the GDE feeding scheme. The food provision by the Department is offered in a variety of ways. Some include two slices of bread, fruit and juice, whereas some would cook porridge, stamp, and soya beans. According to JICA (2007:39), schools with vegetable gardens were fortunate because they could also supplement with vegetables from their gardens.

Most of all health promotion in schools has been going on from strength to strength. However, the challenge remains that coordination and collaboration within the province with regard to what exactly needs to be done was still a huge task to be accomplished (Mohlabi *et al*., 2010), especially by teachers. It was unlikely though that teachers were expected to supervise the feeding scheme on how to prepare the meals and how to keep the feeding area safe and clean. Teachers monitored the needy learners who were supposed to have the meal before they start with the school day for better teaching and learning throughout the day. In cases where there was extreme poverty in children's homes, they received vegetables from the gardens and food parcels, which were mainly coordinated by teachers with organisations in and around the community (Sizanang Centre for Research and Development, 2006).

The misunderstanding of the health promotion concept contributed to the most challenges in the programme. Challenges such as organising meetings and training

for teachers was not possible during school hours, the development of teaching materials for the support HPS concept implementation, which is overbearing (Motlatla, 2007:64). The big challenge was the limited budget provided for the implementation of HPS (JICA, 2007:64).

2.9 IMPLICATIONS OF HEALTH PROMOTING SCHOOLS IN THE GAUTENG PROVINCE OF SOUTH AFRICA

In the Gauteng Province, South Africa, although the HPS programme is a promising approach (Mukoma & Flischer, 2004; Lazarus, 2006), there are serious practical implications that can hamper the programme.

2.9.1 Professional development

According to ISHP (2012), within the HPS programmes, a professional nurse runs the school health services. The allocation of learners to a professional nurse is 1:2000 ratios, and the enrolled nurse or the enrolled auxiliary nurse can possibly be of assistance. According to the ISHP (2012:20) the professional nurse is primarily accountable for co-ordinating the implementation of the ISHP, conduct the individual learner assessments and to provide on-site services which is not always possible because of the huge shortage of health professionals in schools.

The health education and promotion constituents of the ISHP should be provided by the health promoters who might be full time members of the School Health Team who by virtue of being health professionals might be based at facilities or part of the PHC outreach teams (Terburgh, 2015). Professional development for teachers was in a form of workshops, which were conducted among the pilot schools (Hay, 2009). Mostly, the training focuses on HPS activities and not the comprehensive approach.

2.9.2 Resources

Resources are very important for the HPS programme to succeed (Mohamed, 2015). Moreover, the challenges that affect schools today is that the DBE does not employ doctors, psychologists, social workers, and nurses in schools for the immediate support of learners and staff because such services were not regarded as part of the school's package (Jourdan *et al*., 2016). The discourse with ISHP is minimised by human resource, which is very much limited to health professionals even though they

are working in schools where there are teachers who can assist to a great extent because they are available five days a week (Deschesness *et al*., 2010).

Moreover, HPS should not be seen as discrete endeavour but a new paradigm in the thinking that infuses the whole school community (St Leger, 2001; Inchley, *et al*., 2007). It is just unfortunate that the collaboration between the three departments has loopholes in a sense that the DBE and the DSD are partially involved although it is stipulated in the ISHP that they are in unison (Mohamed, 2015). The ISHP (2012:17) further stipulated that the DoH is responsible for the provision of the package of school health services and the DBE creates an enabling environment. The enabling environment includes the planning, managing and monitoring of the programme, facilitating access to schools and services, and coordinates other role players.

Kwatubana and Kheswa (2014:1717) report the lack of cooperation when school health nurses visits schools because schools have no idea about the programme (Mohamed, 2015). It might be assumed that since the programme is applying the top-down model, going down to school there is still a massive misunderstanding as to how the staff can be involved. The schools under research in HPS are mostly under-resourced, which makes them to contemplate that it would not be possible because they do not have resources. Hoyle *et al*., (2008) assert that schools are not without resources but they have the existing structure of leadership and management, including the teachers.

2.9.3 Collaboration

One other implication is that although both policies from DBE, DoH and DSD would like to prevent many of the challenges learners are facing in schools. However, it is not clear as to which barriers needs to be addressed. It is mentioned like that because learners in schools are faced with so many barriers, which affect learning (Landsberg *et al*., 2011; Nel, Nel & Hugo, 2013:14). As listed in the ISHP (2012), the role of school health nurse includes immunisation, health screening, health promotion, and health education. This is such a blanket responsibility because it can mean any barrier or less than what is expected by schools. Schools meet the community every day. Hence, teachers do not have strategies to work with parents.

2.9.4 Attitudes, perception and beliefs

The issue of promoting health in schools raised diverse attitudes, perceptions and beliefs towards teachers (Leahy *et al*., 2016, Jourdan, 2011). Learning barriers are diverse in nature and they are not covered by the intervention, which is done by the health professionals in schools (Kwatubana & Kheswa, 2014). The teacher attitude is that they are there to teach learners and they do not perceive themselves as health professionals. It is a serious challenge for teachers to promote health in schools as it raises confusion. This is easily translated to how a mere teacher who is teaching any subject besides Life Orientation/Life Skills cannot guide learners to take the right decisions regarding their health, basically because they feel it is not their rightful place to do so.

The attitude about diversity in barriers to learning and the feeling to change from known to unknown way of teaching and assessment can be a barrier on its own (Engelbrecht & Green, 2001). Moreover, when working in such context, teachers' perception, beliefs and attitude towards school health promotion needs to be seriously attended to and the training is due (Peu, Napoles, Wenhold, Mostert-Wentzel & Seane, 2010:34). Irrespective of the educational goals in education, the word 'health' in schools will always hold controversy (Mohamed, 2015) as to who is supposed to be involved even though it has been clarified in the documents such as Education White Paper 6 (2001); SIAS (2014) and ISHP (2012). The change in attitude, perception and belief can shift from being negative to positive provided teachers are in the forefront in schools in terms of understanding what they can contribute.

2.9.5 Vision, management and leadership

Without a proper vision, management and leadership in any school will be hard to promote health in schools (Mohamed, 2015). According to Bush (2007), the essential requirements for quality education and school development lies in the effective leadership and management and not on the programme itself. In addition, the leadership style can be influenced by the context of the school. It has to be remembered that HPS in Gauteng Province is a joint venture by the three departments (health, education and social development). Although the vision has been stated in the ISHP (2012) and the responsibility of each department has been outlined, still there

are challenges that affect the functionality of the programme, and the challenges are in the line of leadership.

Within this programme, Gauteng Province has taken the top-down approach in leadership where everything is decided upon by the provincial leadership and applied by schools as such. It can be mentioned that the HPS practice in schools is run by policy and not by the experience of each school as Wright has clarified it (Wright, 2009). In addition, it has further been indicated that these policies have not been developed with the principals as well as those whom the policy has to influence. According to Landsberg *et al*., (2011), leadership is very crucial to develop and sustain school health.

In this case, the principal and the teachers can play a greater role in the health of children (Terburgh, 2015). St Leger (1998) confirms that teachers are the central focal point in the promotion of health in schools. In addition, the main challenge is that teachers' roles are not clear since the conceptualisation of the framework is not clear depending on the needs of each school and region.

2.9.6 Whole school development

The whole school development is the most comprehensive approach for developing HPS (Jourdan *et al*., 2016). It is referred to as developing the school in all its features as an organisation for the purpose of setting it in a context, which will allow provision of quality education (WHO, 1998; Education White Paper 6, 2001; IUHPE, 2009) by improving the quality of teaching and learning. According to Donald *et al*. (2010) and Landsberg *et al*., (2011) the whole school development is in line with the ecosystemic framework basically because it favours the development of all aspects pertaining to school life for effective teaching and learning. It also involves all role players, all systems around the school and collaboration within government departments (Gray *et al*., 2006).

In its nature, the whole school development covers health education, physical education, health services, nutrition services, counselling, psychological and social services, healthy and safe school environment, health promotion for staff and community involvement (IUHPE, 2009). In many instances, the application of whole

school development or integrated school health promotion is misinterpreted, because schools can focus on nutrition services or health education through Life Orientation and yet claim that the program is integrated. The lack of information and understanding about the concept, jeopardise the good things, which come about the whole school development (Mohamed, 2015).

Lazarus *et al*., (2000) describe the whole school development as the one that caters for all the components for better teaching and learning. In conclusion, the HPS concept is still a huge challenge given the fact that there is a long tradition of health education still applied in schools (Renwick, 2003). That will take a considerable amount of time for teachers and school communities to understand the difference between health education, health promotion and HPS as well as between theory and practice. Without the application of a rigid HPS project in schools, it could be possible for each school to implement based on the needs analysis.

The complexity of school system is not easy to go by, especially with its top down approach, which has hierarchical multi-dimensions. The latter include the school structure, curriculum, staff relationships with each other, learners, parents and the community, district and provincial officials as well as the NPO's (Inchley *et al*., 2000; Waters, Cross & Runions, 2009). The Bronfenbrenner's systems theory involves all subsystems in the schools' system (Donald *et al*., 2002). In other words, it focuses on creating an environment that is conducive for all involved in school community as it promotes the combination of all strategies to promote health and to cater for those who are expected to be actively involved (Larsen & Samdal, 2008).

Success of schools in the HPS is actually not based on the whole school approach, it is mainly based on the traditional or topic based approach in health (Adamowitsch Gugglberger, & Dür, 2014), which often fails to be integrated into the ethos of the school. Hence, the promotion of health in school is diluted into school health services since its focus is on discrete activities.

Moreover, if the HPS can be applied as a whole school approach with all its core elements in place the integration can be achieved (Inchley *et al*., 2007). It can be argued that if the HPS approach can be aligned to the whole school curriculum (Hoyle,

Bartee & Allensworth, 2010), surely there can be possible integration of services provided. In support of the possible integration, Hoyle *et al*. (2010) underscores that there should be an understanding that HPS is not an extra burden but rather another way of doing what the school is busy doing on a daily basis. SHS are the main responsibility of the health sector. Therefore, if their goals are not aligned with the educational goals, there would be a huge challenge for schools to implement (Richardson, 2007).

According to Laberge and Campeau (2010), the point of integrating HPS activities in schools has always been a challenge since schools have their own academic priorities, which sometimes are extended by continuous educational changes and which can then compete with the health programme. In addition, Clarke Sullivan and Barry (2010) found that schools are finding it hard to have space, time and resources to accommodate HPS programme in their already overburdened timetable. Much of what the HPS programme need is not to interrupt the academic programme in schools but to work with and in schools, especially when they have to attend to the medical challenges faced by learners in schools.

The SIAS document confirms that the role of health professionals is to give advice to the schools whenever there is a need to do so (DBE, 2014), but the teachers are less willing to engage and understand about the HPS. Instead they prefer to be told what to do, which is the far opposite of the HPS approach, which requires their participation and collaboration in school (Gugglberger, 2011). For teachers when they receive collaboration by stakeholders, it tends to be more of a relief since the stakeholders utilise their expertise in some of their duties. For example, social workers, psychologist, nurses, etc. collaborate with schools to attend to learners' health challenges, which interfere with learning (Bootzin, Bower, Crocker, & Hall, 1991).

It is very important for teachers to understand their roles in a HPS for the purpose of sustainability and ownership. However, many schools, even provinces, rely on external stakeholders to run the programme and that deprives them of ownership of the programme in school (Rowling & Jeffreys, 2000). The Gauteng Province got a helping hand to promote health in schools by the JICA. The framework covers few HPS elements and mostly it is the activities that are done in schools. These activities

are nutrition, hygiene, sanitation, HIV and safe and clean environment. As it has already been mentioned above, that attending to HPS in this manner creates a huge gap where there would be lack of collaboration, lack of support, lack of leadership and management, lack of understanding as well as lack of commitment from all structures (Adamowitsch *et al.,* 2014). To close the gap on what and how the whole school development should be like, the benchmarks for effective school health programmes is presented in the next section.

2.10 BENCHMARKS FOR EFFECTIVE SCHOOL HEALTH PROGRAMMES

A school health programme just like any other programme has standards that measure their effectiveness over a period of time. According to UNESCO (2010), together with UNICEF and WHO these benchmarks are as follows:

2.10.1 A comprehensive approach

A comprehensive approach is broad approach that covers a variety of health issues among schoolchildren and the school community as a whole. It does not focus on single topic (Marx *et al.,* 1998).

2.10.2 Integration

Integration of school health programme is when health is not only addressed as a single subject, but it integrates other subjects' areas in the curriculum (Mohamed, 2015).

2.10.3 Empower learners

According to WHO (1996), school health programmes focus on empowering learners in the schools and also in the community to live healthy lives through subjects such as Life Skills and Life Orientation.

2.10.4 Supportive school policy framework

Marx *et al*. (1998) highlight that a school health programme is not supposed to be another programme, which burdens the school with its multi-dimension strategies. However, the programme can be integrated within the school policy framework depending on the needs of the school. According Swart and Pettipher (1999), teachers are found to be overwhelmed by various programmes that are brought to them in

schools. Moreover, Engelbrecht and Green (2001) suggest that it should be seen as the opportunity to review how educational activities can be done differently.

2.10.5 Teacher training

Teachers are the main contributors to the success of the school health programmes (Jourdan *et al*., 2016). Therefore, it requires that they are well trained and supported with sufficient resources, which enable them to be actively involved (Engelbrecht & Green, 2001; Renwick, 2006). By resources, it implies both material and human resources. In-service training and professional development and support will empower teachers to understand school health beyond classroom and topics such as drug abuse, HIV/AIDS, teenage pregnancy, STDs, nutrition, and oral hygiene.

2.10.6 Collaboration with health services

For school health programmes to succeed, there should be collaboration with the health services where there is an opportunity for learners to be screened, identified and assessed for health problems which affects learning (DBE, 2014). This enables the teachers to understand learners who experience difficulties in learning.

2.11 BENEFITS OF HEALTH PROMOTING SCHOOL PROGRAMME

Health promoting school is a promising programme with benefits to the school community (Marx *et al*., 1998). The benefits are possible provided the school has a comprehensive approach, which includes skill development, integrated health services, pay attention to equity issues, physical and social environment, closer involvement with parents, and the community (Jourdan *et al*., 2016; Renwick, 2006).
According to the literature, the health promoting school framework produces better health outcomes for learners, especially when the curriculum is linked with the school's physical environment and the community wherein a number of factors which have an effect in the learners' health have a better opportunity of being addressed unlike when it is only explored through the teaching of Life Orientation or Life Skills (Mohammed, 2015). The advocacy of school health outcomes works better on a number of factors which form part of school health and has an impact on the learners health, attitudes, behaviour, knowledge, and practices. These benefits are as follows:

2.11.1 Skill acquisition for learners

The most important part of the HPS is to empower learners with skills and competence. A number of documents emphasise the importance of skill learners would have or benefit from the programme, these documents include the WHO (1996:14) where "students have opportunities to gain skills with respect to specific and relevant health issues" WHO (1993:12). It also include skills such as decision-making, negotiating and problem solving are an important part of the curriculum and should constantly be emphasized". In addition, Allensworth (1993:16) underscores that "special skills students need include techniques for problem solving, decision-making, refusal skills, negotiation, media analysis assertiveness, behaviour contracting, and mediation".

2.11.2 The school's social environment

The benefits on the school's social environment are described in many different ways including the psychosocial environment (WHO, 1995) and the school ethos (National Health and Medical Research Council (NHMRC, 1996). Subtle elements of the social environment are difficult to segregate. According to WHO (1996), these elements include discipline procedures, violence reduction strategies and support strategies for learners with learning disabilities.

The body of evidence suggests that learners' experience of the school plays a greater role in shaping their health behaviour during adolescent and beyond (Marx *et al.,* 1998; Donald *et al.,* 2002; Preiser *et al*., 2014; Wevers, 2012). In addition, schools that provide the conducive environment are likely to produce learners with better health and good academic results.

The 'Mind Matters' programme in Australia with the Commonwealth government indicated that schools can make a huge difference to the mental health of students which in turn can translates into a better learning outcomes (Australian Council For Educational Research (ACER), 2004). Moreover, the school's social environment suggests that the relationship between teachers and learners and among learners themselves is crucial for any health promotion initiative (Samdal, *et al*. 1998; Northfield, St Leger, Marshall, Sheehan, Maher & Carlisle, 1998). A negative attitude that can be displayed by teachers towards other learners in schools can lower down learners' sense of confidence and destroy their self-esteem.

2.11.3 Educational outcomes

It can be proper to say children learn better when they are healthy (WHO, 1995). This means that schools that take an integrated and holistic approach to educate its children and which puts emphasis on teacher effectiveness and the participation of parents as well will appear to offer greater opportunities for children to learn effectively and to gain a number of skills, which are the foundation to a better learning. Therefore, the HPS has the right position to facilitate learning capacity for learners.

A meta-analysis by Symons, Cincelli, James, and Groff (1997) confirms a strong link between poor health behaviours, the low health status and educational outcomes. The latter include grades and classroom performance; educational behaviours, which cover attendance at school and participation in school activities and lastly, student attitudes, which cover self-esteem and lack of control.

2.11.4 Health services

For a number of years, schools have opened their doors to allow health and other associated professionals to screen or prevent some diseases to schoolchildren. Some indications in the literature suggests that school health services interventions would have been more active if they operated more closely with the schools themselves (NHMRC, 1996; Brellochs, 1995), basically because schools alone have a limited influence on learners health status and health behaviours.

Besides, schools are effective in their health promotion intervention when their programmes are in a way focused on cognitive outcomes; involving the appropriate components of HPS; enabling teachers to gain new knowledge and skills through professional development and to use resources, which are quiet engaging and interactive to the work of teachers (WHO,1996). One other benefit of school health promotion in this regard is that using schools as sites to maximise immunisation is effective (St Leger, 2006), provided the health professionals and other stakeholders who visit the schools are able to contribute with building teacher knowledge and skills and acquaint with the school designed health programme (Went, 1992).

2.11.5 School based health policies

The literature review concerning all the major international HPS has ultimately identified school policies as the most integral part of their success because they are used as part of a comprehensive school health programme (St Leger, 2006:26). Policies form a proper guideline as to what needs to be done regarding the health needs of a particular province, district or a school. Over and above, school-based health policies allow the school to focus on the issues that are likely important to their school community, especially with the consultation of key school community stakeholders (NHMRC, 1996; WHO, 1996).

2.11.6 The school's physical environment

The physical environment of the school is the most significant feature in all different models of the HPS. Basically, because it includes school buildings, which must be adequately furnished, ventilated and lit, the drinking, washing and toilet facilities with appropriate water facilities, playground facilities with shades (trees) and covered areas, the recycling of renewable material, and the disposal of waste material (Tones & Tilford, 1994; NHRMC, 1996). Nevertheless, a vast amount of literature suggested that if the physical environment is not appropriate, learners also experience a vast amount of barriers to learning (World Bank, 1993; WHO,1996) instead of positive environment, which can enhance mental health of learners (Wulf, 1993).

2.12 CONCLUSION

In conclusion, health promotion and HPS are all concepts that developed from WHO with the main purpose of improving the health of children in schools, which mostly are in impoverished areas. The theoretical framework in line with the conceptual framework demonstrated the importance of structures within the system for the purpose of complete health for all learners. There are strategies and principles for HPS. However, implementation differs according to countries and regions, making it difficult to promote health in schools, even though the need for health in schools is there. Single topics and maybe an addition of two to three health topics are regarded as integration of health.

The collaboration of departments is sometimes compromised by the fact that there is a lack of accountability in terms of the developments of health promotion in schools.

The gap with regard to the role that can be played by teachers is that teachers are not fully engaged in the process since the approach in the entire health promoting schools programme has received a “top to bottom” approach. It all begins with the national department, flows to the provinces and filters down to the districts and finally to the schools. This follows the Bronfenbrenner’s ecological systems theory where every system has its own responsibility in developing the HPS.

The responsibility of all these other systems is clear. On the contrary, when it comes to the role of a teacher as promoter of health in schools focusing on the factors or barriers, which affect learning, in education, it is not clear at all. Most of the programmes, which are delivered in schools, although they affect health of children in schools they can only be dealt with by health professionals. Therefore, clarity, with regard to what could be the role of teachers as promoters was dealt with in the next chapter.

CHAPTER 3
THE TEACHER AND THE PROMOTION OF HEALTH IN SCHOOLS

3.1 INTRODUCTION

The role of teachers in the promotion of health in schools is presented by multiple roles, which overlap with other levels in the system of education. According to Power (2006), teachers are the most valuable assets for the nation because they are at the heart of the learning process. Power (2006) further indicates that the quality of education depends on the status, training and quality of teachers as well as the availability of suitable material and support services. Several research studies confirmed that schools are the setting to promote health for learners (Mukoma & Flischer, 2004; Samdal & Rowling, 2013; Jourdan *et al*., 2008, 2011, Marx *et al*., 1998; St Leger, 1998). As a matter of fact, “they are places where society’s main concerns all converge” (Jourdan, 2011).

It can be assumed that it is a melting pot of health challenges ranging from emotional, spiritual, physical, as well as psychological. As teaching practitioners, they are responsible for teaching, transferring knowledge, motivating, developing understanding of health issues, as well as facilitating learning to learners. Teachers are qualified practitioners who are hired to work in a school setting. Hence, the school can control and rationalise the work of teachers and learners when applied within the HPS framework (Apple, 2001).

Schools are settings where learners spend most of their time and teachers are there to guide them (Shung-King, 2013). Much of what is written about teachers address the issue of teachers being able to create the classroom that enables and supports learners to feel emotionally, physically and intellectually comfortable (Coleman, 2001). Teachers who are able to do this are teachers who are able to create the social environment of the class where learners feel accepted and supported (Preiser *et al*., 2014).

According to Renwick (2006), teachers are critical role players in the HPS as they are main agents in finding the balance and sanity essentially needed in providing for many expectations from education authorities. The manner in which the HPS programme is presented to the teachers does not give them allowance to work around many challenges they face as teachers because it is more focused on school health services where health practitioners are designated (Kwatubana & Kheswa, 2014).

As part of their work and responsibility, teachers meet with parents and the community (Kwatubana, 2014). They teach learners with learning barriers and they find themselves in an environment that is not much conducive to teaching and learning and without proper implementation of HPS programme. They find themselves in a situation where nothing seems to be progressing.

Unlike many years ago, the teaching profession is changing rapidly today, and the role of a teacher is changing as well (St Leger, 2000; Jourdan, 2011). The increasing changes in the educational reform brought about the inclusion of learners with diverse learning needs and barriers in the classroom (Landsberg *et al*., 2011), and that makes teaching to become complicated and frustrating job ever. Above all, owing to overcrowding and urbanisation, learners are faced with the outbreak of a number of health issues in schools of which teachers are supposed to attend to through the curriculum delivery, pedagogy as well as to give support to learners and their families (Ntagungira, 2014).

Moreover, these challenges seem to be insurmountable because Viljoen, Kirsten, Haglund, and Tillgren (2005:81) indicate that teachers take implementation as an extra task and an aggravation of their burden. In addition, it has become more demanding profession to handle (Quirke, 2015).

The perspective of teachers when it comes to HPS is based on school health services that can only be administered by health professionals. Hence, they do not work along with the school health nurse during their visit (Kwatubana & Kheswa, 2014). Basically, teachers perceive health from a traditional perspective where children are sick and they need to be taken to the doctor (Allensworth, 1995; Mashau, 2011) and where they focus on the change of lifestyle (Nordin, 2016). However, the changes in the

educational profession require teachers to be students in their own profession where classroom teaching that covers health matters is no longer central (Samdal & Rowling, 2013).

Health has been defined as the absence of disease in the body (WHO, 1986; Marx *et al*., 1998). This concept has been defined in terms of physical well-being and a complete state of health. To complement the definition, health education has been offered as part of the curriculum in schools. As time goes on, peoples' health has been improved through health promotion developed by the WHO, which paved a way to address many health issues in hospitals and universities (WHO, 1996). In the HPS, issues that are related to health have the specific time allocated in the formal curriculum in the subjects like Life Sciences, Life Orientation, Life Skills, Social Sciences, and Hospitality (DBE, 2012).

The provision of health and caring services which is done by the health professionals through screening, and prevention of disease as well as career guidance marks the functionality of the integrated school health programmes (ISHP, 2012, DoH, 2011; DBE, 2014). In addition, the social and physical school environment, community relationship and the staff relations with their learners form part of the hidden curriculum where things done at school are observed and practiced without any formal teaching (Renwick, 2006). To understand the role of teachers as promoters of health in schools, the next section focused on the models, teachers' understanding and perceptions of their roles in HPS.

3.2 HEALTH PROMOTING SCHOOL MODELS

Health promoting school is a framework for health promotion in schools. To ensure that the role of teachers in schools is clearly defined, models from various countries were looked into in order to have a better idea of how health promotion is done in schools as well as to reach the maximum success in the implementation of health promotion in schools. A very brief outline of the modules will be given with the intention not to give a detailed description. The WHO (1999) report postulates that alongside with the six constituents of health promoting school, the schools should further be guided by the following principles:

- To foster health and learning with all the measures at its disposal and in its remit;

- To engage both health and education officials, including teachers, students and parents as well as the community leaders in the efforts to promote health;
- Always strive to provide a healthy environment, school health education, and school health services together with community projects and outreach, health promotion initiatives for staff, nutrition and food safety initiatives, opportunities for physical education and recreation, and programmes for counselling, social support, and mental health promotion;
- To implement policies, practices that respect an individual's self-esteem, provide multiple opportunities for success, and acknowledges good efforts and intentions as well as personal achievements;
- Strives to improve the health of school personnel, families and community members as well as students and works with community leaders to help them understand how the community contributes to health and education (WHO, 1999:19).

Booth and Samdal (1997) identified the key components that unify all HPS models as the formal curriculum, the school ethos (the social climate), the physical environment, the policies, and practices of the school, the school health services, and the school-home-community interaction. The HPS model has become the international model of best practice (Quirke, 2015), even if the definitions and concepts of the model vary based on the circumstances of the developing context. According to the Australian Health-Promoting Schools Association (AHPSA), HPS models differ nationally and internationally because each is highly context-specific, considering special cultural aspects and needs.

The HPS models are underpinned by the Ottawa Charter principles of health promotion, emphasising the empowerment and influence of the users (Quirke, 2015), that is, the school staff and students, but no specific models have been developed. Rather, the schools themselves have been encouraged to develop approaches based on their specific needs. The other reason mentioned by Samdal and Rowling (2013) was that little systematic evaluation of HPS initiatives has taken place. Therefore, it is difficult to identify specific models that can be implemented in any context. Simovska (2012) explains that, in practice, the concept of HPS has been interpreted differently

in different cultural, geographical and educational contexts, therefore obtaining a wide range of meanings.

Different interpretations emphasise different aims and expected outcomes of HPS. Jensen and Simovska (2002), in a publication mapping different models of HPS used in different countries, observed that the models of HPS use different visual ways of illustrating the model at work in the particular country in which they are developed. However, because they are all informed by the Ottawa Charter (WHO, 1986), they share certain identifiable commonalities (Cushman, 2008). Similarly, Jensen and Simovska (2002) comment that a variety of approaches and many different ways in which components of HPS were constructed, reconstructed and deconstructed over time are employed in different educational and cultural contexts.

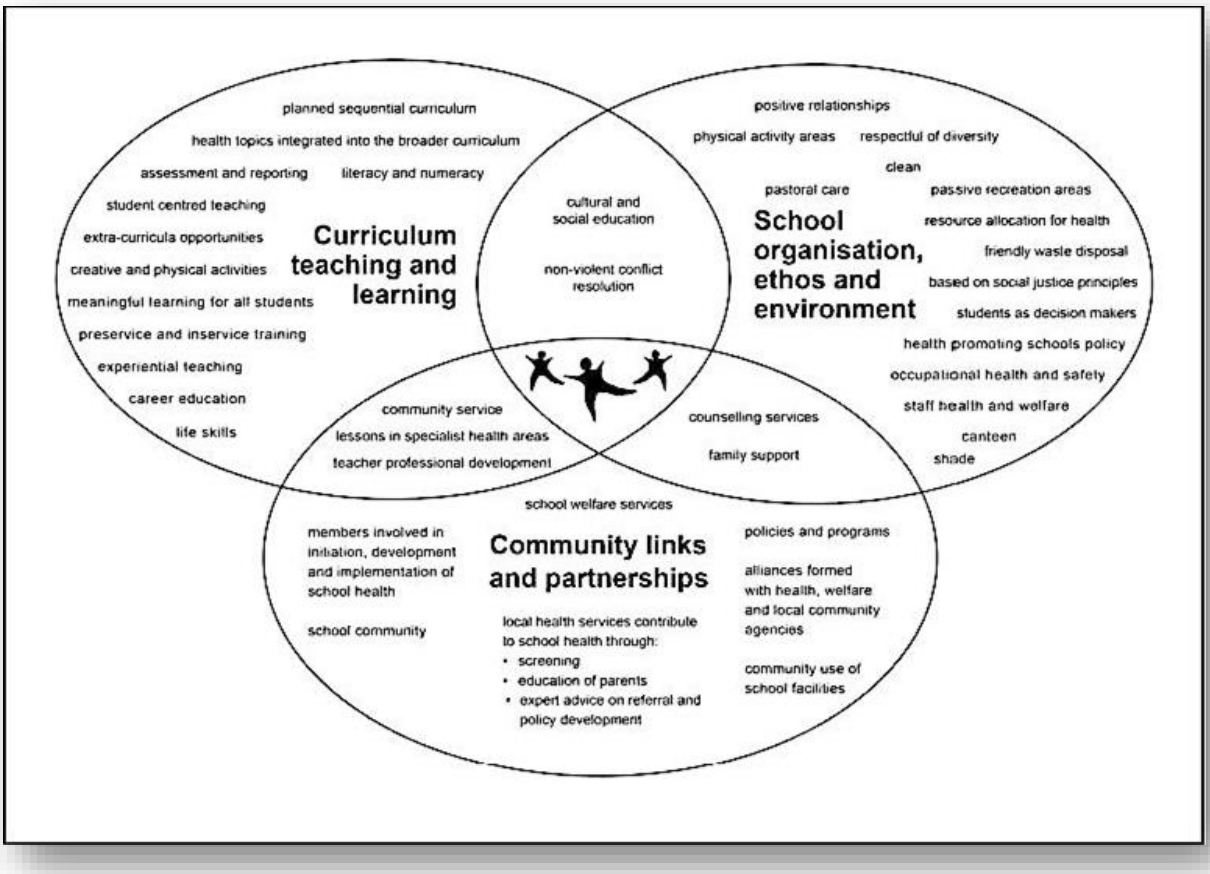
In addition, they emphasised that dynamic interplay exists among various political, socio-economic and other aspects, which influences what priorities are set and which methods are implemented in the development of the HPS approach in each particular country. Jensen and Simovska (2004) made the important assumption that it is not possible or desirable to create a model of a HPS that is universal to all countries as needs and circumstances differ. Every model is a result of dialogue and consensus among its constructors and has meaning within a certain value framework in a particular context (Whitman & Aldinger, 2009). They maintained that a HPS is more of a process of contextual interpretation than an outcome of the implementation of the global principle (Jensen & Simovska, 2002).

The following section presents examples of HPS models and their components from different countries and continents, the Australian, New Zealand, UK/Scotland, Finland, Iceland and United States of America's health-promoting school models. The purpose of presenting HPS models from different contexts is to show how these models are context-specific, based on the needs, priorities, and circumstances of different countries. They take different graphic shapes and have different components. Each model is a result of the context of its development. A comparison of the models is made at the end.

3.2.1 The Australian Health Promoting Schools Model

This model is composed of three intersecting components: curriculum, teaching and learning; school organisation, ethos and environment; and partnership and services. For each component, feasible activities have been developed to enable schools to attain the HPS status. Australian schools have embraced the HPS model for its cost-effectiveness, efficiency and efficacy. The model is built on the inter-sectoral collaboration between health and education sectors in an attempt to promote well-being of individuals and communities (Renwick, 2006). The three components synergistically form a HPS framework.

Figure 3.1: The Australian Health Promoting Schools Model



Source: Renwick, 2006

3.2.2 The New Zealand Health Promoting Schools Model

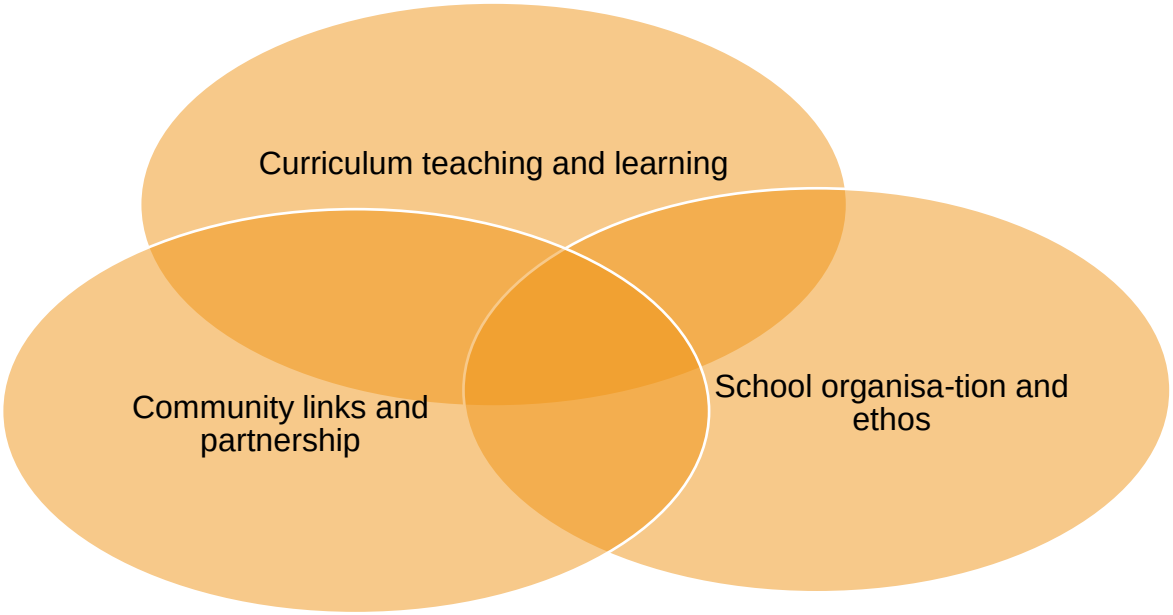
The New Zealand Health Promoting School (HPS) Model has been embraced by New Zealand health and education practitioners to assist in planning for strategies to enable the implementation of the HPS concept and to make sure that the implementation is co-ordinated within the three components. The curriculum, teaching and learning component, which includes key school community issues, skills, knowledge, attitudes, teaching and learning methods, comprehensive, sequential health and physical education programmes, as well as resources, ensuring that health is integrated across different curriculum areas.

The school organisation and ethos component include relationships (staff, learners and community), school organisation and practices, policies and codes of behaviour, physical, social and emotional environment, health as an integral part of whole school

management, and planning. The community links and partnerships component include the involvement of the wider school community in health-promotion activities, in line with the needs of the school community. This involves positive working relationships on which to build collaboration and partnership, particularly between parents and health service providers, but also between health and education sectors.

The model is composed of three intersecting components, namely, curriculum, teaching and learning, school organisation and ethos, and community links and partnership, as presented in Figure 3.2 below:

Figure 3.2: The New Zealand Health Promoting Schools Model

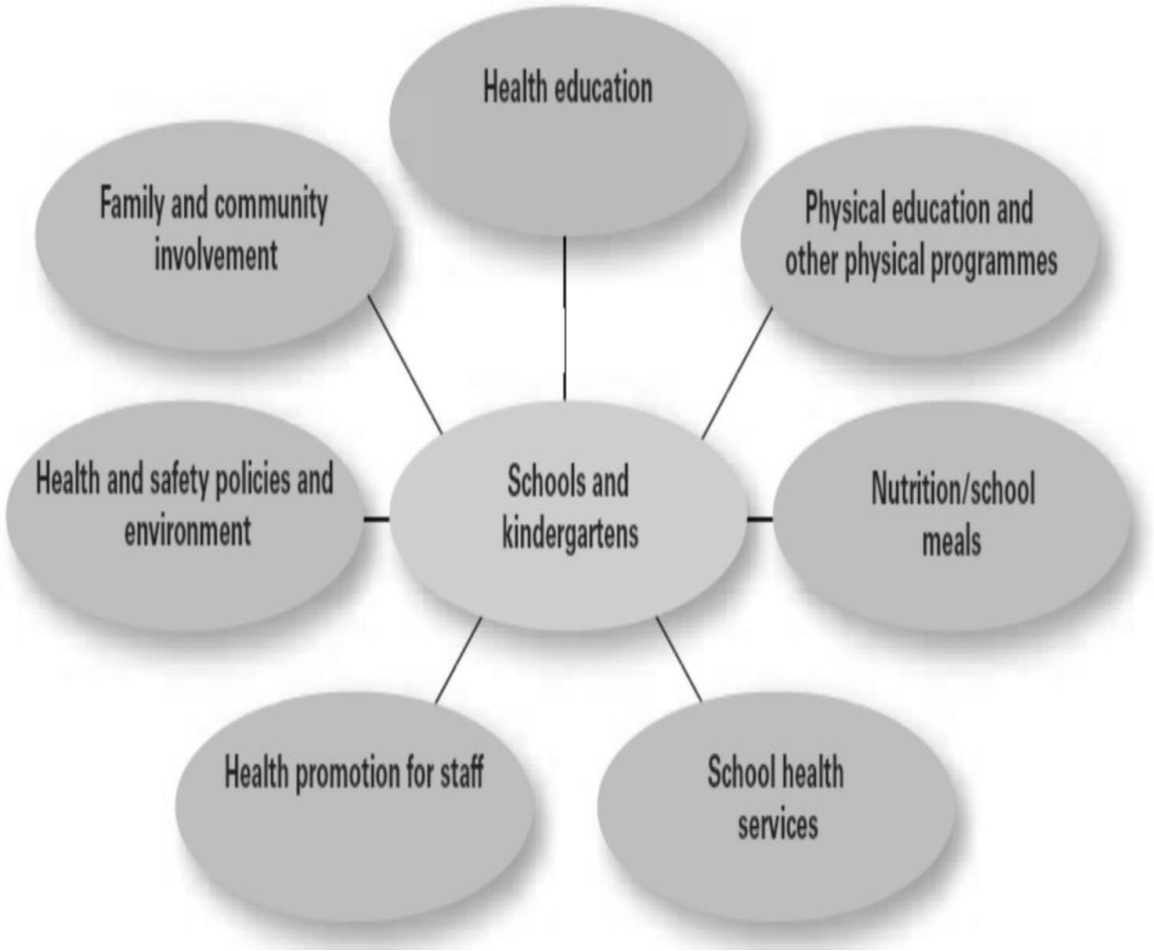


Source: New Zealand Ministry of Health, 2003

3.2.3 The Iceland Health Promoting Schools Model

Barnekow *et al.,* (2006) indicate that the HPS Model in Iceland was developed to support schools wanting to engage in health promotion in its wider range. It covers seven components, namely, family and community involvement, health education, physical education, nutrition and school meals, school health services, health promotion for staff, health and safety policies and the environment. To achieve this, there should be entailed involvement of all the stakeholders in planning together the possible strategies to improve the school system (Barnekow *et al.,* 2006).

Figure 3.3: The Iceland Health Promoting Schools Model



Source: Barnekow *et al.,* 2006

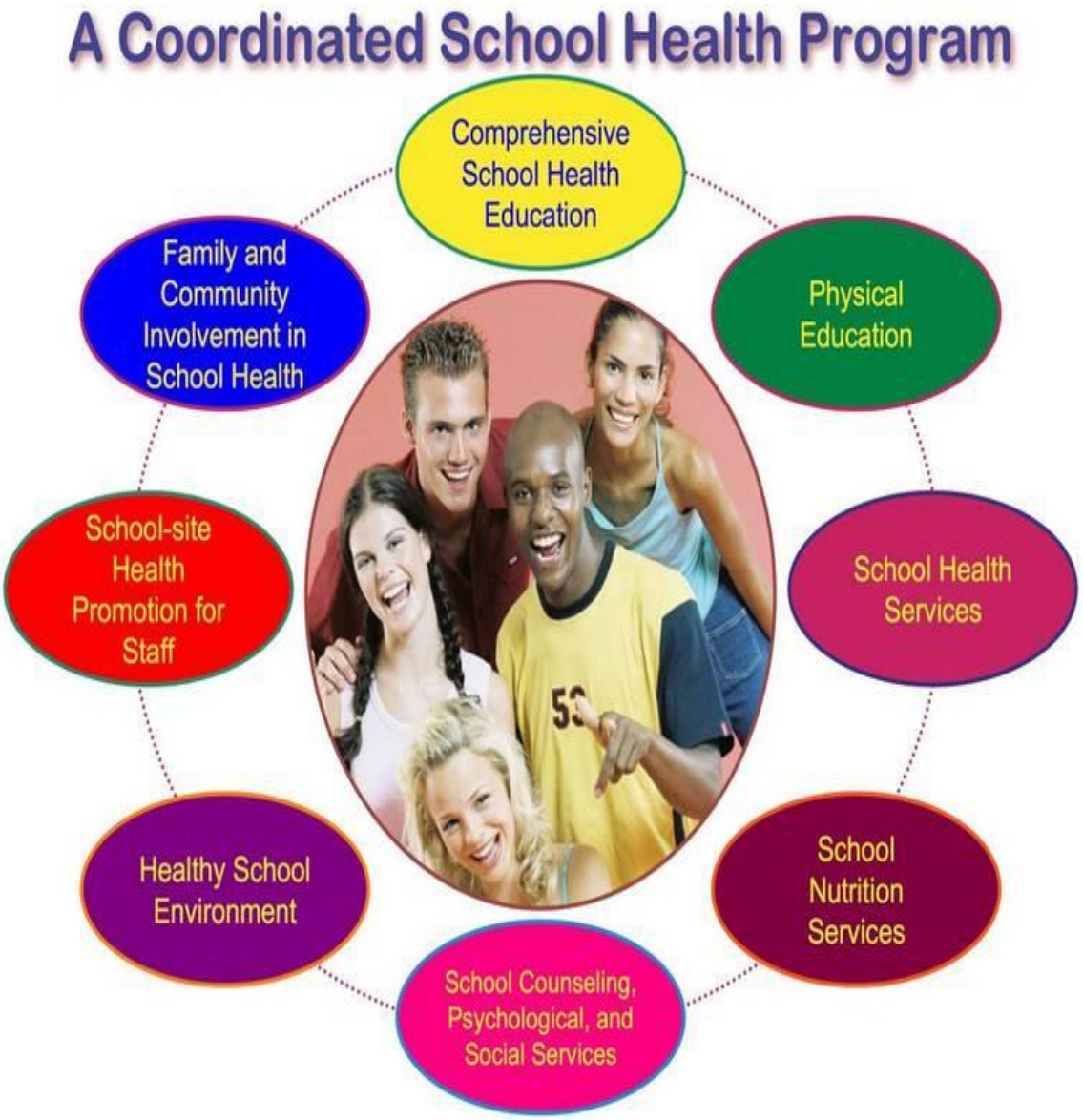
3.2.4 The US Co-ordinated School Health Programme Model

The US programme for HPS is called the Co-ordinated School Health Programme (CSHP). Therefore, in the US, the health model for schools is composed of eight interrelated and interlinked components.

According to several researchers (Deschesness *et al*., 2003; Samdal, 2008; Allensworth & Kolbe, 2009:8), these components are as follows:

- **Health education,** which is a planned, sequential curriculum that addresses the physical, mental, emotional, and social dimensions of health;
- **Physical education,** which is a planned, sequential curriculum that provides learning experiences in a variety of activity areas that all students enjoy and can pursue throughout their lives;
- **Health services** are provided by health professionals and are available to students to appraise, protect, and promote health, including counselling and educational opportunities;
- **Nutrition services** provide access to a variety of nutritious and appealing meals that accommodate the health and nutrition needs of all learners;
- **Counselling and psychological services** are services which are provided by professionals to improve students' mental, emotional and social health;
- **Healthy school environment** involves the physical and aesthetic surroundings and the psychosocial climate and culture of the school that affect the well-being of students and staff;
- **Health promotion for staff** provides opportunities for the staff to improve their health status through health assessment, health education, and health-related fitness activities; and
- **Family and community involvement** is an integrated school, parents and community approach for enhancing the health and well-being of students.

Figure 3.4: The US Co-ordinated School Health Programme Model



(https://www.ucps.k12.nc.us/cms/lib/NC01910453/Centricity/Domain/2583/Coordinated-School-Health-image-for-SHAC.gif)

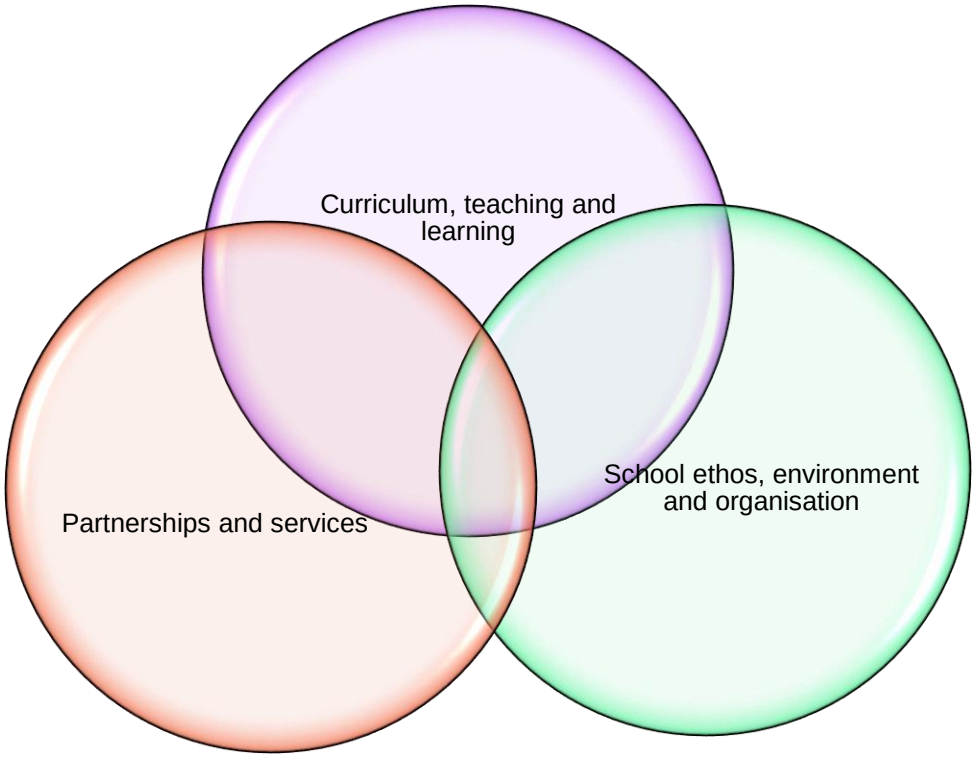
3.2.5 The South African Health Promoting School Model

The health promoting school (HPS) Model in South Africa is based on three main critical components that anchor the HPS. These components include the curriculum, teaching and learning, school ethos, environment and organisation as well as the partnerships and services (ISHP, 2012). This Model covers the crucial elements of the school in addition to the broader perspective of the HPS concept.

Owing to the nature of challenges in the Gauteng Province, paying attention to the social issues of the school was crucial. Under curriculum, teaching and learning Life Orientation/Life Skills is used to address health issues in the classroom (formal curriculum) and also informal curriculum where gardens have been established to supplement nutrition in schools (Sizanang Centre for Research and Development, 2006). This was done with the help JICA and that of other stakeholders in and around the community. Schools maintain their physical and social environment for the purpose of an enabling environment suitable for teaching and learning.

Above all, schools were encouraged to form partnerships with the society and the learners health challenges were attended to by the school health service nurse. Even though there is a need to promote health in schools, the role of teachers in the model is not clearly defined.

Figure 3.5: The South African Health Promoting Schools Model



Source: ISHP, 2012

The models presented above resemble almost similar components in the efforts to address health issues in schools. However, to understand this clearly, the models will be compared against each other in the next section.

3.2.6 A comparison of Health Promoting School models

The comparison of HPS models was done in terms of the core aspects discussed above. The dilemma on what constitutes a HPS is still lacking, and it reflects as a barrier to the successful implementation of HPS universally. Likely, several researchers (St. Leger, 1998; Stewart-Brown, 2006; Gugglberger & Inchley, 2014; Nic Gabhainn, O'Higgins, & Barry, 2010) noted the importance of having a similar model to address the definition of HPS and how to implement it in schools.

A research project of nine studies conducted by Mukoma and Flischer (2004) reflects that the concept of HPS was still developing. Two decades passed by and still there is a huge argument on what a HPS is and what is not. It is not amazing though because even today, this concept is not well understood, especially in the education domain where teachers are not well informed as to what to do. Hence, the concept is misconstrued for traditional health education and it is hard for teachers to go beyond that.

Various models from different countries gave an understanding of how each country handles the promotion of health in schools depending on the needs analysis of each country. Depending on the needs of each country components were placed in accordance of their priority. Africa as well as South Africa in particular has serious challenges facing children ranging from malnutrition to socio-pathological ill health where schools are the best possible places to promote health because of the challenges within the communities ranging from unemployment, poverty, substance abuse, as well as illiteracy (Ntagungira, 2014).

In line with other HPS models that are based on the WHO initiative for promoting health in schools, South Africa designed its needs specifically according to the context (Samdal & Rowling, 2013). Basically, they share some similarities and also differences. Above all, these models serve in a more comprehensive and multifaceted

approach because in one way or the other, they serve purpose to the schools by providing learning opportunities.

The interesting aspect about these models is that they are built on the inter-sectoral collaboration between national DBE and the national DoH. In some other cases, the national DSD as well as the NGO's form part of the collaboration. In this case, the New Zealand and Australian models are very much open with their models since it shows very clear responsibility for each department or section. The lack of specific responsibilities in the collaboration between sectors jeopardises the most intention to create conducive environment for learning in schools and to promote the health and well-being of learners and staff (Ntagungira, 2014; Mohamed, 2015).

There are similarities in the content and structures of the New Zealand and Australian and South African HPS models. These similarities are portrayed by the circles that interact with each other and the HPS is in the centre. To be specific, the US and Iceland models are outstanding in their approach because they basically offer distinct health education and nutritional services, which in other models they are not clear. They also have seven similar components, with counselling and psychological social services included in the US Co-ordinated Schools Health Model. The health promotion of the school staff and of the entire school community is mainly emphasised in the US, Australian and Iceland models. Besides the similarities in most models, it is important to note that there are also differences that make them to be very distinguished from each other.

For instance, other models do not offer counselling and psychological social services to learners. Health education is offered across the health subjects in the Australian and New Zealand models, whereas the US and Iceland models have health education as a standalone subject. The models inform the policies and vice versa as well as the framework that can be used by the schools in particular. The US does not have school policy in its model whereas the Iceland, Australian and New Zealand models have school policies. Each model deals with the components according to the needs and culture of their country and communities. The Iceland and the US models are different in their approach as well as their structures.

One model that is outstanding in its approach is the Iceland model, which also serves the kindergartens. The Iceland model makes it clear that the model also serves kindergarten schools, something that other models do not show. The approach differs completely with the models and sometimes they can be confusing because the US model covers the social environment under physical education whereas in the New Zealand and Australian models, the social environment is under ethos and school organisation. In the Icelandic model, it is unclear where the environmental aspect of the HPS model is addressed. The Australian model makes its expectations for discipline and behaviour clear, while these remain unclear in other models. It also emphasises an in-service and a professional development component for their schools that other models do not have.

The South African model is similar to the New Zealand model where curriculum teaching and learning, community links and partnership and school organisation and ethos form part of the framework. The approach used in South Africa is a top-down approach, where the national DBE design school health policies that are then utilised by schools without much revision aligned to the particular setting. However, the South African model, just like other models, lacks other components that complete and caters for the needs of the school community as a whole.

One other aspect is that although health promotion is done in schools this time around, teachers are not fully involved because their roles are not defined within the framework. Again, the collaboration between the departments is a good thing in itself. However, in some cases, this collaboration is not well established or there is dominance of the DoH. How teachers promote health and how they play their role in the society is not well defined.

In the process of evaluating the models presented above, it was found that these models have nothing specific about a direct role of teachers with regard to HPS although they are in the forefront in schools. It is clear that all models have their shortcomings because they all have their strong points where they seem to excel and their weak points where important elements such as the role of teachers is not outlined.

With all the differences in what constitutes HPS, the implementation of the concept and its elements is still a serious concern, not to mention the role and importance of teachers. As long as teachers in schools do teaching, teachers will always remain the critical connection for classroom access to reach children and adolescent of the most critical health issues within the school and the community at large (St Leger, 1998). The next section will present teachers professional identity in order to understand their role as promoters of health in schools.

3.3 TEACHER PROFESSIONAL IDENTITIES AS PROMOTERS OF HEALTH

According to Jourdan (2014), teachers' professional identity can be defined as how teachers perceive themselves within their profession. Owing to the nature and profession of teachers where they have to juggle with so many roles in their profession, they find it hard to define their identity (Jourdan *et al*., 2008). According to Renwick (2006), the teacher's job is defined in terms of their personality, abilities, talents and skills, perception, and beliefs.

Lauermann (2013:1) and Jourdan *et al*., (2016) alluded to the fact that the teacher's personal sense of responsibility has a great influence with their instructional practices, their psychological well-being and their learners learning in particular. It is also believed that besides the training, which teachers go through to be qualified as teachers, it is a calling, which is also qualified by the factors mentioned above. It is bound in their lives, their biographies and the kind of people they become in the process (Fullan & Hargreaves, 1992; Hargreaves & Fullan, 2012).

Throughout the decades, the landscape of teaching has transformed (Renwick, 2006). When government and societies changes, it calls for schools to change their ways of learning and teaching (Mohamed, 2015), as well as the understanding of health promotion in schools in support of learners in schools (Deschesness, 2003). Professionals in the education sector need to reconceptualise their roles and to change their *modus operandi.* Children in South Africa and everywhere in the world encounter more health challenges now than before.

The traditional health education can no longer prevent all health challenges since there are many health issues that can affect the success of learning in schools (Jourdan,

2014). Therefore, it requires that teachers in any school need to strive to be lifelong learners even within their teaching profession. In the process, teachers need to understand their identity in the HPS. What is it that they can do to promote health in school?

According to Jourdan *et al.,* (2016), when teacher's identity has been perceived as static traditionally, it is understood as being influenced by a number of factors such as the interpreting and re-interpreting of professional experiences (Beijard, Meijer & Verloop, 2004). Because of their experiences, teachers construct meaning depending on what is of value and fundamental to them (Mohamed, 2015) and obviously the curriculum is of importance (Jourdan *et al*., 2016). Curriculum is designed by national departments on which teachers in schools have no influence. Teachers' identity is constructed from the technical aspects like the classroom management and by being subjects experts (Beijard, *et al*., 2004).

Teachers who are subjects' specialists might find it hard to implement the whole school approach since they may not be able to see themselves in their individual role as teachers (Jourdan *et al*., 2016). Health promotion programme in schools suffers low engagement by teaching staff than core subjects like Life Orientation. Over and above, teacher professional identity is an interaction between personal experiences of teachers and the socio-cultural environment of the school where they work (Day & Gu, 2010).

It is very important that teachers should be given enough support to understand their roles within the HPS programme. Otherwise, it will often remain a marginal aspect of teachers' work (Audrey, Holiday & Campbell, 2008). Teachers need to participate in workshops, which develop them on coping skill.

3.3.1 Teachers' beliefs and perceptions in health promotion

With regard to teachers' beliefs and perception in the health promotion programme, much research has been devoted to contextual factors but with less emphasis on their perceptions (Jourdan *et al*., 2011). The teachers' beliefs and perception in health promotion plays a vital role in ensuring that teachers are involved in the program at schools (Mohamed, 2015). Teachers participate in the programme especially if they

believe that the vision, aims and goals of the school will be achieved by the initiative (Jourdan *et al*., 2008; Tjomsland *et al*., 2009; Shung-king, 2013; Mohamed, 2015).

In addition, Mohamed (2015) indicates that their belief to be able to show effectiveness as well as the training before the programme gives them an opportunity to work along the vision of the school. Health promotion is basically based on the faith and ability of teachers to take charge of their own destiny (Tjomsland, 2010). That exactly means that teachers are responsible for many issues in a school. In a way, trust in teachers and how they contribute to the development of their capacity can be a base for international co-operation (Jourdan *et al*., 2008).

Teachers' perception is influenced by various issues such as the sense of job satisfaction and motivation aligned with their work and the psychological needs, which are relations, their competence and autonomy (Strydom, 2011).

Odora Hoppers (2001) asserts that empowerment occurs when people start to pride themselves as worthy human beings who are inferior to none. It means that teachers in their beliefs and perceptions of what they do in the classroom or the school in relation to health promotion cannot be determined by what they have or have not, but it can only be determined by their own self-efficacy, which prompt them to be creative and innovative. Factors such as the perceptions of the health promotion programme's efficacy, teachers' own self-efficacy beliefs and the teacher burn out can contribute immensely in how they participate (Han & Weiss, 2005).

Teachers perceive themselves as professionals who are based in the classroom (Strydom, 2011). Teachers' practice and perception in health education inspires them to develop projects in a school (Jourdan *et al*., 2010b). Jourdan *et al*., (2011) report that teachers' beliefs and perceptions in health promotion literature has not been researched about and that has a potential to hinder the development of health promotion in schools.

3.3.2 Teachers and the teaching of health promotion

Teachers in their profession are called teaching practitioners who focus on teaching children in a school (Quirke, 2015). The changes in the dynamics of teaching as well

as the focus on environment compels teachers to be able to understand how they can move from the traditional way of teaching to the health promotion kind of teaching (Jourdan *et al*., 2016). The old way of teaching focuses in the classroom and if the learner is not performing well, the deficit is with the child (Landsberg *et al*., 2005; Nel *et al*., 2013). Classroom teaching is central to what teaching is since this is where teachers get to influence their learners about health issues.

However, with the health promotion approach, learning and teaching takes place in every context with which the child is in contact (Bronfenbrenner, 1992). This implies that the teacher cannot only teach the child in the classroom and conclude that it is the child who is failing without considering the context, which the child revolves around (Donald *et al*., 2010). The environment and how it affects the child was discussed in detail in chapter two (see: 3.8). The context has a critical impact on a child. In fact, it has to do with the teacher's knowledge, skill, attitude, and ability when the teacher will have to work around components of health promotion to support the child. Besides teaching Life Orientation in the classroom, there are issues, which the teacher can contribute in the process of promoting health through teaching. According to Strydom (2011), these issues are as follows:

- In the first place, teachers need to influence learners' health knowledge, attitude and practice through observation to see if whether they understand. Through interaction with learners, the teachers are able to see if whether they are practicing what they have learnt.
- In the second place, the teacher needs to show through the Annual Teaching Planning (ATP), which has been provided by the provincial guidelines to address a number of health topics that are apparently found in the previously disadvantaged communities.
- In the third place, the teacher is expected to ensure that there is sufficient time to address health topics in and outside the classroom. This is one challenge that teachers often struggle with when they have to engage in health promotion programmes and activities; they often indicate the lack of time to be involved as the obstacle (Marx *et al*., 1998). Moreover, the curriculum guidelines notional time is limited and mainly focused in the classroom curriculum (Renwick, 2006; Jourdan *et al*., 2016). The health promotion in school has a number of activities, which are

supposed to be done outside such as caring for the physical environment of the school in the form of gardening. The notion that children are at school to learn, gives a little room to do health promotion activities (Deschesness *et al*., 2010) such as those at school as it will be taken as child labour. According to the curriculum structure, the only time learners are outside during school time is when they are doing physical activity that forms part of Life Orientation in school (CAPS, 2012). In a way, the curriculum seems to be rigid when it comes to health promotion as it does not cater for such activities (Marx *et al*, 1998; Viig *et al*., 2010).

- In the fourth place, as part of health promotion, teachers need to empower learners to improve the health and to increase control in their decision-making skills. Therefore, they need to teach learners about the generic skills, which include conflict resolution, self-esteem building, decision-making, refusal, as well as pro-social and problem solving skills (Strydom, 2011).
- In the fifth place, teachers need to understand the different learning styles of learners in their teaching. That can be done by allowing learners to be actively involved and to collaborate during the learning process. Finally, the teachers need to utilise adequately the teaching and learning material in their disposal and to use various instructional strategies and methods in their teaching (Deschesness, 2014). The issue of resources in the classroom is a challenge for teachers and hence it has affected teaching and learning.

3.3.3 Teaching as health promotion in service of the community

Teaching is seen as a health promotion in service of the community because what teaching and learning covers in the classroom is one way or the other serving the community through learners (Tjomsland, 2010). Often, teachers act as role model of health promoting behaviours to learners at school and this covers establishing smoking areas or smoking signs that prohibit smoking at school, controls littering, encourage hygiene behaviour of washing hands as well as eating healthy food (Jourdan *et al*., 2010b).

However, there are matters that teachers are not able to attend to since they are not trained to do so. This especially pertains to issues that require school health services where learners have medical problems, which can only be attended to by school health

nurses, and sometimes they have problems, which can only be attended to by social workers or therapist (Mohamed, 2015; Preiser *et al*., 2014). Teachers as go between the school, learners and the community they have to balance how they do their roles, so as to bring harmony within the health promoting school. Teachers in their roles they are expected not only to teach about health but also to nurture the learners (Renwick, 2006; Strydom, 2011).

For the purpose of this chapter, the next section will explore how teachers perceive their roles as promoters of health in schools and how they conceptualise health promotion and promotion of health in school. It will also consider health promotion in Gauteng Province, as well as the barriers to health promotion. A thorough discussion on health, health promotion and HPS was dealt with in Chapter 2 (See: 2.4).

3.3.4 Health promotion and teachers understanding

Within the post-modernisation, the teachers' role is interpreted in terms of including the need to enable and motivate learners to learn (Davies, 1994). This interpretation fits well with the health promotion definition, which is a process of enabling people to increase control over, and to improve their health (WHO, 1996). The huge responsibility now lies with all teachers in schools to understand that their roles no longer remain in the classroom but to promote the total health of learners in school (Viig & Wold, 2007).

According to St Leger (1998), teachers are core role players in the implementation of health promotion in schools as it is a major philosophical shift in education. Despite the fact that teachers are passionate about their profession, still they are overwhelmed (Engelbrecht, 2001) with the fact that they are in the forefront for the programme to succeed. The most difficult aspect in the progress of HPS is that health and education are two different biomes, which require a better and clear understanding of the teacher's roles (Mohamed, 2015).

Consequently, teachers' understanding of HPS is notably important to promote the health of learners. In a HPS, responsibility for children's health lies with the parents and teachers are no exception since they are *in loco parentis* in schools. Jourdan *et al*. (2008) contend that the position of teaching staff is difficult to maintain in an

environment marked by multiple models. Throughout the ages, teachers' roles were confined in the classroom where teaching and learning takes place.

However, the new dispensation and the socio-pathological problems children face in schools calls for teachers to play their roles beyond the teaching scope. According to St Leger (2000), the teacher is the fundamental agent in school health programme anywhere in schools and little will occur unless more attention is based on teachers. In the health promotion model, teachers' roles can no longer be based and understood in terms of curriculum (Preiser *et al*., 2014; St Leger, 2000) in the classroom only. However, it has to be extended to a more integrated approach.

Despite changing roles in the teaching field, many teachers view health promotion in school as another burden imposed to them by the DoH (Engelbrecht, 2004; St Leger, 1998). Teachers are prime gatekeepers, who require a flexible framework and guidelines in order to implement health in their schools. The main difficulty for teachers to play their roles is not actually any other reasons other than their understanding of the concept (Jourdan *et al*., 2015).

Various reasons are obstacles for teachers to be able to play their roles. Viig and Wold (2007) demonstrate the mission of the school as an obstacle for success because schools basically have education and not health as their mission. In this way, teachers may experience a conflict of goals between health and education as they struggle along to participate in the programme (Mohamed, 2015). Studies about health promotion in schools have shown that if it has been applied successfully, it may possibly lead to the improvement of both health and education goals (Schagen *et al*., 2005; Lee, Cheng, Fung & St Leger, 2006; Cushman, 2008).

Teachers' understanding of the concepts is very important as it can also be a barrier if their understanding is limited or poses some challenges in their roles (St Leger, 2000). Their understanding is, however, met with many different things, which mainly they are misconception about the health promotion. Teachers' role is to educate children in schools as they teach children the basics of health (Jourdan, 2011) as well as to understand what they learn. Nevertheless, when it comes to health promotion in schools, their understanding

is that it is the concept in the health sector only, which can only be addressed by health professionals in schools (St Leger, 1998).

This understanding is based on the fact that schools mainly concentrate on children's health issues, which according to the ISHP (2012) can only be addressed by health professionals in schools. The SIAS policy (2014) clearly indicates that the health professionals' role is screening and assessment of various health issues that can hinder learning in schools. Research confirms that health and education are interlinked (Marx *et al*., 1998; Quirke, 2015; Samdal & Rowling, 2011).

However, teachers see health and education as separate sectors which do not have any relationship and based on that, their feeling is that the whole health promotion in schools programme is imposed on them (Renwick, 2006; Jourdan *et al*., 2011; Mohamed, 2015). It can be assumed that although teachers are professionals, their role in the classroom extend to other roles even though they are not trained to do so (Quirke, 2015). The implementation of health promotion in schools is somewhat very confusing to teachers basically because the total understanding is based on activities such as nutrition, hygiene, physical environment, and school health services (St Leger, 1998).

Above all, the school health services dominate the schools to a point that teachers do not see themselves as promoters of health. It could be the fact that the concept "health" is mainly used in the health sector; hence, teachers are able to say it has nothing to do with education. Teachers' *status quo* defines them as teaching practitioners; hence, their training focuses on classroom teaching and nothing more (Renwick, 2006; Preiser *et al*., 2014). Until recently, some higher education institutions are training teachers on health promotion in schools (Peu *et al*., 2015), albeit teachers do not have the necessary knowledge, resources and skills to promote health in schools (Preiser *et al*., 2014).

Teachers have limited training, which is in a form of workshops conducted to equip them (Terburgh, 2015). However, that does not suffice the expectation that they will be able to play their role as promoters of health in schools. Health promotion programmes in schools were initiated as measures to eradicate many health challenges experienced by learners especially in previously disadvantaged schools (Peu *et al*., 2015). Many of these health challenges can only be dealt with by health professionals as per teachers' understanding

that health promotion in schools has to do with health professionals. Focus has been on children's physical health (Mashau, 2011) in school, which is done by school health nurses because it has to do with the screening, assessment, and prevention of disease (DBE, 2014).

Health promotion in schools is seen as an initiative, which can only by addressed by specific teachers and within a specific subject. In many schools, a particular teacher who addresses health issues through Life Orientation/Life Skills subject tackles health promotion (Peu *et al*., 2015). In some instances, in a subject, it focuses on particular topics that are the main concern within a particular region, province, district, or community. Owing to the many roles presented by teachers in schools, they believe that they are already over-burdened with work (Preiser *et al*., 2014) and they were not ready to do more because already they have less resources, overcrowded classrooms, lack of knowledge etc. To many teachers, health promotion programme can be used to address single problems within the school such as drugs, teenage pregnancy as well as nutrition but did not know how it could be done (Peu *et al*., 2015).

The collaboration between the school and the health sector in the service delivery to schools can yield positive result where learners would succeed in their studies because their health is taken care of by both sectors (Mohamed, 2015). Teachers' understanding of health promotion in schools in the manner mentioned above could hinder the progress of the programme and how they can play their roles as promoters of health in schools. As such, their participation in the programme is very important.

3.4 TEACHERS PARTICIPATION IN HEALTH PROMOTION IN SCHOOLS

When health promotion has been introduced in schools, it is ideal for teachers in school to participate to ensure sustainability and ownership of the programme, although not all teachers would react positively to the programme (Mohamed, 2015; Renwick, 2006). Viig *et al*., (2010) hold the view that staff participation is very important as it serves as a requirement for health promotion in schools. Teachers' participation in the HPS requires of teachers to move from their status quo to focus on making difference in the lives of children in schools (Simovska, 2004). In essence, that will require a closer view at their readiness, professional development and how they relate with the parents/community.

3.4.1 Teachers readiness for health promotion

Health promotion in school is a programme that is facilitated in schools for the purpose of promoting the total health of learners and staff in particular (Marx *et al.,* 1998). Nevertheless, teacher readiness is very important to promote health (Mohamed, 2015). Several factors can determine the readiness of teachers towards the health promotion programme in schools. These factors range from the environment in which teachers find themselves. It can be the physical environment or the social environment of the school that can determine their readiness.

Schools that are former disadvantaged or quintile 1 and 3 had challenges ranging from physical environment where the classes were overcrowded with the teacher ratio of 60:1 as well as dilapidated classroom with broken furniture. (Roux, 2013; Hay, 2009; Mohlabi *et al*., 2010). No matter how much teachers would like to be involved in the promotion of health, this kind of environment will always be a limiting factor (Preiser *et al.,* 2014).

It should be noted though that if teachers are pessimistic about the programme, no matter how good the environment is, their participation will always be low (Viig *et al*., 2010). The same applies to the social environment of the school, which can also be a crucial factor where teachers are supposed to be able to relate with learners as well as the other staff members (Donald *et al*., 2010; Persson & Haraldsson, 2010). In addition, if teachers could observe changes in learner behaviours and good parental relationship, they could be likely to accept to play their role as promoters of health (Viig *et al*., 2010).

It can be argued that building relations in school is quite a difficult thing to maintain because of various factors which can play a role in how teachers can relate with staff members, parents, learners as well as the overall school community. For example, owing to teachers' lack of knowledge and skills about health promotion in school programme, the health promotion responsibility is under a certain committee and focuses on particular subject such as Life Orientation/Life Skills (Mohamed, 2015).

However, if the understanding is that all teachers need to be involved to lessen the burden of the committee or the Life Orientation/Life Skills teachers then teachers will be likely to be ready to participate basically because it has become the responsibility of all (Inchley *et al*., 2007). On the same note, if health promotion is institutionalised within the school, there would be sustainability in the sense that there will be a shared responsibility among the staff and the vision would be constructed into the school's activities (Tjomsland *et al.*, 2009).

Too often when a programme such as health promotion in school is introduced, teachers feel overwhelmed (St Leger & Nutbeam, 2003; Marx *et al*., 1998) with responsibility. Moreover, this challenges their readiness in terms of participating fully (Mohamed, 2015) with a better understanding of what it means to be a health promoter, and often their attitude would seem to be negative in a way (Strydom, 2011). The promotion of health in education is a difficult concept for teachers to accept because it is likely to be seen as a health sector concept and above all teachers do not feel the need for it in school (Clarke *et al*., 2010).

It can be assumed that leadership in school can also play a role in motivating teachers to participate as Wright (2009) and Mohamed (2015) distinguished that principals can be an influential factor to enable teachers to be ready. Fullan (2001) highlights that principals are gatekeepers of change; and as such, they are able to provide resources and support from other stakeholders for the purpose of motivating teachers to participate and commit in the programme (Wright, 2009). It is clear that without their leadership readiness, teachers will always be a difficult thing to achieve because they will lack direction for the programme. Viig *et al*. (2012) assert the position of a principal as one, which is strategic in bringing about change through policies and various structures within the school.

The leadership role of the principal in the health promotion programme validates the positive effects of the programme with its top-down approach of authority whereas teachers would approach the programme from the bottom-up approach, which gives it a meaningful collaboration within the school (Viig *et al*., 2014). In addition, Viig *et al*., (2014) also noticed that lack of reinforcement, authority and ownership by the principal could have a negative impact on the implementation and integration of the programme.

In addition, Kremser (2011) notes the misunderstanding by the principal where the promotion of health in school has been reduced to mere activities, which were allocated to specific teachers in schools since it was viewed as time consuming in the school, and that has contributed to lack of cooperation from other staff members.

In most cases, health promotion in schools is a top-down approach, which compromised the principles of health promotion where the element of empowerment is undermined (Berry, Murphy, & Coser, 2014). Similarly, the top-down approach makes it a bit complicated for teachers to be involved as Quirke (2015) has indicated that the most successful health promotion programmes are the ones that considered the bottom-up approach because not only specific teachers are involved, but also the whole school community is involved.

3.4.2 Teachers attitude on health promotion

The attitude of teachers when it comes to their role as promoters of health in schools is very important as it is the background for the successful programme in school (St Leger, 1998; Tjomsland, 2010). The health concept has been used in education though. However, health promotion in school is a bit complicated in the context of education. According to St Leger (1998), teachers are the main role players in the school context and the expectation is to provide quality education for all, irrespective of their religion, health status, barriers to learning, and disability. Regardless of that, Shung-King (2014) and Kwatubana and Kheswa (2014) indicate that teachers have negative attitude towards health promotion in schools since they raise the element of lack of skills on how to accomplish it.

For health promotion to succeed though, schools are expected to be fully involved in the programme. Moreover, the critical matter then is when teachers are not able to find their ways to promote health in schools. Health promotion as a concept falls within the health fraternity, which makes it difficult for teachers to penetrate and make a difference in the lives of the children (Peu *et al.*, 2015) and basically, because it moves away from the traditional approach to health to another level, which requires schools to engage in the holistic approach of health, which is health promotion.

Health promotion in schools is also challenged, and that is where teachers are resistant and not in positive response towards the concept. Nonetheless, their attitude and understanding of health promotion need to be attended to provide an environment where healthy teaching and learning occurs in schools.

The other attitude can be because of the unfamiliarity with the concept in education. Health promotion concept is not a familiar concept in the education domain, except for physical health and life skills, which mainly focuses on educating learners about health issues (Jourdan *et al.,* 2016). A research conducted in a number of countries where teachers were asked about their understanding of health promotion in school, reported that their understanding was totally different from what the concept is all about (St Leger, 1998; Jourdan *et al*., 2008; Renwick, 2006). In their understanding, it was all about health professionals rendering health services in schools, and teachers did not feature anywhere.

Research has proven it repeatedly that the suitable place to promote health for learners is schools (Mukoma & Flischer, 2004; St Leger, 1998; Samdal & Rowling, 2011; Kremser, 2011; Quirke, 2015). This cannot be denied because teachers are there to influence learners through teaching and learning. However, the unfamiliarity in the concept hinders the progress of health promotion in schools.

3.4.3 Teachers' professional development and health promotion

According to St Leger (2000) and Jourdan *et al*., (2016), for teachers to make health promotion in schools to work, they need professional development. The main aim of professional development is to help teachers to have a clear understanding of the schools mission and its ethical limits (Jourdan *et al*., 2008) and also the fact that there is a lack of qualified staff to promote health in schools (Bruce, *et al*., 2012). Therefore, it is worthwhile to train teachers as well.

Contrary to this conviction of professional development for teachers, Markham and Aveyard (2003) found that there is no need to train teachers to be promoters of health if health could be a cross curricula theme done by all teachers. Viig et al., (2012), echoed the same sentiment in their findings where in-service training was not essential

at all since health promotion activities might be taking place in schools and teachers were not aware.

Probably, teachers would participate in the programme if they believe that it would bring out positive educational outcomes (Tjomsland, 2010; Jourdan *et al*., 2011) and if the principal could allow time for professional development for teachers (Samdal & Rowling, 2011). All teachers need to reimagine the discourse of health issues; how they work among each other; how they link with the community and how they change their view towards health services in school for the purpose of supplementing health professionals.

Teacher professional development is very important for school health programmes as it improves the implementation process (Jourdan *et al*., 2008; Heward *et al*., 2007) as well as to build teacher's commitment, understanding, skills, and their attitude (Jourdan *et al*., 2016). According to Simar *et al*. (2007), teachers who have gone through HPS training tend to be involved more frequently in projects and have more integrated approach to health than those who do not have training (Jourdan, 2011). Again, teachers who are trained are competent and they feel motivated. According to Viig *et al*., (2010), it has been acknowledged internationally that well-motivated and competent teachers are essential for the delivery of quality education.

Hopefully, within the health promotion programme in schools, it is mostly the health coordinators who received training on how to promote health. Other than that, the effectiveness of training is hampered by the rest of staff who are not aware of the policy and its effectiveness in school (Deschesness *et al*., 2010). In a research conducted by Jourdan *et al*., (2008) and Peu *et al*., (2015), it is said that although the core business of the school is mainly focused on educational outcomes, schools should embrace health-related initiatives because poor health of learners inhibits learning.

To increase teacher professional development, there is a need for on-going teacher professional development and teachers' professional learning (Jourdan, 2014; Leahy & McCauig, 2014). The department as a top-down approach to health promotion conducts professional development and professional learning (bottom-up approach)

is done by schools based on the needs analysis of the school (Mohamed, 2015). According to Easton (2008), teacher professional development focuses on the knowledge, skills, attitude, and behaviour.

Kwatubana (2014) found that teachers' lack of training by the DBE could possibly contribute to the failure of some programmes. Similarly, Deschesness (2010) notes that the lack of leadership and support from the DBE has been found to be challenging the implementation of health promotion in schools even though there were policies and guidelines to keep with the health promotion principles. The weakness in the health promotion approach by the government is said to be in a sporadic manner (Aldinger *et al*., 2008).

3.4.4 Teachers' relation to the school community and health promotion

Literature review found that schools do not exist in isolation of the communities that they serve (Mohammed, 2015; Viig *et al*., 2010). Schools cannot exclude parents from being involved since community participation is a statutory obligation as its participation has been emphasised (ISHP, 2012; DBE Integrated Strategy on HIV, STIs, and TB 2012-2016, 2012; NSNP, 1996). Community links and partnerships are one of the elements of a health promotion in schools (Marx *et al*., 1998) and it completes any model of health promotion that is to be implemented in any school (Kwatubana, 2014). However, how teachers involve the community is still a difficulty (Deschesness *et al*., 2003).

It is said to be difficult because parents are unwilling to engage or they are too busy to play their role (Clelland *et al*., 2013). Teachers' relation to the community is very important for the promotion of children's health (Peu *et al*., 2015; Mohamed, 2015). Teachers promote health for learners through teaching inside and outside the classroom. Bearing in mind that teachers find it difficult to reach the community, health messages that are taught to learners are not supported by the community.

According to Clelland *et al*. (2013), without the good relationship between teachers and the community, there is likely to be a discrepancy between what is communicated and practiced in school as well as what is communicated and practiced at home. Mashau (2011) indicates that teachers often defend their territory and can go to a point

whereby they can decide on how parents can be involved in schools. This is often done through meetings that parents are informed about their children's performance and also how they can raise funds for schools (Mohamed, 2015).

In addition, Mashau (2011) and Kwatubana (2014) indicate that such kind of involvement is a token participation and there is a need for real participation. This is contrary though with the health promotion approach, which encourages empowerment of the community (WHO, 1986). Lack of involvement by the community can be seen as a barrier that hinders the success of health promotion in schools (Kwatubana, 2014). It is not a prerogative for teachers to relate to the community and their frustration on how to involve parents in the promotion of health of their children is a reality.

According to Kwatubana (2014), it has been proven that schools that involve the community in their efforts to promote health have reported fewer problems in relation to implementation as well as the execution of health processes. However, to foster a proper relation between teachers and the community, schools would have to develop strategies on how to involve the community in the promotion of health for learners. Above all, there is a need for professional development for teachers that will enable them to foster a better relationship with parents and the community at large (Clelland *et al*., 2013).

3.4.5 Teachers' predicament in relation to health promotion

Several research studies have proven the importance of health promotion in schools (St Leger, 2004; Samdal & Rowling, 2011; Jourdan *et al*., 2016; Ntagungira, 2014; Mohamed, 2015). It has been indicated that although research is positive about health promotion in schools, not all teachers would engage fully in the programme in terms of commitment, and the value of the programme to them (Jourdan *et al*., 2008; Mohamed, 2015; Viig *et al*., 2010). Now that in some schools health promotion has been left in the hands of school health committee, the effectiveness of the programme in schools is not clearly observed as it is more based on the school health services where nurses are in the forefront (Kwatubana & Kheswa, 2014).

One most challenging factor with the health promotion in schools is when teachers receive little time of training without much rigorous training (Leahy & Mc Cauig, 2014; Jourdan, 2014), without finding out what could be their needs in order to promote health in schools (Strydom, 2011; Hay, 2009). The next section will focus on the health promotion needs of teachers.

3.5 HEALTH PROMOTION NEEDS OF TEACHERS

Teachers just like learners also need support regarding their health to function exceptionally well (Gray *et al.*, 2006). The health promotion approach in schools initiative puts teachers on the forefront, irrespective of their needs to be involved. Schools are positioned as a setting for health promotion (St Leger 1998) and that calls for teachers to acquire a new sense of values along with new ways of teaching (Strydom, 2011). It is important though not to undermine the role of a teacher in the promotion of health (Gray *et al*., 2006).

Teachers' perceptions and their experiences play a great role in a way they influence learners in schools. As a result, they need to feel that their health is promoted as well for the purpose of the programme to be successful (Strydom, 2011). It is very important for teachers' needs and their competencies to be considered.

Teachers' needs of support for learners who have serious barriers to learning as compared to their normal roles and responsibilities are not attended to. With regard to their needs, Hall and Engelbrecht (1999:230) identify the needs of teachers as the need for knowledge, emotional needs, the need for support, and skills. Very often, when teachers are frustrated with children in the classroom, it affects their emotions, which also affects their health in general. Hence, their emotional needs are to be addressed on a cognitive level (Strydom, 2011)). In the first place, the emotional and cognitive support of teachers is necessary to determine the success of effective health promotion (Marx *et al*., 1998).

3.5.1 Emotional needs of the teachers

One thing that stands in the way of health promotion development in schools is the teachers' emotional tendency, which hinders them in the endeavour to support learners in schools (Strydom, 2011). This tendency ranges from among others

ignorance, job satisfaction, anxiety, confusion, uncertainty, feeling of discomfort when dealing with learners, as well as the feeling of failure (Mahlo, 2012). Their emotional needs also include acknowledging different skills and expertise of each teacher in the school, which is often not acknowledged since many teachers would like to stick to their job description.

Bearing in mind that health promotion in many countries is a “top-down” model, which does not address teachers specifically, there is a need for teachers to participate in the transformation of education (Renwick, 2006), by sharing the mission and vision of the HPS.

3.5.2 Need for knowledge and skills about health promotion

The knowledge and skills about health promotion for teachers is very much necessary because without the proper knowledge on how they should promote health, it will not be easier for teachers to participate in the progress of health promotion (Tjomsland, 2010).

In the first place, there is a need for in-depth knowledge of the philosophy of health promotion in schools and for teachers to develop a better understanding regarding the concept and how to apply it in their context (Migglioretti *et al*., 2012). This is very crucial because the concept has been developed from the health perspective wherein only the medical concepts are dominant (Ntagungira, 2014). The amount of health promotion knowledge shared to teachers during pre-service and in-service training seems to be very limited.

The training on teamwork and collaboration is critical for the success of health promotion in schools (Tjomsland, 2010). The health promotion concept can be very intimidating since it is a borrowed concept from health and it is also unknown in education. Many teachers, from their training institutions, lack the necessary training about health promotion to teach learners (Mohamed, 2015) or else they are not used to teamwork and collaboration. However, it can be appreciated if the teacher is guaranteed support from the knowledge of another team member. In case a learner presents challenge, the teacher is able with the backup of other team members to invite others or the school health team to make decisions and to solve problems where

learners can benefit from their teachers as well. In this way, all learners benefit from their teachers at school (Mahlo, 2012).

Above all, the need to be informed about the changes in line with their profession cannot be denied as well as the support to bring about a new education paradigm within the school. To make it easier for teachers to be involved the health promotion in school, the vision and the mission of the school needs to be very clear concerning the practical implications in supporting learners (Mohamed, 2015; Leahy & Mc Cauig, 2014).

3.5.3 Teachers need for support in health promotion

For teachers to succeed in the promotion of health in schools, they need support from all stakeholders to start with (Viig *et al.*, 2010). Support is defined as an enabling mechanism that addresses the needs of learners, as well as the education system, with the aim of focusing on preventing and minimising barriers to learning and development and to help create a conducive environment for learning (The Department of Education, 1997).

In education there is Education Support Services (ESS), which is given to support teachers as it plays a vital role in the supply of quality teaching and education by strengthening the provision of services which is provided at different levels such as school, district, provincial, and national level (Strydom, 2011).

Technically, the systemic role of health promotion support services given to teachers by stakeholders in education, and by teachers as service providers to learners and their parents is essential for the purpose of transforming education and to change mind-set regarding health in schools (Jourdan *et al*., 2016). Hence, support from teachers, parents and community is necessary for the success of the school (Strydom, 2011; Power, 2006) as it has been indicated in Bronfenbrenner's (1992) (theoretical framework. Likewise, Lazarus (2006) recognises the fact that the collaboration of community services as well the NGOs is crucial for the development of the well-being of the school community.

The implication for teacher support though is to move away from only supporting the individual learner to supporting all learners in a school. It can be argued that before teachers can be engaged in any programme, professional development is necessary to develop teachers' competency in various components of the health promotion in schools (Jourdan, 2016). This can also be possible by utilising the available structures within the institution where teachers can get immediate attention where they discuss their frustrations and challenges in their comfort of their school (Strydom, 2011).

Teaching can be a lonely profession, especially if the teacher wants to execute the responsibility alone. However, through collaboration with other teachers, they can possibly make use of opportunities to develop their competencies and their capacity (Viig *et al*., 2010). The SBST is available in schools to develop support for teachers, learners and parents.

According to the teachers' profession, they are expected to give support to learners, hence they need support themselves (Renwick, 2006). Despite their professional responsibility to support learners according to the Education for All (EFA) programme in South Africa, teachers are often confronted with a number of obstacles. One of the greatest obstacles was the need for support from the other systems, which helps in the development of children in the promotion of health in schools (Mahlo, 2012). Part of support for teachers in the promotion of health required that teachers would share information, their experiences and challenges they face in the support of learners. Therefore, to overcome this, the subsequent needs must be taken into consideration (Weare & Gray, 2003).

These needs include the levels of support established to support the teachers at school. The role played by different levels of support for health promotion can play a significant role in the development of teachers as it can boost their confidence and understanding regarding health in schools (Wevers, 2012). Besides, it can also provide the better quality in education. The support of teachers in a form of peers can also spread to the whole school to strengthen the health agenda (Tjomsland, 2010; Viig *et al*., 2010). This could not only enhance the teachers in a particular school, but it can also spread to teachers who are in schools, which are not yet labelled as HPS.

Support for teachers can also go by working in consultation with other stakeholders through and within the school community (Viig *et al*., 2010). This could also be done through joint planning of activities, sharing important information about learners experiencing barriers to learning, involving parents and the community, sharing ideas on how best to support learners as well as supporting learners and teachers respectively.

The common goal for teachers in support of learners and their personal support goes a long way to provide a platform for collaborative roles that can lead to problem solving in other areas (Preiser *et al*., 2014; Power, 2006). It is through this process where teachers can become experts in their schools through training and workshops done in and out of the school where networking between teachers could aid in gathering valuable knowledge and expertise as well as providing support (Viig *et al*., 2010). The need for support is also crucial because more learners experiencing health challenges are accommodated in schools (Jourdan *et al*., 2008). Therefore, teachers need to find ways to support them before more challenges are identified.

Now that there is a paradigm shift in education where health of learners is very important for effective learning, it is very imperative for both teachers and learners to receive support during this stage of transformation in education (Department of Education, 1997). The burden faced by teachers in support of learners would also require support programmes that would address their cognitive and emotional needs (Strydom, 2011).

3.6 TEACHER EXPERIENCES ABOUT HEALTH PROMOTION IN SCHOOLS

The background of Gauteng Province, in South Africa with regard to the health promotion in schools is that it is ahead of all other provinces with its development (Mohlabi *et al*., 2010). Owing to the nature of the province (smallest and overcrowded), most pilot projects were initiated by the government to reduce barriers faced by learners in schools. This is the case with the health promotion in schools programme where 14 schools in the province were used as the pilot schools. Few years down the line, the selected schools still experience challenges that were identified by various researchers around the province (Mohlabi *et al*., 2010; Kheswa & Kwatubana, 2014; Roux, 2013).

3.6.1 Participation of teachers in health promotion is not clearly stated

Health promotion in schools is done in schools to promote the health of children in schools (WHO, 1986). It is mainly done and carried over by the health professionals who would administer immunisations, screening and health education (ISHP, 2012; DBE, 2014). However, the most important entity missing is the role of teachers as promoters of health in schools. In South Africa, the SIAS policy document in its roll out plan indicated that the training of teachers in health promotion is crucial (DBE, 2014). However, the policy is unlikely to indicate specifically the role of teachers in the promotion of health.

Kheswa and Kwatubana (2014:1717) found that “there were no teachers involved in the process of the implementation of the ISHP in the participating schools”. Teachers seem to be marginalised and left only to teach in the classrooms.

Apparently, many teachers know and understand health promotion as the responsibility of the Life Orientation teachers and this understanding weakens the efforts to promote health in schools provided teachers’ role was not outlined (Peu *et al*., 2015). Both 2003 and 2012 revised school health policies were very much focused on the health professionals to provide PHC in schools without much emphasis on the teachers (ISHP, 2012; Shung-King, 2013; Kwatubana & Kheswa, 2014). Despite the will drive of the government to drive health in schools, the passive involvement of teachers would always strain the process of promoting health in schools.

Landsberg *et al*. (2005) indicate that the collapse in one system will affect the functionality of other levels too. Teachers only receive the directives from the district, which then acts under the Provincial authorities. Although there are clear roles demarcated for each level in the DBE (see Table 2.5), still teachers are not receiving any health promotion support from their districts, except for health promotion activities that were initiated during the 2006-2010 period when there was support from all departments as well as the JICA.

3.6.2 Teachers confused about the elements of health promotion in school

The health promotion concept has been developed by the World Health Organisation (WHO) to promote the health of children in schools (WHO, 1996). To achieve its goals, WHO developed five components of health, which must be considered when developing policies for each country, province, district, and schools depending on the health challenges they face (WHO, 1998). The concept is more health goal-focused than educational goals (Preiser, 2014). In some instances, health goals seem to be contradicting the education goals where teachers are not fully participating or resistance towards the programme (Kwatubana & Kheswa, 2014; Mohamed, 2015; Preiser, 2014).

In Gauteng schools, health promotion is defined in terms of vegetables gardens, hygiene and feeding schemes that were mainly provided to schools and they were in low socio-economic communities (Mohamed, 2015). These schools were mainly primary schools and they were under the status of quintile 1 and 3 respectively. According to the WHO initiatives, the five components underpinning health promotion in schools were very broad in terms of covering all factors that makes the schools to be healthy and alive.

According to Donald *et al*., (2002) and Samdal and Rowling (2013), each institution chooses the elements according to its necessities with regard to the challenges in their context. However, in Gauteng Province, the HPS approach missed the three most important elements. They are as follows:

- Counselling and psychological services (suppose after screening for HIV/AIDS and other communicable disease which might be chronic in nature how should the learner cope with learning after that);
- Health promotion for staff (workshops and seminars which were attended by teachers were meant to help teachers to work on health promotion elements which have been designed on the policy); and
- Family and community involvement (the immediate context has the very influential impact on the development of the child).

3.6.3 Lack of understanding on health promotion and implementation of policies by teachers

The section above indicated the elements that underpin health promotion in the Gauteng Province. However, owing to lack of understanding of the policies and the implementation of the needs according to the schools, the policy remained as they were because teachers who were supposed to implement it did not understand them (Inchley et al., 2007). The health promotion in Gauteng schools focused mainly in primary schools, although the policy has extended its plan to Grade 12 through the subject Life Orientation (CAPS, 2012). The policy is not very much specific on how teachers can apply the elements in schools except for screening, which is done by health professionals (ISHP, 2012; DBE, 2014). Above and beyond the ISHP that holds the central part of health in schools, there are various policies that are also embedded in the support of learners and promotion of health in schools and these are Education White Paper 6 (2001) and the SIAS policy document (2014).

The SIAS document is currently used in schools to help teachers understand how they can support learners who are experiencing barriers to learning. Without their understanding of the ISHP and Education Whiter Paper 6, completing the requirements of supporting learners according to SIAS document has left a great confusion because these policies are interwoven to each other (Kwatubana & Kheswa, 2014; Shung-King, 2013). Hence, the understanding of one policy would help with the application of the other documents. The dawn of 1994 has seen various programmes initiated with the purpose of improving children's health through knowledge and practices in particular schools (Kwatubana & Kheswa, 2014).

Programmes such as Primary Schools Nutrition Programme (PSNP), Road Safety Programme, Crime Stop, Environmental Safety Programme, HIV/AIDS Life Skills Education as well as the Mental Health and Substance Abuse programmes were developed from various sectors in the country (Macnab *et al*., 2014). These policies only focused on single risk factors and intervene in such a narrow approach (Hawkins, Catalano, Kosterman, Abbot & Hill, 1999), which does not address all problems in a comprehensive manner.

Instead of achieving the intended goals in line with the ISHP, they tend to be very much fragmented and at the end they lose focus because no one is held responsible of the failure (Shung-King, 2013). However, the focus is on teachers who are at the receiving end of the programme basically because they have made sure that implementation of the policy is achieved in the classroom as well as in the school.

3.6.4 Poor management of the health promotion programme by officials

According to Kwatubana and Kheswa (2014:1717), “there were no clear admin procedures followed at the participating schools”. The management of health programmes in schools seem to have no clear direction as to what is happening and who is responsible. Nevertheless, the ISHP (2012) has indicated how the project was to be examined (Shung-King, 2013). For the purpose of clear coverage and quality service delivery, the DBE is making use of the “Education Management Information System (EMIS), Learner Unit Record Information Tracking System (LURITS) and SIAS tracking devices to monitor and evaluate the integrated strategies” (Kwatubana & Kheswa, 2014:1715).

The top-down model in management leaves behind the trail of poor management in the HPS (Mohamed, 2015). Although Fink and Stoll (1998) suggested that changes occur best when the top-down or bottom-up approach is utilised where the larger system provides direction and support to schools. The effect of poor management is not only seen in and between the systems’ levels; it is also seen with the teachers at schools. According to Shung-King (2013), the school service data has been inconsistent and of poor quality which also has disabled the monitoring of progress and as well as its impact in schools. What is not clear is that research is done in and out of schools but the teachers are helpless unless something can be done to keep them on board.

Poor management has a negative implication on the functioning of both structures. The lack of understanding of the concept and the negative attitude by managers in both health and education sectors makes it difficult to implement the health services in schools in a much integrated manner (Kwatubana & Kheswa, 2014; Mohamed, 2015). In addition, some school principals did not allow the school health personnel to enter their premises just because their knowledge of the policy in school health is

assumed to be lacking. There are principals who still have the mentality that health services are conducted in health institutions alone, they are not meant to render their services in schools (Mohamed, 2015).

The principal's understanding as managers weighs heavily on the whole initiative in a sense that their support to the SBST and the staff in general can be very much limited. On a supervisory level, the work done by nurses is not checked as to what is happening throughout the year. Problems highlighted by nurses remain unattended and in a way nurses who are at a low operation level become frustrated ultimately due to lack of support from the management.

3.6.5 Lack of collaboration between the partnering departments

The perception of inter-sectoral collaboration is a critical component of health promotion (WHO, 1986). Moreover, partnerships have been found to be very difficult to develop in a HPS (Samdal *et al*., 2010). In addition, to develop the effective partnership, it requires effective collaborative models as well as stakeholders readiness, clear vision, financial support, creative leadership, time as well clear professional roles (Center for Mental Health and School, 2008). Probably, the challenge in the creation of health promotion in schools is that it draws together two or more sectors which is the DoH, the DBE and the DSD, each with its own goals and objectives (ISHP, 2012).

The ISHP is an integrated document in its nature because it is a document issued by DBE and DoH. However, the collaboration was not seen in schools where school health services were done (Mohlabi *et al*., 2010). In participating schools, teachers were not working together with the nurses because their line of communication would be the principals of the schools (Kwatubana & Kheswa, 2014).

What was questionable though was the relationship between the health sector, DSBT and the SBST, which was contrary to the stipulation by the ISHP where they were supposed to work together (ISHP, 2012). Teachers in schools could only provide with accommodation for the health professionals whom they have never met (Kwatubana & Kheswa, 2014:1717) to discuss health issues affecting the schoolchildren and the community at large. Although what the nurses were doing in schools was on the

integrated policy, teachers had no link with them. They can only refer children according to the SIAS document stipulations without much understanding of the document itself (DBE, 2014).

Most of the referral did not go far because parents were not even aware of what was happening in schools (Terburgh, 2015) since they would not even pitch when they were called (Mashau, 2011). Sometimes if the case was not very serious, they did not take their child to where they were referred (Shung-King, 2013). According to Kwatubana and Kheswa (2014:1717), in most schools, the personnel were not aware of the integrated policy in use; hence, they would still use the HIV, SIAS, Health, and Inclusive Education Policies in isolation. This was not done by schools only, by the districts as well.

The elements of health promotion in schools have been divided into sections that were run separately from the whole vision of providing health in an integrated manner. The collaboration of the departments was hardly seen operating in unison (Preiser, 2014; Naidoo & Wills, 2009; Fullan, 2007). This has been confirmed by Macnab (2014) to say the delivery of the programme was often compromised by limited collaboration between the disciplines outlined as health teachers. Although the roles of DoH and DBE was clearly stated in the ISHP the DSD was not heard or seen rendering health services in schools (ISHP, 2012).

The health promotion definition states that it is a process of enabling people to increase control over, and to improve their health (Samdal & Rowling, 2014). The weakness in the collaboration of systems in a way fails to empower teachers in schools to perform their roles as promoters of health in schools (Preiser, 2014). In addition, the definition moves beyond the action performed by systems to integrate with each other, that it was not only the individual challenges, which could have an impact on the health of children in schools. However, a wide range of social and environmental factors can affect the health of children as well (Kwatubana, 2014).

Much focus is on the physical aspect of health; hence, the assessments and screening of children in schools. The social aspect, lifestyle and certain behaviours were

addressed separately in schools. The environment where children learn is of utmost importance that it could not be ignored in any way (Ntagungira, 2014).

3.6.6 Lack of synergy between stakeholders affects teachers

Promoting health in schools should be understood from the Bronfenbrenner's ecological framework through which all systems (micro, macro, exo, meso, and chrono) should be integrating and collaborating (Bronfenbrenner, 1994) to meet the needs of children in schools through the teachers who interact with them on a daily basis. Nevertheless, the synergy where stakeholders were supposed to work together seem to be weak in the sense that there are many cracks through which things are not coming together for the purpose of the goals to be reached by the department (Shung-King, 2013; Mohamed, 2015).

Within the three departments, each has its own HPS goals to achieve, which are not well communicated to the other department and that send conflicting messages to the schools (Mohamed, 2015). The DoH is observed to be active in the domain of DBE where the approach of health promotion in schools is more focused on school health services under the PHCU.

The relationship between the health professionals and the schools on how they promote the health of learners seemed to be lacking. However, in the document by the DoH (2011), schools were supposed to organise a place where health professionals could assess the learners. Kwatubana and Kheswa's (2014) study revealed that in the participating schools, there were no extra venue for screening and assessment for learners. According to Simovska *et al*., (2016), quiet often, the aims and desired outcomes between the systems clash with the education agenda. Not all teachers were involved in the HPS implementation programme, only those who were in the committee (Kwatubana & Kheswa, 2014).

3.7 HEALTH PROMOTION STRUCTURES AND PRACTICES

Structures and practices are essential for the promotion of health in school to support teachers and learners. The HPS concept gives the theoretical framework for countries, districts and provinces to apply within their context (WHO, 1996; Viig *et al*, 2010). Subjects and health topics are used to address issues that affect children's health in

schools. Moreover, different structures are utilised to support teachers and learners. Nevertheless, research that pays attention on teachers as promoters of health in schools specifically was not found.

Teachers only receive health programmes to address health in schools with less understanding on how to do it (Mashau, 2011, Preiser, 2014). Therefore, for teachers to understand their roles within the HPS framework, they need to understand structures, which administer health promotion in schools. These structures are SBST and the DBST and they were discussed in section (3.9). Apart from the structures that support in the promotion of health, there are also health promotion practices discussed below.

3.7.1 Life Orientation/Life Skills

According to Strydom (2011), the movement towards PHC and the context in which it has taken place has led to the implementation of Life Orientation in schools as a subject it is used as a vehicle to promote health in schools (Roux, 2013). Simultaneously because of the limited number of health professionals, this has led to the usefulness of Life Orientation teachers in school to support learners (Strydom, 2011). For example, in Ireland, health is a subject in its own right, whereas in other countries it is infused within other subjects; in France, it is placed as civic education where it focuses on health and citizenship and in Portugal, it is considered personal education where the focus is on personal and social development (Jourdan et al., 2008).

According to CAPS (2012), Life Skills is paramount to the development of learners as it is concerned with the social, intellectual, emotional and physical growth of learners and as well as how they are integrated. Before teachers can engage themselves in teaching Life Orientation/Life Skills, they need to possess the skill to promote intellectual, emotional, mental and physical health. They need to be in their rightful position to support learners who are experiencing challenges in the elements mentioned above.

Due to a number of factors faced by teachers in the classroom, at some point they can fail to promote such because the reported to be deeply stressed and high absenteeism

rate among the teachers due to illness and some other problems they face in their lives (Strydom, 2011). The HPS concept is holistic and an umbrella to concepts in health and Inclusive Education (IE). Hence, the CAPS: Life Skills (2012) and CAPS: Life Orientation (2012), indicate the time allocation for Foundation Phase and senior phase in particular as shown in Table 3.1 and Table 3.2

Table 3.1: Instructional time in the Foundation Phase

Subject	Grade R (HOURS)	Grade 2 (HOURS)	Grade 3(HOURS)
Home language	10	8/7	8/7
First additional language		2/3	3/4
Mathematics	7	7	7
Life skills	6	6	7
Beginning knowledge	(1)	(1)	(2)
Creative arts	(2)	(2)	(2)
Physical education	(2)	(2)	(2)
Personal and Social Well-being	(1)	(1)	(1)
TOTAL	**23**	**23**	**25**

Source: Curriculum Assessment Policy Statement: Life Skills (2012)

Table 3.2: Instructional time in the Senior Phase

Subject	Hours
Home language	5
First Additional Language	4
Mathematics	4.5
Natural Sciences	3
Social Sciences	3
Technology	2
Economic Management Sciences	2
Life Orientation	2
Creative Arts	2
Total	**27.5**

Source: Adapted from Curriculum Assessment Policy Statement: Life Orientation (2012)

Although it is very important for teachers to promote health by teaching Life Skills/Life Orientation, the time allocated for it in schools is very minimal.

3.7.2 Curriculum differentiation

In order for the teacher to respond to the diverse needs of learners, curriculum differentiation is a key strategy to do so. It is a key strategy because it involves a process of modifying, changing, adapting, extending and varying teaching methodologies, teaching strategies, assessment strategies, and the content of the curriculum. According to the Policy on SIAS (DBE, 2014), curriculum differentiation takes into account learners' level of functioning, interest and backgrounds. In addition, it can also be done at the level of content, teaching methodologies, assessment, and learning environment. To achieve equality and equity in education and ensure that more learners achieve their full potential and eventually access the world of work, curriculum differentiation needs to be put into practice.

According to Tomlinson (2001), curriculum differentiation refers to the efforts of teachers to respond to diversity among learners in their classrooms. Reaching out to all learners when teaching creates the best learning experience in the classroom. In a

way, curriculum differentiation is essential because of the mere fact that learners who experience barriers to learning may fail to execute certain tasks when they are compared to the rest of the class. This is where the teachers in their practice need to identify and support learners who have various needs in the classroom in order to create a pleasant and positive learning experience.

3.7.3 Health promotion and related topics

A number of research focuses on activities and topics that teachers can address in schools. Topics such as nutrition, HIV, hygiene, obesity, bullying and so forth have been researched about. In Scotland, the focus is on healthy eating (Inchley *et al*., 2007); and in the Netherlands, the focus on health promotion covers sports and physical exercises, social skills development as well as personal care (Leurs *et al*., 2007). On the contrary, in Norway, all schools have chosen the improvement of learners' well-being and learning environment in their programmes (Viig *et al*., 2010).

There are topics addressed within the curriculum using the following learning areas: Life Orientation, Life Skills, Arts & Culture as well as Natural and Social Sciences (Strydom, 2011). Topics that require professional expertise are mainly done by organisations such as clinics, police, health department, and NGO's. The following figure presents health promotion related topics, which are addressed in schools by various organisations.

Table 3.3: Health related topics

- Substance abuse
- Sexual transmitted diseases (HIV/AIDS)
- Environmental education
- Violence
- Mental health
- Disease prevention
- Measles outbreak
- Food and nutrition
- Physical activity
- Road safety

These topics are addressed by other organisations by a mere fact that teachers are not competent when it comes to these topics; hence services for South African Police Service (SAPS), Clinics and Road Safety services are used to address the challenges in schools. The approach of attending to health topics in schools seeks to attend to challenges such as outbreaks within the particular area or the community; hence, it calls for specific services (Waggie *et al*., 2013). Teachers' understanding of health promotion in schools is when the school is promoting health topics that affect learners (St Leger, 1998).

3.7.4 Resources and the promotion of health

The availability of resources in a HPS is crucial for the progress and the practice of the programme (Mohlabi *et al*., 2010). In the first place, human resources are needed to plan and to organise activities within the school (Mohamed, 2015). This can include provincial officials, district officials, school officials, health officials, NGO's, and community members who then collaborate, even though research is done in schools. Teachers will need assistance from other stakeholders who then can provide advice on health policies in school; counselling to learners who have emotional and social problems; policy development and disease outbreak from health professionals.

The schools where HPS programme were researched about were schools in the disadvantaged communities (Mohammed, 2015) where the school is classified under quintile 1 and 3 and learners do not pay school fees. This places the school in a position where they can only receive funds from the DBE. Hence, one of the roles of the School Governing Body (SGB) is to raise funds (South African Schools Act (SASA), 1996) to carry some of the needs required by school.

That means in the second place teachers needed funding for the health projects and activities that could be planned in the school. Teachers, together with the SGB could plan to raise funds by conducting fundraising with the parents of the school. Lastly, literature indicated the need for physical resources to support the project and activities such as dustbins for recycling purposes; taps to promote hygiene (washing of hands before and after eating or coming back from the bathroom); garden tools for gardening projects. Depending on the needs of the school, there could be more resources

needed to support teachers to do their roles in schools as well as the classrooms (Jourdan, 2016).

The issue of resources is often understood as something that can be brought to schools. On the contrary, according to St Leger (1998), the principal and the management of the school are human resources that can bring about the functionality of the programme in schools. Various researchers argue that it is crucial for the principal and the management to buy in the HPS programme (Mohamed, 2015; Ntagungira, 2014).

The SIAS policy document has shown the approach to identify barriers to learning in schools. The next section will present the barriers to learning in the health promotion context and the ecological system model.

3.8 THE ECOLOGICAL SYSTEM AND BARRIERS TO LEARNING IN THE HEALTH PROMOTION CONTEXT

The Ecological Systems Theory emphasises the importance of the environment to understand the learner (Bronfenbrenner, 1994). According to Bukatko and Daehler (1998), the multi-layered environment in which the learner functions on a regular basis can only examine the process of learner development. Section 1.6.1 has given thorough discussion about the theoretical framework. Hence, this section will clarify the practical effect of the theory of the learners with barriers to learning in the health promotion context.

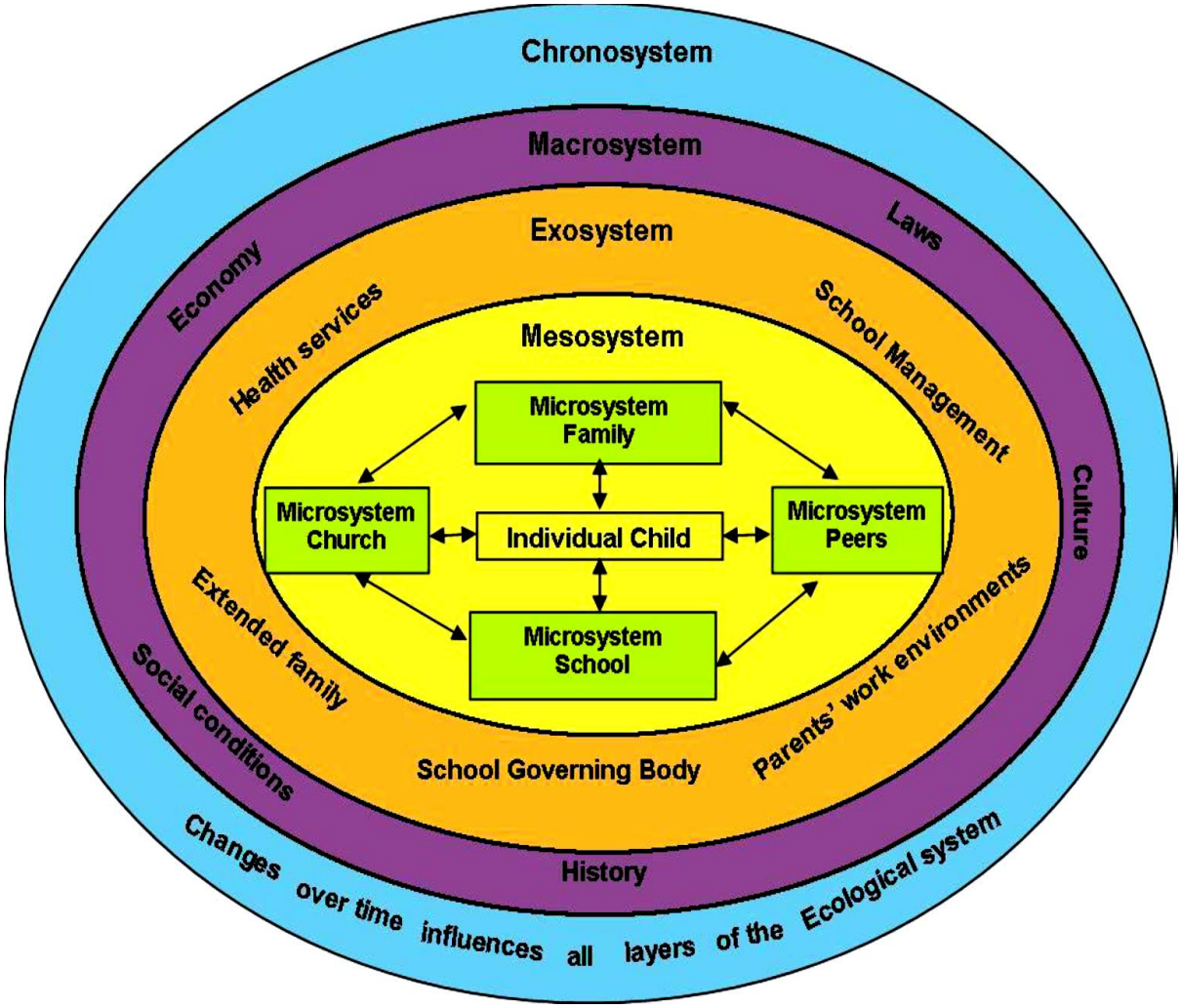
The understanding of the theoretical framework has to be understood in terms of understanding that what happened in all systems level directly and indirectly affect the role of teachers as promoters of health in schools.

According to Gabriel *et al*., (2010), the principles that form the foundation of the ecological systems theory were highlighted as follows:

- The framework focus on the child;
- A child is affected by the settings where they belong;
- The family is the critical setting for the child;
- The development of a child is determined by the experiences in the settings where the child spends time in; and
- The connections among various settings, has an effect on the development of a child.

The relationship between the systems will be discussed below to show how the five systems impact the development of a child in a more practical manner.

Figure 3.6: The Bronfenbrenner's ecological model



Source: Eisemann *et al*., 2008:223

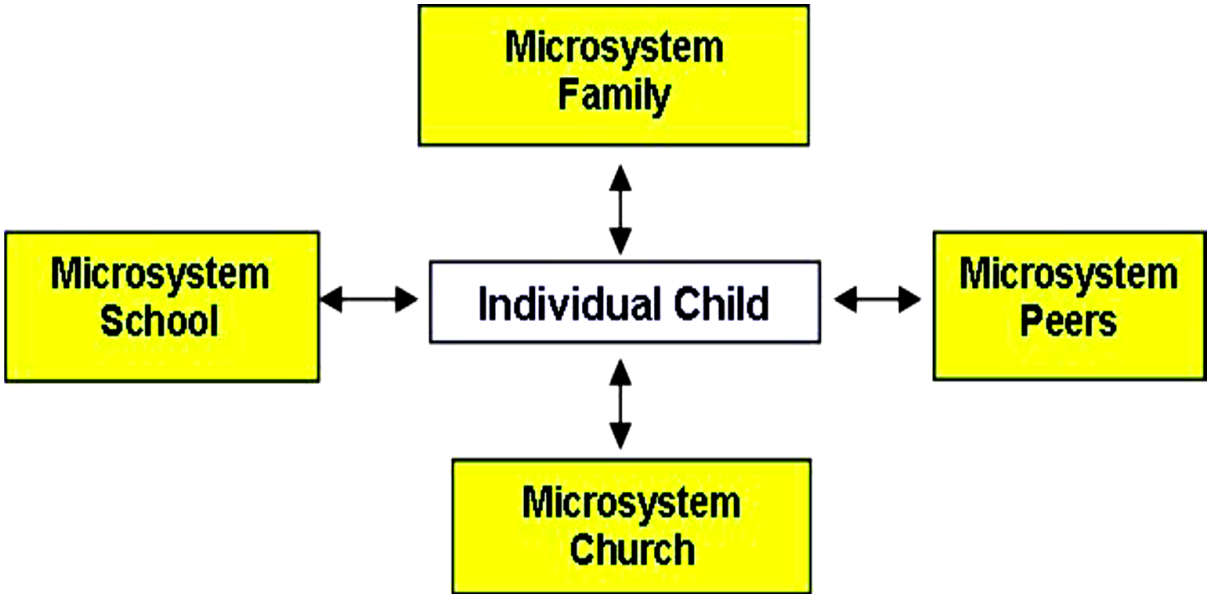
3.8.1 The microsystem

The microsystem is the core component of the system where the child develops (Bronfenbrenner, 1979). The home and the school are very influential in the development of a child. It is in this context where the child experiences the feeling of security and develops trust and maturity with the significant people. According to Swick and Williams (2006), the child learns how to live and to create a healthy personality in the family. The same applies with what is taught in the church; what is taught at school as well as the peers determine how the child grows.

The following factors in the microsystem environment can result as a barrier to the development of a child. These barriers are poor relationship between a child and the parents; poor relationship between a learner and the teacher, poor relationship between a learner and the peers, which can lead to social rejection, violence at home (domestic) and at school. The microsystemic barriers that can affect the child include the stressful lives of the family where parents could have gone through divorce, poverty and unemployment (Stack, 2005).

Furthermore, barriers with schools can include inadequate understanding of health promotion in schools, teacher attitude; inadequate support from staff, an inadequate curriculum management; overcrowded classrooms and the unavailability of support services as well as the LTSM. The microsystem is presented in the diagram displayed in Figure 3.7.

Figure 3.7: The microsystem

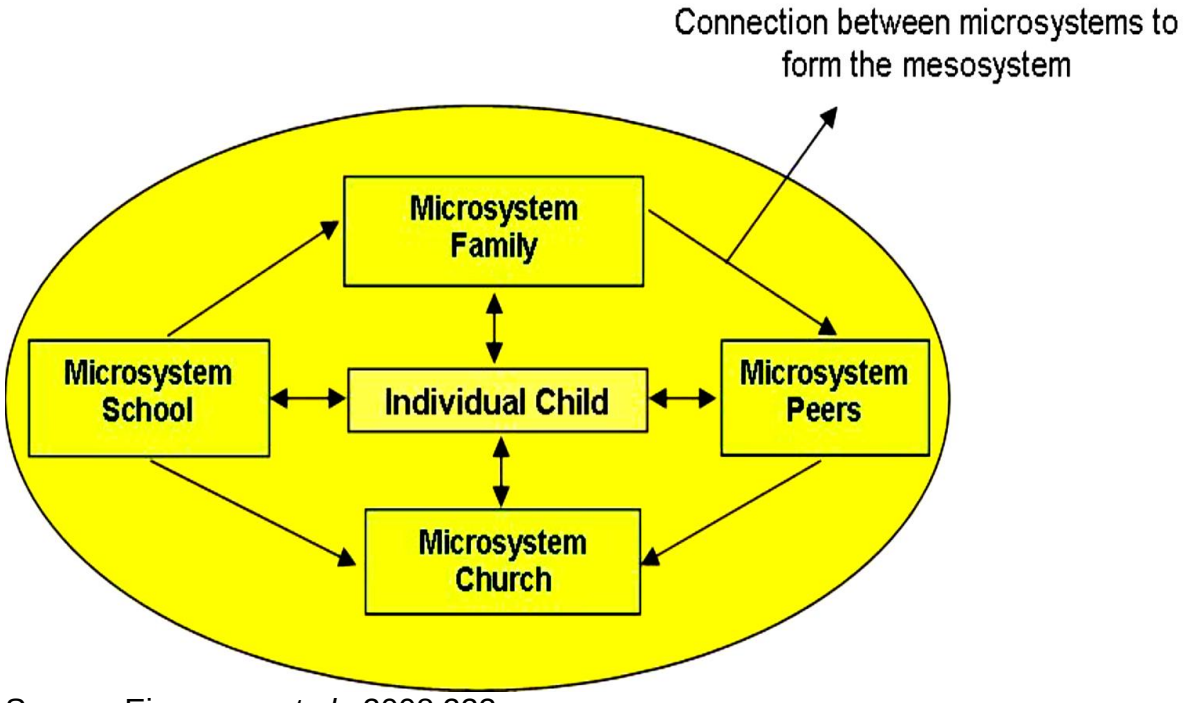


Source: Eisemann *et al*., 2008:223

3.8.2 The mesosystem

The mesosystem represents the relationships between settings in which the child revolves (Stacks, 2005); in this case, the relationship between the home and the school and vice versa (Bronfenbrenner, 1979). The relationship between the systems has an impact in the development of a child. Hence, Swick and Williams (2006) indicate that the real power of mesosystems relies on the connection it brings between the microsystem of the learner. The quality brought about by the interaction between different microsystems will also have an impact in the learner development. The quality of interaction between parents and the school, parents and the community institutions (church, after care centre, the library) as well as the social interaction with the peers plays a role in the development of a learner. Figure 3.8 below presents the mesosystem level.

Figure 3.8: The mesosystem



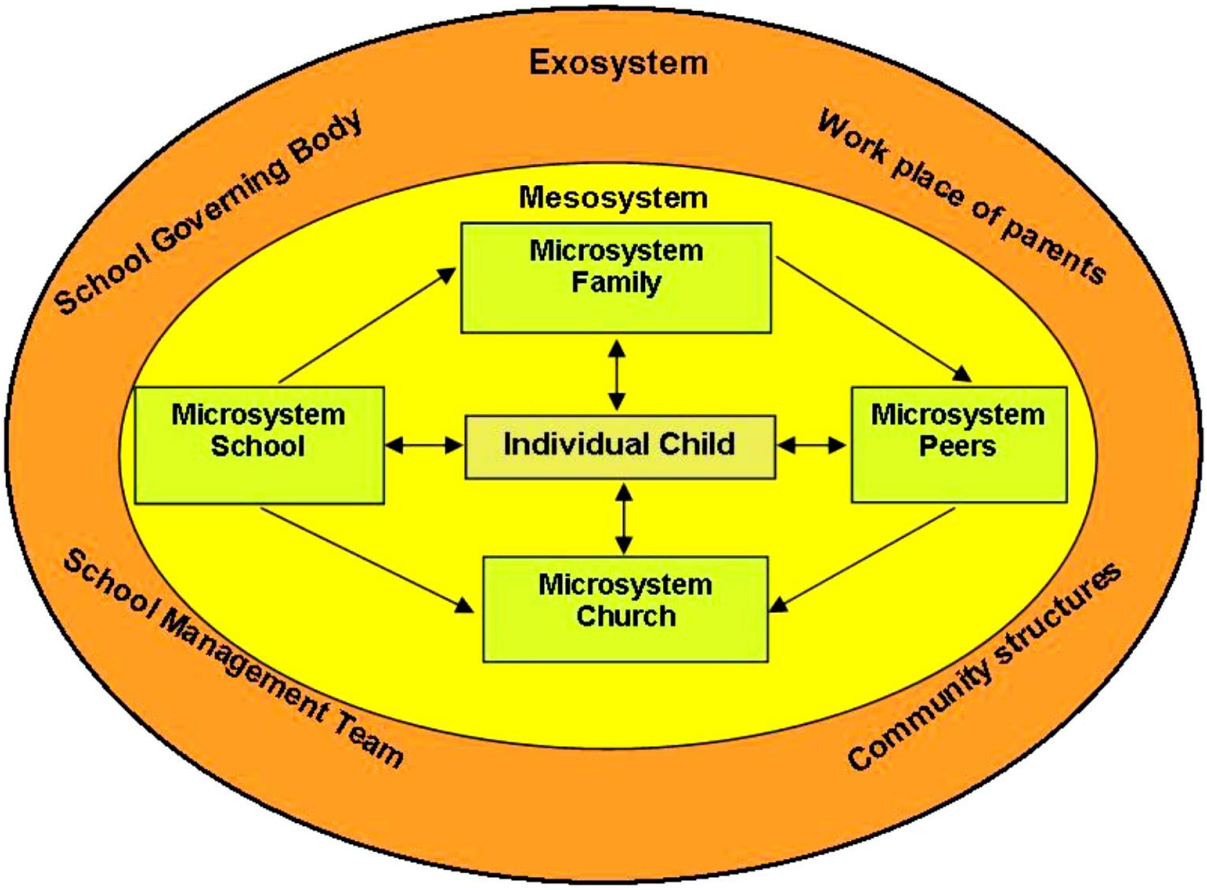
Source: Eisemann *et al*., 2008:223

3.8.3 The exosystem

The exosystem is the layer where learners are not in direct contact with but have an influence in their development (Bronfenbrenner, 1979). The exosystem presents the structures where decisions are taken. This can be the decisions by the SGB; parents' workplace where their financial status can determine the provision of resources which promote learning at school, the churches with their moral behaviour as well as the library for the engagement in shaping the love for reading.

The exosystem can be beneficial if the community has enough resources to promote health development for children. However, the nature of employment where parents are away from home and their children will have to be looked after by guardians, grandparents and in some instances, where there is no one to assist, their homes will be child-headed homes. The status that can be brought about parents work can have an impact in the children development in terms of helping with their schoolwork because they will arrive home late and already exhausted. This can also have a huge impact when parents can fail to attend important parents meetings whenever they are called by the school (Swick & Williams, 2006). This relationship is presented below in Figure 3.9.

Figure 3.9: The exosystem



Source: Eisemann *et al*., 2008:223

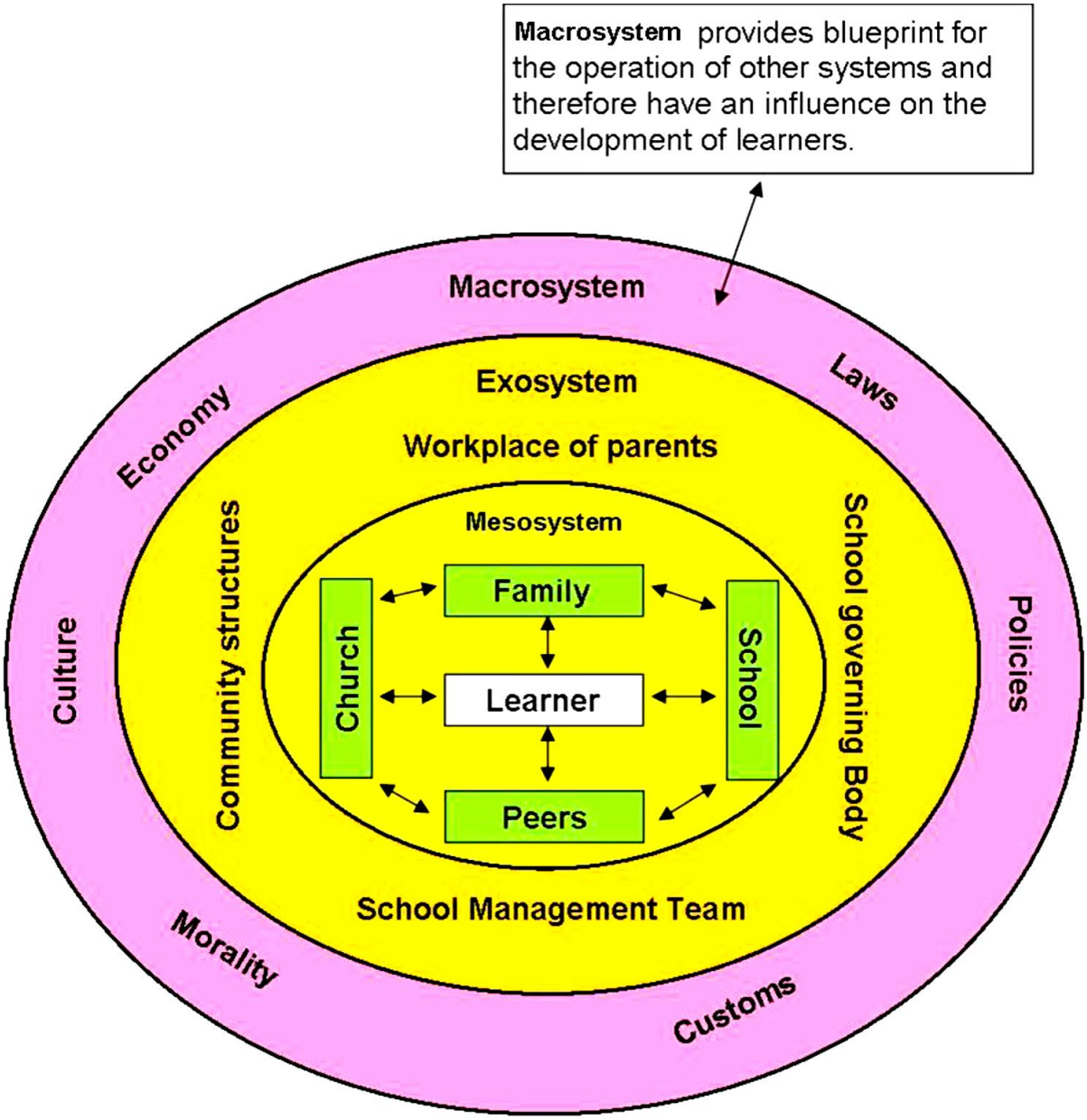
3.8.4 The macrosystem

According to the Bronfenbrenner (1979), the macrosystem is the larger context as well as the layer, which is furthest to the child. However, decisions taken in this structure have an effect in the learner development. All systems operate around the macrosystem. Although the environment is regarded as the very important element of the child development, the macrosystem represents the policies development by the national departments, values, morals, beliefs, traditions and laws shared among people (Onchwari *et al*., 2008).

Owing to decentralisation of power to the provincial departments and districts, the implementation of health promotion policy can be slowed down as they will be moving in different stride as they effect change in different ways (Wildeman & Nomdo, 2007).

Above all, there is an inadequate consultation by experts, service delivery and funding. The macrosystem is presented below in Figure 3.10.

Figure 3.10: The macrosystem



Source: Eisemann *et al*., 2008:223)

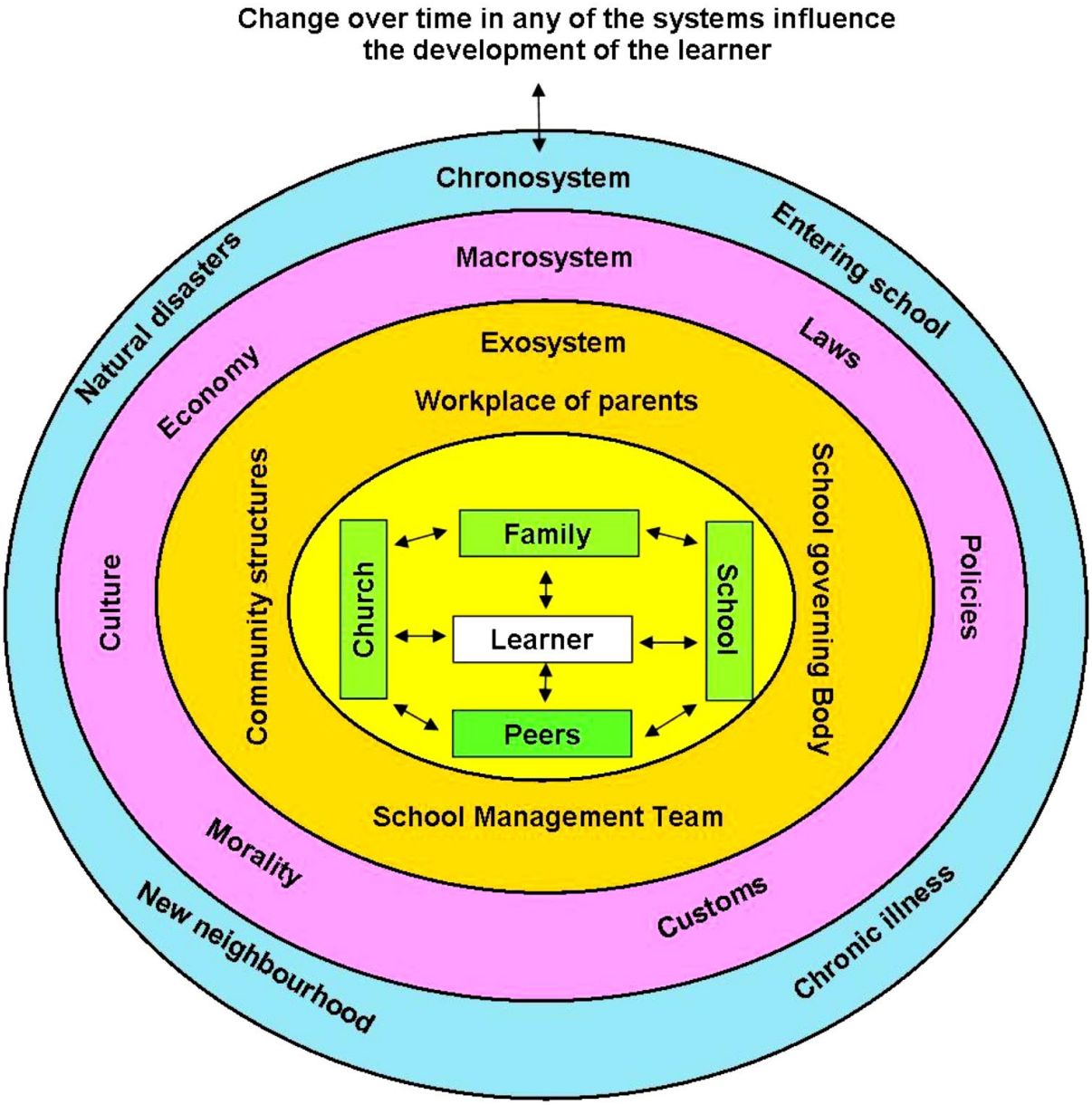
3.8.5 The Chronosystem

The Chronosystem is defined as the environmental changes over time (Bronfenbrenner, 1979). According to Hosek *et al*. (2008), the transitions that occur over time in one of the layers of the ecosystem will affect learner development. The

chronosystem focuses more on the transitions when the child leaves home to school. Swick and Williams (2006) also indicate that the focus is also on the transitions such as divorce, death or a chronic illness such as HIV/AIDS, cancer or diabetes.

The adjustment processes can be better or worse depending on how it was handled. A child whose parents were financially stable if they happen to lose a job and cannot maintain the family or death of a parent, which forces children to be taken care of by the guardian who can abuse them. The changes, which are provided by the chronosystem, are presented on Figure 3.11 below.

Figure 3.11: The Chronosystem



Source: Eisemann *et al*., 2008:223

The above explanations with regard to the relationship between systems have indicated clearly the effects that can be caused by these systems in the development of a child. The effects of systems in the development of a child therefore can cause barriers to learning which has been presented in the following sections.

3.9 HEALTH PROMOTION AND THE MANIFESTATION OF BARRIERS TO LEARNING

Promoting health for learners who experience barriers to learning in schools has not been a new thing because of the diversity of their problems (DBE, 2014). For decades, learners have been catered for in many ways. In the first place, the deficit model has been used to determine the learning barriers of learners (Landsberg *et al*., 2005), and because of this model, learners have been treated differently. The system of education, the schools as well as the teachers have the obligation to teach these learners (Education White Paper 6, 2001). In the schools, this calls for teachers to identify learners experiencing barriers to learning as early as possible, and to give necessary support, by observing learners carefully (DBE, 2014).

To clarify learners experiencing barriers to learning, there are two concepts that need to be clarified. That is, Learners with Special Educational Needs (LSEN) who are described as learners who have special educational needs. This implies learners who have needs that are different from those of the average learners, the reason why their needs are special (University of South Africa, 2003). These needs may include factors such as a special seat because they have problems with their sight; a special learning material such as a braille, hearing aid because they cannot hear well and possibly additional support from the teachers (Engelbrecht *et al*., 2006). These learners have special needs because of modifications in their learning.

However, the term "LSEN" does not place learners in an amicable position since they may be discriminated against because of their barrier to learning (Hay, 2009). The introduction of the concept in South Africa almost two decades ago under two commissions, namely, The National Commission on Special Needs in Education and Training (NSCNET) and the National Committee for Education Support Services (NCESS) saw the amalgamation of these two commissions under the leadership of Prof Sandy Lazarus. The latter came up with the Report, which was entitled Quality Education For All: overcoming barriers to learning and development. This gave rise to the shift in the concept LSEN to learners experiencing barriers to learning because LSEN is a broad concept, which does give a better explanation as to why learners have to be excluded in the normal system.

It is also the responsibility of the teachers to identify learners who experience barriers to learning (DBE, 2014). According to the Department of Education (2005:58), this includes learners who:

- are in need of an enriched programme;
- are in need of a support programme;
- require diagnostic help in specific aspects of a learning programme;
- have a learning barrier;
- are over-aged;
- have problems because of mismatch between home language and the language of teaching, learning and assessment;
- have physical disabilities, e.g., vision, speech;
- have health problems, e.g., illnesses, hunger;
- have problems with emotional stability, for example due to harassment or violence;
- do not attend school regularly; and
- show signs of abuse or neglect.

As part of health promotion in schools programme, the factors above indicates that all children in schools need support from their teachers. According to the SIAS (2014) policy document, it is clear that learners need support from their teachers as well as their families. Hence, support is coordinated to ensure that they receive full support even from all stakeholders in the education system. However, responsibility of supporting learners with barriers to learning is assigned to qualified persons employed by either educational support services or special schools, which could be nurses, psychologist or therapists (ISHP, 2012; DBE, 2014).

According to Unisa (2003: 100), the procedure would require the class teacher to identify learners experiencing barriers to learning. Under this procedure the teacher would

- Discuss the matter with the principal;
- Make a written appointment with the educational support services; and
- The educational support services assessed each learner individually, using such means as formal assessment media (IQ and other tests)

Then depending on the findings of the teacher assessments, one of the following methods is adopted:

- The learner is referred to a special school.
- The learner is given individual assistance by the learning support service.
- The learner is referred to a private person, e.g., a psychologist or therapist, who had to be paid by the parents for help.
- The school is given specific guidelines for assisting the learner, for instance through placement in a special school.

According to this procedure, the role of the teacher was limited to only identify and refer the learners to experts without screening them with regard to the learning barriers. Besides, the challenge was that people who specialise were only a handful and the workload was too much (Kwatubana & Kheswa, 2014; ISHP, 2012) and the names of learners experiencing barriers to learning might remain on the waiting list for a long time before they were granted an appointment to a particular school. The process became complicated as the condition of learners deteriorated. In this case, if the SBST was in place and functional and the role of the teachers was clear, it would have been easier to assist learners in case they would have to wait and where there is limited number of health professionals.

In essence, barriers experienced by learners needed to be attended to first in the classroom and secondly collectively by all within the support structures, including the national, provincial, DSBT and SBST.

Nevertheless, According to Unisa (2003:100), the modern method of support focuses on the teachers' roles in this manner:

- The teacher's responsibility is to identify and assess learners experiencing barriers to learning based on their schoolwork or some problem that they may be experiencing in that area.
- The teacher helps the learners as s/he would normally deal with the problems that occur in class.
- If the problem is not solved, additional attention has to be devoted to it. The teacher now proceeds to tackle the problem in a more penetrating way in order to find out

more about its nature and causes. This enables the teacher to provide the learner with help in a more intense and probably more appropriate way.

- If the problem remains unsolved, the teacher realizes that additional assistance is needed, and he/ she now collects all the data on the matter, makes brief notes about the case, and proceeds to discuss it with the SBST. The team will give the teacher practical hints on how to deal with the problem, which the teacher puts into practice. Joint action continues until the problem is solved or until it is realised that the learner needs more specialised help.
- If the problem persists or remains unsolved after the attempts of the teacher and the SBST, then the team would bring in the DBST (see, DBE, 2014).

According to Mahlo (2012), it is evident that the above-mentioned procedure requires teachers to have specific knowledge and skills to enable them to identify and help learners who experience barriers to learning in their classes, cultivating their positive attitude towards learners experiencing barriers to learning to ensure that they are willing to accept these learners in classes and assist them. The Bronfenbrenner's ecological framework unfolds as the difficulty in supporting the learners' moves from teachers to the SBST and to the DBST.

The challenge when it comes to the roles of teachers in promoting the health of learners is when the policy is not clear as to what teachers are supposed to do exactly. There is more admin without proper support for learners experiencing barriers to learning. This gives a clear understanding why teachers might not be able to comprehend and to conceptualise their roles as promoters of health. The ISHP (2012) is not clear about the roles of teachers as promoters of health.

Barriers to learning in health promotion include disease and disease prevention as well as health education. To prevent some of these diseases, Shung-King (2014) and SIAS (2014) indicate that teachers will be administering deworming to children in schools. Besides, there is a huge confusion between health promotion and Inclusive Education in schools since teachers' understanding is that it has to do with disability.

Meanwhile, barriers to learning in education imply those barriers that are caused by systems and they interfere with learning for children in schools. These barriers can be

in the form of systemic and socio-economic barriers (Education White Paper 6, 2001). These barriers are because of the interwoven barriers around the child. These barriers can be in the following manner:

3.9.1 Systemic barriers and health promotion

Above all barriers that can affect learning in school, the systemic barriers stand in as immediate barriers to learning because they affect teaching and learning directly (Wevers, 2012). These barriers are listed below as follows:

3.9.1.1 Lack of resources

In the first place, for learners to learn properly, they need infrastructure and LTSM (Ntagungira, 2014). Many schools lack basic and suitable material for them to learn in schools. Without much explanation, the lack of basic learning material for learners in schools is a barrier. In the second place, inadequate facilities at school are also a barrier that hampers learning (Landbrook, 2009). Apart from the resources mentioned above, there is also lack of human resources where it has been indicated in a number of research that there is an inadequacy in terms of people who can promote health in schools (Terburgh, 2015; Kwatubana, 2014; Mohamed, 2015; Preiser, 2014).

3.9.1.2 Overcrowded classrooms

According to Engelbrecht, *et al*., (2006), overcrowded classrooms will have an impact in how learners learn in the classroom. Education systems struggle to cope with overcrowded classrooms (Ainscow & Sandill, 2010). Teachers often have challenges when it comes to giving support to learners in the classroom because of high teacher ratio.

The status where classrooms were overcrowded gave stress to the teachers since they were expected to complete a specific quantity of work (Eloff & Kgwete, 2007). In addition, Eloff and Kgwete (2007) argue that communities in rural areas have overcrowded classrooms where classrooms have 50 and more learners. In addition, these kinds of classrooms in these communities often do not have adequate resources to teach, and in some cases, they are understaffed where teachers could even find it hard to provide individual support.

Overcrowded classrooms that are not well ventilated can be a hazard to learners' health in term if infectious diseases run quickly as they sit in proximity to each other. Owing to overcrowded classrooms, many children remain unattended to even when it comes to their referrals for further screening. This barrier is not clearly projected in what the ISHP prefers as the barriers to learning, which has to be mitigated by HPS programme national.

3.9.1.3 Inflexible Curriculum

Curriculum is an instrument for the process of education. The nature of curriculum in many instances is inflexible and it does not allow the local teachers to be creative when it comes to health promotion in the school or in the classroom. Besides, the content in the curriculum might not present the reality of where children come from (UNESCO, 2003).

Curriculum should be flexible in terms of addressing all learners' needs. Wevers (2012) argues that curriculum should not be confined to the national of central prescription only. It should be flexible to be able to accommodate learners learning styles as well as the individual teacher's teaching style (Education White Paper 6, 2001). Therefore, the need is for the policy makers to ensure that the curriculum can be modified to accommodate learners learning styles as well as to encourage the approach (UNESCO, 2003).

UNESCO (2009) further posits that the curriculum should aim to achieve diversity by offering universal learning opportunities for all. It should give adequate freedom for schools to apply curriculum to the school context where learners reside. One other thing is that the curriculum must be relevant to the learners. Bornman and Rose (2010: 24) underscore that the best way of "shaping the curriculum is to look at the curriculum through the eyes of a learner rather than to look at the learner through the eyes of the curriculum" because it could be the best way to minimise barriers to learning.

According to Donald *et al*., (2010:19), "health promotion should not be simply tacked onto the curriculum, but be infused into all that teachers do in the teaching and learning process and, especially, how it is done". The principles of the ISHP clearly indicate the aspects that underpin school health in the education arena. The teacher's work at school is mainly based on the curriculum (Renwick, 2006), which is provided by the Department of Education. The HPS recognises teacher development, the curriculum and teacher professional

development in its approach. However, it remains silent on the role of teachers and how they can practice health promotion in their classroom curriculum and their schools in particular. Teachers are central in schools, both in their professionalism and knowledge, which they display in the formal and informal curriculum (St Leger, 2000).

Nevertheless, there is a lack of knowledge on what and how they should actually teach in their classrooms and the school as a whole, which support health promotion (Terburgh, 2015). The lack of knowledge is assumed to have slowed down their pedagogical practice because they do not possess better understanding on what is supposed to be taught in schools concerning health promotion. Questionably, there is a mixed feeling regarding the roles of the stakeholders in the programme because of the high proportion of the involvement of HoD in terms of intervention programmes, which are geared towards the prevention of diseases, and which possibly do not increase control and to empower teachers in schools (Kwatubana, 2018:4).

Among other important matters, the HPS was constructed with the purpose of focusing on the curriculum in mind, although the focus has shifted more on the infiltration of a health issues and the behaviour afterwards (Peu *et al*., 2010). This has impacted negatively because the focus on the curriculum does not respond positively to the pedagogy in the classroom. There are few factors to consider when it comes to curriculum. These factors are as follows:

3.9.1.3.1 Curriculum content

The confusion with regard to the content of the curriculum cannot be ruled out because very often, teachers think about the subject matter of what they teach in the classroom as a challenge. The content of the curriculum from every subject in the school needs to be effective in a way that it must have curriculum-based programmes, which empower both teachers and learners on skills such as negotiating, decision-making, coping, interpersonal, problem solving as well as creative thinking.

3.9.1.3.2 Teaching and learning factors

For teachers to be able to teach correctly according to curriculum to a point where they cater for the needs of their learners, they need to have good teaching approaches and competencies, which reach all learners irrespective of their challenges (Education

White Paper 6, 2001). One important factor that also contributes in the teaching and learning factors is that there must be enough class time allocation to health issues, which often is not possible (Viig *et al*., 2010). Above all, health matters addressed in the classrooms need to move to the community where learners live to ensure sustainability.

3.9.1.3.3 Professional development for teachers

Teachers normally understand and accept the curriculum factors that respond to the educational goal even when it is health promotion programmes (Jourdan, 2011; Preiser, 2014). In a way, the relevant curriculum programme can succeed when there is an integrated professional development for teachers International Union for Health Promotion & Education (IUHPE) (2000). In particular, three main elements guide the HPS curriculum. These elements are as follows:

- **Notional time** allocated to health related issues in the formal curriculum which is offered through subjects such as Life Orientation, Life Sciences, Physical Education, Social Sciences as well as other related subjects;
- The **hidden curriculum** of the school includes the behaviour, which is lived out within the school community (Rowling & Samdal, 2013). That includes the daily conduct of the school. How teachers conduct themselves before the learners in and out the classroom and how they relate with other staff members as well as the parents. Learners often copy what they see from their teachers.
- The **informal curriculum** is that which is included in the extra-curricular activities such as sports (IUHPE, 2005; Morton & Lloyd, 1994).

3.9.1.4 A quest for relevant pedagogy

The approach to HPS originated from the health sector to improve learners' health through teaching owing to the high prevalence of diseases in schoolchildren (Lazarus, 2006). Pedagogy is totally regarded as the role of the school since schools are regarded as the perfect setting for the health promotion (St Leger, 2000). However, if the teaching of health promotion in schools is not clear in the curriculum, there will still be problems that affect both teachers and learners. Currently, in South Africa, schools' focus on health promotion issues is through the teaching of Life Orientation and Life Skills (van Deventer, 2008; Roux, 2011, Strydom, 2011).

This is only done by Life Orientation teachers where issues affecting learners' health in particular are attended to in a holistic manner. Nevertheless, there are issues that remain unattended especially by teachers in the classroom since they are matters concerning families and the community where learners live (Terburgh, 2015). Teachers in their teaching need to understand that learners have different learning styles; therefore, they should apply different learning strategies in their teaching (Education White Paper 6, 2001). In some classrooms it will require the teachers to have not only to differentiate the strategies it will require the teacher to have suitable resources to cater for the learner in the classroom (DBE, 2014).

Now that the focus of health promotion in schools is in mostly disadvantaged communities where learners do not pay school fees and there is a shortage of resources to provide for learners with learning difficulties. Indeed, teaching and learning could be affected by barriers such as inappropriate pedagogy, insufficient support of teachers, inappropriate and unfair assessment procedures, the language of instruction, inflexible classroom management, and inappropriate attitudes (Terburgh, 2015).

Moreover, the provision of support services and resources, with teachers in particular, may lead to an easier conceptualisation of barriers to learning and how the roles of teachers in the promotion of health in school could be (Wevers, 2012). The assumption could be that if teachers understand their roles and how they need to liaise with other systems such as SBST specifically for the purpose of learners who are experiencing barriers to learning, there could be a success in the health promotion programme (Mohamed, 2015).

3.9.1.5 Lack of adequate training

For health promotion to take place in schools, it can also mean that teachers need to be trained on their role as promoters of health in schools. Teachers' self-efficacy is very important to teach in a HPS context. It also implies that they must be both competent and confident in their teaching capacity (Wevers, 2012). Proper training for teachers is very important for the implementation of health promotion in schools. Du Toit and Forlin (2009) raise the concern by teachers where they were indicating the need for a proper training and

not a workshop where they have to do the work themselves. In most cases, the kind of training offered for teachers results in mismatch where what is offered as part of training does not meet the needs of teachers in schools (Wevers, 2012).

3.9.1.6 Teacher readiness for health promotion

The role of teachers as promoters of health in schools is crucial for the success of health promotion in schools as they can bring about transformation and changes in schools (Lindsay, 2007). Teacher readiness in health promotion is affected by the lack of respect when they are not consulted when there are changes in education. Wearmouth, Edwards and Richmond (2000) argue that lack of communication has always contributed to failure in the implementation of programmes because of insufficient notice. Health promotion in schools has proven to be the most important programme. However, it appears that the empowerment of teachers is neglected in the policy development.

Programmes to support learners are done in schools. However, often teachers are not consulted and taken into consideration. The HPS models presented in this chapter showed insufficient involvement of teachers in schools. The implementation of programmes in schools has been reported to be unsuccessful even in the developed countries such as Britain where teachers are reported to have a proper and adequate training (Wearmouth *et al*., 2000).

It is apparent that almost all research in health promotion in schools in South Africa lacks the involvement of teachers in health promotion. Research has indicated that teachers lack understanding of health promotion in school (St Leger, 1998). According to Wevers (2012), research has revealed that teachers have no clear vision with regard to the support strategies to be used to support learners.

3.9.1.7 Teacher attitude

Teachers are fulfilled by their daily interaction with learners. However, if teachers are not equipped to work with diverse learner population, such interaction can be the cause for great dissatisfaction. Attitude forms a great part in the promotion of health in schools. However, teachers' negative attitude is caused by the fact that they do not

feel educationally equipped and they are not willing to be involved in such a difficult and tedious work (Batsiou, Bebetsos, Panteli & Antoniou, 2008).

3.9.2 Societal barriers and health promotion

One of the responsibilities of the school is to influence the society (Marx *et al*., 1998), since there could be barriers that can affect learners at school (Donald *et al*., 2002). The Bronfenbrenner's ecological model asserts that child development happens within the systems, and this refers to the society where children develop (1992). Various researchers stated the following as barriers, which can have an effect in the learning of children (Donald *et al*., 2002, Landsberg *et al*., 2005; Ntagungira, 2014; Mohamed, 2015). Barriers include the following:

3.9.2.1 Lack of parental involvement

Parental involvement is critical requirement for any school programme to succeed. Parents of children who experience barriers to learning are instrumental to the educational change processes (McNab, 2009). The role of parents in the health and education of their children cannot be stressed enough. However, schools find it difficult to build strong links between schools and families (Mohammed, 2015). Research done by Mohamed (2015) discovered that a number of factors could cause lack of parental involvement. These factors are socio-economic circumstances such as alcohol abuse, poverty, unemployment, dysfunctional families, low level of literacy as well as malnutrition (Pieterse, 2010).

Besides the socio-economic status factors, there other factor which influences parental involvement is the relationship between the home and the school. Education is a societal matter where parents should be involved fully in the education of their children. The call for parents to be involved is crucial for schools to be effective (Mewezino, 2010; Clelland *et al*., 2013).

On the other hand, teachers believe that parents distance themselves from schools and this is clear when they are invited at school they do not come (Wevers, 2012). The educational landscape has changed so much that parents are not coping because the school work is far much irrelevant to their level if illiteracy; hence they leave everything to the teachers in schools (Singh *et al*., 2004).

3.9.2.2 Substance abuse

Substance abuse is becoming a serious problem, which affects learning in school. The age of children who are engaging in drugs has changed drastically. According to the DSD (2006), it has been reported that the age of children who are engaging in drug abuse is scary because children as young as 10 years of age are involved in drugs. It is believed that social problems such as unemployment and poverty could be the cause of alcohol and drug abuse (Wevers, 2012). In families where drug and alcohol are abused, children are highly influenced by this behaviour and they can easily copy from their parents and become addicted as well (Bezuidenhout, 2006).

Although children can copy from their parents, there could be other factors such as peer group, personality, home (divorce, death of one parent, domestic violence) and school environment (bullying) and some events of life (Bezuidenhout, 2006). It has been stated that drug and alcohol abuse has an impact in the on the learner's academic achievement as it can affect them psychologically, physiologically and emotionally (Department of Education, 2002c; Van Hout & Connor, 2008). Nevertheless, because learners spend most of their time at school, teachers can assist in overcoming drug abuse for children who are at-risk to learn effectively (Pillay, 2000).

3.9.2.3 Child abuse

Child abuse manifests in various forms, namely, emotional, sexual, physical abuse as well as negligence by parents. The World Health Organisation (2002) has further clarified the form of abuse and how they affect learners' development. These forma of abuse are:

- Emotional abuse is the failure of the caregiver to act and to provide a supportive environment that has an effect on the development of a child. Restricting children to move, ridicule, rejection, threats, discrimination and other forms of hostile treatment forms part of emotional abuse (WHO, 2002:60).
- Sexual abuse is when the caregiver uses the child for sexual gratification. Sexually abused children manifest their problems during schools years, which can also create problems through their adulthood if not attended to (WHO, 2000:398)

- Physical abuse is when the child is harmed physically through beating with hard objects to an extent where children can be treated medically. These kinds of children can display aggressive behaviours in school/ classroom. Sometimes they can often turn to substance abuse as a way to comfort themselves (WHO, 2002:60)
- Negligence refers to the failure of parents to provide for the development of children even when they can. Negligence can be in a form of nutrition, living conditions, education, health, emotional development and accommodation. Any form of child abuse has an impact in the development of a child as it can cause violent behaviours, issues of trust and low self-esteem (WHO, 2002:61).

3.9.2.4 Violence

Violence is an act where force is used to the one who's vulnerable and cannot protect themselves from the person who is inflicting pain to them (Jukes *et al*., 2008; Mthiyane, 2013). Learners are exposed to violence at multiple levels in the community (Cummings *et al*., 2013). These levels are domestic violence, which occurs at home where children are beaten, parents fight each other and the atmosphere is tense as children continue to suffer as victims of such. It is followed by school violence, which occurs at school. This can occur when their teachers abuse the children physically, emotionally as well as sexually. It can happen to the learners through bullying by peers (Mthiyane, 2013). Child abuse in school often changes the school atmosphere into a negative setting; and finally, there is societal violence where children observe negative behaviour from the community. This can be in a form of crime and gangsterism in the community. This kind of abuse can manifest when children are always absent from school for the fear of physical injury and it can lead to serious learning breakdown (Bloch, 2007).

3.9.2.5 HIV/AIDS prevalence

HIV/AIDS is seriously affecting children in one way or the other. Either children can get it from the infected mother and those who are affected because all parents passed because of HIV/AIDS (Basaza & Kaija, 2002). HIV/AIDS affects children where they have to take care of parents who are bedridden as they take over domestic chores. In addition, HIV/AIDS within the family affect children when they are stigmatised and decide to stay away from school rather than to be humiliated at school. Richter (2004)

asserts that some children endure the pain of rejection by the community and family where they can end up as children who are taking care of themselves.

3.9.2.6 Poverty

Poverty has a direct effect on the education of a child irrespective whether it is absolute poverty or relative poverty. By absolute poverty, it means that parents cannot afford financially to support the child in terms of school and other needs required by the learner (Van der Berg, 2008). Parents might not be able to afford the physiological needs where a learner requires money for books and other educational resources (Fry, 2010). In some cases, this can result in child labour where some children would like to supplement the family's income (Hugo, 2006). In addition, Van der Berg (2008) explains relative poverty as something determined by the society where parents live. With their financial status, they cannot be regarded poor in one community but be regarded as poor in another community. Poverty in all its states can have a negative impact in the health of children. For example, learners who are referred for further assessment in clinics or hospitals might not be able to reach such places because parents might not be able to afford money for the transport (ISHP, 2012).

Poverty can move on to affect issues of nutrition where children might not have enough to eat from their families and which has a direct impact in their learning. According to Fry (2010), hungry learners find it difficult to concentrate in the classroom possibly because of their sugar levels, which might be low.

These and other factors in the community can constitute barriers that can affect learning at school, unless support is given to the teachers. This commends that learning barriers do not occur in isolation, the challenges are interwoven within the systems (Bronfenbrenner, 1979; Ntagungira, 2014).

3.9.3 Medical barriers and health promotion

The focus in promoting the health of children in schools is moving away from the deficit model/medical model since learning is seen as integrated (Landsberg *et al*., 2011). It is not only the barriers within the child but the socio-economic elements can contribute as well. However, the medical barriers cannot be ruled out, since here and there children will have to take their medication to stabilise their condition. These medical

barriers include barriers such as hearing loss, visual impairment, epilepsy, motor disorder, memory problems, attention problems, cognitive disabilities as well as intellectual disabilities.

Moreover, the medical problems will need to be attended to by the medical professionals as it is stipulated in the ISHP (2012). However, this cannot dismiss the fact that teachers are the main team members when it comes to working with children in schools. For teachers to understand these medical barriers, they will need to be empowered as to how to work with these children in the school and classroom environment. This applies to all schools where children are enrolled; they need support from their teachers although much of medical attention will come from the school health nurses (Terburgh, 2015).

3.10 CONCLUSION

This chapter provided the health and the promotion of health by teachers as the research base for this study. The background study on health promotion was derived from the literature and models from various countries were evaluated to see how teachers assume their roles as promoters of health in schools. To understand all these, their professional identity in terms of promoting health in schools was investigated as well as their needs in health promotion.

As part of the study, teacher experiences towards health promotion in the Gauteng Province was conceptualising the context in the schools. The chapter also focused on the policies and practices guiding the promotion of health in the province. Topics related to health promotion as well as the barriers, which affect learning, were discussed as well.

CHAPTER 4
RESEARCH DESIGN AND METHODOLOGY

4.1 INTRODUCTION AND ORIENTATION

The aim of this chapter is to give details about the research methodology used in the study as well as to describe the research approach used, and to give an overview of the research design. This chapter outlined the data collection and methods used in the analysis of data. In addition, the ethical considerations regarding qualitative research was discussed as it is regarded as the most important aspect of qualitative research because it involves exploring, examining and describing the lived experiences of participant in their natural setting.

4.2 RESEARCH AIMS AND OBJECTIVES RE-EXAMINED

Health promotion is relatively a new phenomenon within the South African education context (Shung-King, 2013). Therefore, it requires major adjustment and paradigm shifts. Apart from the development of relevant education policies, there is a need to establish appropriate and effective support systems by all levels in the education system (Terburgh, 2015). The central point of the delivery of health promotion in schools is the classroom as well as the school in general. Whether health promotion is implemented in South African schools or not, research indicates that learners experience many health issues in schools, which affect teaching and learning (Donald *et al*., 2010). Hence, the main objective of this research was to investigate how teachers could promote health in the schools.

To recapitulate, the following questions were used to guide the study. The main question, which guided the study, was:

- **How do teachers conceptualise their roles as promoters of health in the schools?**

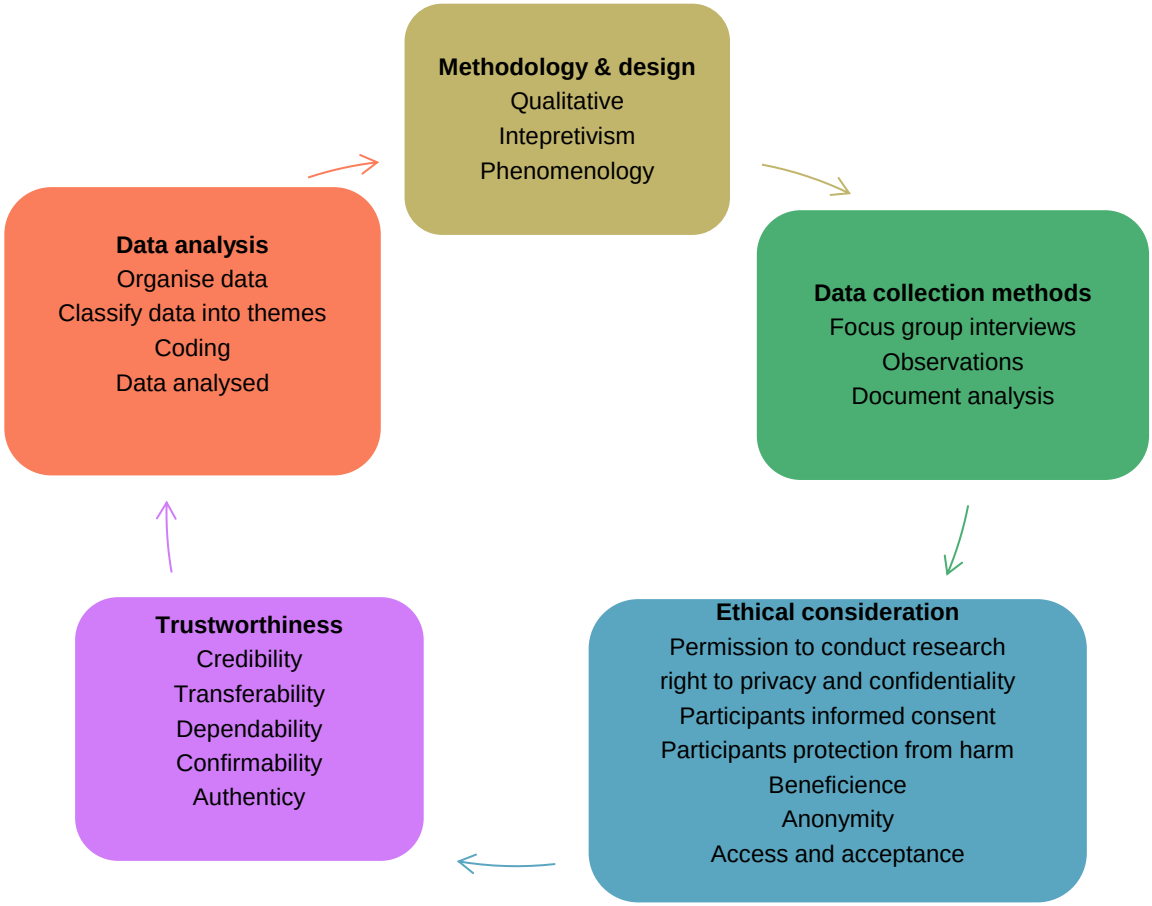
The following sub-questions, which also directed the research endeavour, were:

- How do teachers perceive health and health promotion in schools?
- How do teachers in their pedagogical practice promote health in the school?

- What can be presented as a possible framework for the teacher as a promoter of health in the school?

The following figure explained how the study was executed.

Figure 4.1: Research methodology summary



4.3 RESEARCH PARADIGM

This section begins by discussing the paradigm used in this research. According to Creswell (2007); Durrheim (2009) and Nieuwenhuis (2010a), any scientific study is embedded within a particular research paradigm. According to Durrheim (2009), paradigms are fundamental to research basically because they influence what is to be studied as well as the manner in which the question has to be studied.

4.3.1 Paradigms in research

A paradigm is defined as a model that contains as set of legitimated assumptions and a design for collecting and interpreting data (Bailey,1994; Lichtman, 2010). Equally, Glesne (2006) defines paradigms as maps for scientific communities determining critical issues for its members in order to address and define acceptable explanations and techniques to solve the defined problems. Likewise, Mertens (2009) defines paradigm as an approach used to look at the world and it is composed of certain philosophical assumptions that guide and direct the thinking and action.

Further, Nieuwenhuis (2010a) asserts that a paradigm addresses the fundamental assumptions taken on faith, like beliefs about form and nature of reality, which is the ontology as well as the belief about knowledge, which is the epistemology. In addition, Nieuwenhuis (2010b) describes a paradigm as a way how the researcher go about with the purpose of finding whatever is believed to be known. In essence, paradigms serve as the lens through which reality can be interpreted.

The implication is that in the research world, a research design cannot be isolated from the researcher's paradigmatic perspective (Lichtman, 2010). This means that the way we think the social world is constituted, it is our ontology and it shapes how we can get to know about it. Certainly, the way we look at things (epistemology) and the methods we utilise to search for that particular knowledge is basically the methodological paradigm (Mertens, 2010).

Hatch (2002:11) indicated that there are four research paradigms, which are identified in Table 4.1. In principle, these paradigms are discussed below.

Table 4.1: Different research paradigms

	Ontology nature of	**Epistemology what can be known**	**Methodology how knowledge**	**Product forms of knowledge**
Positivist	Reality is out there to be studied, captured and understood	How the world is really ordered, knower is distinct from the known.	Experiments, quasi- experiments, surveys, correlation studies	Facts, theories, laws, and predictions
Post- positivist	Reality exist but is never apprehended	Approximation of reality, researcher is data collection.	Rigorously defined qualitative methods frequency counts, low level statistics	Generalisations, descriptions, patterns, grounded theory
Constructivist	Multiple realities are constructed	Knowledge as a human construction, researcher and participant construct understandings	Naturalistic qualitative methods	Case studies, narratives, interpretations, reconstructions
Critical / feminist	The apprehended world makes a material difference in terms of race, gender and class	Knowledge as subjective and political. Researcher's values frame of enquiry.	Transformative inquiry	Value mediated critiques that challenge existing power structures and promote resistance.

Source: Hatch, 2002:11

These four paradigms are based on the argument that schools of scientific thought could reach paradigm status when they have literally generated answers to the following questions (Hatch, 2002:498):

- What are the fundamental entities which the universe is composed of?
- How do these interact with each other and the senses?
- What questions can legitimately be asked about such entities and what techniques are employed in seeking solutions?

According to Denzin and Lincoln (1994), a paradigm consists of three features, which give a better understanding of the research to be done. These aspects are:

- Ontology - which raises the basic question about the nature of reality;
- Epistemology - which raises the question of how we know the world; and
- Methodology - which focuses on how we gain this knowledge.

According to Creswell (2003:8), the constructivist paradigm is applicable and significant to the study for the reason that assumptions identified in this research maintain that individuals seek understanding of the world in which they play, live and work as they tend to develop subjective meaning of their experiences and the fact that meaning is directed towards certain things.

In the next section, the focus was on research design and research methodology involved in the study.

4.4 RESEARCH DESIGN

Research design is an extensive research plan that covers a number of aspects of the research approach right from the start to the end of the research findings (De Vos *et al*., 2011). According to Gibson (2010), research design involves working on a particular way of following through research question in relation to a set of data. The type of research design that is pragmatic to a particular research project determines the aims and objectives of the research. However, Van Maanen (1983) warned against the application of wrong tool that it could be better than having no tool at all as valid. Therefore, careful consideration of the choice of a research design was given for this research.

Optimistically, the role of teachers as promoters of health in schools is much dependent on the quality of human actions, attitude of teachers, organisational practices, as well as the approaches. Walker and Evers (1999) affirm that an investigation into a particular phenomenon can best be catered for by a qualitative research approach by saying that the distinctive human dimensions of education must grasp the meanings of actions, individuality of persons and the uniqueness of events. In line with Lemmer's (1992) and Merriam (2009) report, qualitative researchers have the ability to access hidden data.

The nature of this study was on experiences, perceptions and the understanding that teachers have with regard to their roles as promoters of health in schools. This study has adopted the qualitative research design as it endeavours to understand the situation rather than to explain the human action derived from the perspective of the insider to the situation (Babbie & Mouton, 2007). Besides the policies that guide health promotion programme in schools and the provincial officials who are working on the ground together with the district officials, teachers are the most suitable participants in this research study, especially when it comes to their role as promoters of health in schools (St. Leger, 1998; 2000; Jourdan *et al*., 2011; Preiser, 2014).

Again, Babbie and Mouton (2007) indicate that the perspective of individuals in research possibly widens the themes of research. The only way to understand and to describe human experience is when the qualitative methods are used. Nevertheless, it calls for the maintenance of humanity throughout the research process as it is not possible though to escape the subjective experience. Therefore, grounded on this argument, that qualitative researchers are able to access hidden information the qualitative research design was engaged in this study.

4.5 QUALITATIVE RESEARCH

Qualitative research is described as any type of research wherein the research results were not obtained from statistical analysis (Litchman, 2010). Furthermore, Lincoln and Guba (2000) define qualitative research as a systematic investigation into the implication of the study where the researchers study the phenomenon in its natural settings with the purpose to understand how the participants make sense of their experiences.

The main objective of a qualitative approach in this study was to explore areas where no prior information regarding the role of teachers as promoters of health in schools exists as well as the description of behaviours, themes, attitudes, and needs in addition to relations that are pertinent to the areas analysed (Creswell, 2013). The use of qualitative approach in the study helped to discover the nature of participants' behaviour, perspectives and experiences of which there is little knowledge about (Maree, 2011; Terre Blanche *et al*., 2006). To enable the researcher to engage in the emotions of the participants, data were collected using in-depth interviews (Leedy & Ormrod, 2010).

As a result, for the researcher before engaging in any kind of research, it is imperative to know the nature, scope and the characteristic of the research design to be used for the reason that maximum quality, validity and reliability of the research output can be ensured. For the purpose of this research, features of qualitative research are discussed below.

4.5.1 Features of qualitative research

According to Brikci and Green (2007), qualitative research is measured by its aims, which often relate to the consideration of some features of social life along with its methods which produce words, instead of numbers as data for analysis. A number of literatures allocate noticeable features to qualitative research, which basically make a distinction of it from other research approaches (Lincoln & Guba, 1985; Eisner, 1991; Bogdan & Biklen, 1992; Hancock, 1998; Patton, 2002). These features are as follows:

- Qualitative research uses natural context as the source of data. There is no attempt to manipulate the circumstances under study as is the case with experimental quantitative research because the researcher attempts to observe, describe and interpret the context as they are.
- In qualitative research, the researcher acts as a human instrument of data collection. Hoepfl (1997) indicated that in qualitative research, data are collected through direct encounters with individuals either through observation, group interviews or one on one interview. Mostly qualitative researchers use inductive data analysis. Data collected are used to develop theories and concepts, which are used to understand the social world.
- Researchers in qualitative research pay attention to the eccentric as well as the prevalent with the purpose to find the uniqueness of each situation.
- Often qualitative research has an interpretive character, which aims at determining meaning events have for individuals who experience them and the interpretations of meanings by the researcher.
- Lastly, qualitative research reports are descriptive in nature as they combine expressive language and the presence of voice in the text.

In conclusion, to the features of qualitative research, one of the features is its emergent design where researchers focus on the emerging process of the research. Patton (2002) indicates that as understanding deepens regarding research, the emergent design allows for openness to adapting inquiry where the researcher is able to evade getting locked into flexible designs that reduce receptiveness of discovery as they emerge.

4.5.2 Different types of qualitative research strategies

The above section discussed the predominant features of qualitative research. Nevertheless, there are different types of qualitative strategies accessible to the qualitative researcher. These strategies include grounded theory, ethnography and phenomenology where each strategy has its own focus. Hence, the researcher has selected the qualitative research strategy that would best respond precisely to the research question of this study. The difference in research strategies has been illustrated in Table 4.2.

Table 4.2: Different qualitative research strategies

Different qualitative research strategies				
Focus	Case study	Ethnography	Phenomenology	Grounded theory
CENTRAL RESEARCH QUESTION	What are the characteristics of the phenomenon?	What is the culture of a group of people?	What is the meaning of experiences to people?	What theoretical constructs, themes and patterns evidenced in data?
PURPOSE OF THE RESEARCH	Examine a single case in-depth in order to understand the person or phenomenon	Understanding the relationship between behaviour and culture	Description of an experience from the participants' point of View	To derive at a theory that link participants' perspectives to general social sciences theory
NATURE OF RESEARCH PROCESS	Study bounded cases. Focus on natural context	Studies sites. Focus on naturally occurring processes	Studies individuals Focus on lived experiences	Studies a process Focus on interactions
DATA COLLECTION METHODS	Interactive fieldwork Formal and informal Interviews. Some use of quantitative measures	Participant observation Structured interviews Artefact or document observation	In-depth unstructured or semi-structured interviews Purposeful sampling of 5 to 10 individuals	Draws from historical records, interviews, observations, variable, multiple units
DATA ANALYSES METHODS	Interpretational search for themes Structural search for patterns in discourse Reflective-rich portrayal of participants' views	Event orientated Structured indexing and coding Constant comparative method	Meaning orientated Search for themes and patterns across participants Open, tentative, intuitive	Concept orientation Open axial, selective coding Constant comparative method
REPORTING OF FINDINGS	Analytical narrative Reflective narrative	Holistic description of everyday events Assertions	Thematic narratives	Analytical story

Source: Gerber, 2008:4

Based on the discrepancy in the different qualitative strategies outlined above, the best qualitative strategy to respond to this study was the phenomenology. Through the latter, the researcher gains insight on the role of teachers as promoters of health in schools as experienced and perceived by participants. According to Fouché (2002), insight to the phenomenon could only be gained by entering the natural settings of the participants and engage with them regarding the experiences as promoters of health in schools.

4.5.3 Phenomenology

The aim of the phenomenological research strategy was to understand and to interpret meaning given by participants to their daily lives (Creswell, 2014). To be able to do all this, the researcher entered the participants' life world and placed herself in their shoes to determine how they feel. According to Finlay (2008), the researcher aims to open up to see the world differently by putting aside and focus on how they are experienced. Long interviews with up to ten people are used in the phenomenological study as a method of data collection. Through purposeful sampling multiple individuals who have experienced the particular incidence were identified.

It has been noted that all participants are Life Orientation/ Life Skills teachers, who in one way or the other are promoting health in their classrooms, their experiences differ depending on their ages, experience in teaching and different views on how to promote health in schools.

4.6 POPULATION AND SAMPLING

In research, population refers to individuals who hold similar characteristics whereas sampling refers to the elements in the population carefully considered to be part of the study. The population targeted in this research included teachers in Gauteng Health Promoting Schools. According Strydom in De Vos (2002: 192), "a sample is studied with the purpose of understanding the population from which it was drawn". The beginning of the health promotion programme in the Gauteng Province started with 14 schools. Owing to a large number of HPS in the Province, it could have been unrealistic to include all 14 schools and teachers in the investigation of the study.

However, a sample was drawn from the total population where three teachers in six schools were selected. According to Marshall (1996), a suitable sample size is one that sufficiently gives answers to the research question.

For the purpose of this study, the researcher used purposeful sampling. Purposeful sampling is defined as a technique that involves the conscious selection of certain subjects to be included in the study by the researcher to provide the anticipated results (Crookes & Davis, 1998; Creswell, 2003). According to Creswell (2003) sample is beneficial to the researcher because it gives answers to the research questions.

Purposeful sampling was applied in the study to select participants based on their experience which they have acquired since 2006 when the HPS programme was initiated in the Gauteng Province. Furthermore, only Life Orientation teachers were chosen because it was assumed that they would yield the most needed information about the health promotion in schools. According to Morse and Richards (2002), these participants must be prepared to participate in research as well as to share the information.

4.7 THE ROLE OF THE RESEARCHER

According to Barret (2007), the nature of qualitative researchers is to seek to understand the phenomenon that is observable through interactions, actions, events or talks. In this instance, the researcher is subjective and literally accepts that reality is created by the involvement of participants in research where the researcher forms part of the study (Maree, 2011).

According to Clifford, French, and Valentine, (2010), and Bloor and Wood (2006), the researcher acted as a mediator in the focus groups interviews by facilitating the groups as she generated the conversation. As an observer, the researcher shifted her focus as new settings and themes occurred in order to understand the context fully (Leedy & Ormrod, 2010).

After the collection of data, the researcher acted as a medium of discovery and interpreted data and its meaning (Josselson *et al.,* 2003). Basically, the objectives of the researcher as an observer were hidden from the participants since the researcher

was seen as the member of their school after a while unlike the scientific observer (Babchuk, 1958). This was also possible because the researcher played the role, which was well defined and natural to schools (Terburgh, 2015).

Depending on the researcher's logic and the knowledge acquired during the study when it comes to final interpretation of the research report, data analysis, interpretation of results and clarification of concepts were interwoven (Barret, 2007). The final report presented the researchers' logical interpretation of the study and mainly the evidence of the study.

The researcher was trained as a secondary school teacher. Her teaching experience is more than 20 years in various schools situated in Limpopo Province and the North West Province. Her specialisation was in Learner Support. As a concerned educator and parent her main interests are the promotion of health in schools.

4.8 DATA COLLECTION

Data collection is the stage when the researcher would enter the research field with the purpose of collecting particular information, which will give answers to the research question. In this study, data have been collected using the qualitative data technique where there were six focus group interviews from six HPS. Qualitative data have been utilised because the researcher wanted to gain in-depth understanding of the teachers' role as the promoters of health in schools (Creswell, 2014).

4.8.1 Data collection methods

There are various methods to collect data. Qualitative data collection methods naturally include interviews, document analysis and observations. Moreover, it may also include historical analyses, surveys and case studies (Savenye & Robinson, 2004). For this study, the following data collection methods were used, namely, Focus group interviews, observations as well as document analysis.

4.8.1.1 Focus group interviews

Focus group interviews refer to the group of people who sat in informal settings for the purpose of discussing a particular topic given by the researcher as they share their knowledge and experiences in conducive settings (Clifford *et al*., 2010). In addition,

DiCicco-Bloom and Crabtree (2006) suggest that in a focus group, participants share their common understanding about the study. Focus group interviews with six groups of teachers were conducted; one at each school with three participants.

In a qualitative study, interviews occur when the researcher asks one or more participants general, open-ended questions and record their answers (Creswell, 2008; Maree, 2011). In addition, Creswell underscores that open-ended questions allow the participant options to respond to the questions. In this case, to give participants an opportunity to share their first-hand experience in the HPS, the focus group interviews were conducted as well as their relevant views with regard to the topic (Lauer, 2006). Furthermore, the focus group interviews were useful because the researcher had limited time to do research and it helped in revealing the participants, beliefs, experience, and attitudes without the fear (Creswell, 2008:1998).

The researcher was aware that in focus group interviews, some participants may be vocal than others (Nieuwenhuis, 2007) especially when they would like to respond before their turn. Therefore, the researcher explained to the participants how research was going to be conducted and they were given titles such as Participant 1 Participant 2 and Participant 3. It was done in this way to avoid some difficulties, which were going to be incurred by the researcher later on when she would have to discriminate among the voices of individuals in the group (Creswell, 2008).

The most important thing to do though when conducting any interview is to follow the following general steps of which Creswell (2008, 228) noted the following:

- Identify the interviewees
- To determine the type of interview the researcher will use
- During the interview, voice record the questions and responses
- Take brief notes during interviews
- Obtain consent from the interviewee to participate in the study.

The nature of focus group created a process of sharing and comparison among the participants through its three ultimate strength that are shared through all qualitative methods, which are context and depth, exploration and discovery as well the interpretation of the whole study. Focus group interviews are distinguished from any

other form of interviews because they use group discussion to generate data from the participants (De Vos *et al*., 2005), unlike the individual interview (Kitzinger, 1995).

Through the well-defined purpose of the study, which was created by the researcher, the participants were able to provide more information within a short space of time. Morgan (1997) confirmed the strength of focus group to produce more data as it was stated that it has the ability to produce more information regarding the topic of interest.

Focus group interviews were suitable for this study because when participants were in one group they felt comfortable and they were free to speak their ideas, experiences and feelings (Calderon, Baker, & Wolf, 2000) with regard to health promotion in schools. In the second place, the focus group leaves room for discussion where the participants were able to extend the discussion throughout. Finally, the focus group interviews were conducted with the Life Orientation/Life Skills teachers who were leaders of health promotion in schools or SBST coordinators.

The use of focus group interviews was more convenient in the sense that there were several advantages than the disadvantages, which could be observed. According to Alveson (1996), Conger (1998), Hartas (2010), Mitchell and Jolley (2010), these advantages refer to:

- the flexibility to follow unanticipated ideas during research;
- probing for response when the response given by the participant is not clear;
- giving more explanation to the concepts when they are not understood by the participants;
- higher level of responses unlike when using the questionnaires;
- high opportunities to advance empirically supported new ideas and theories;
- more opportunities for in-depth explorations of the phenomenon under research; and
- responses which are more relevant and of interest to the researcher.

Although focus group interviews have high number of advantages, there are also disadvantages of which time is the prime factor of which the researcher has no control. The time taken to arrange for interview schedule, finding suitable time for the participants and the duration it can take to complete each interview. Although it was

indicated that interviews will take 30 minutes to one hour. There were instances where the participants wanted to say more and there were instances where their responses were shorter than expected. The other biggest challenge, which the researcher faced was the time it has taken to generate verbatim transcripts of the interviews.

4.8.1.2 Observations

Observation is regarded as the process of gathering open-ended, first-hand information by observing people and places at a research site (Creswell, 2014). Field notes were taken. The combination of field notes and observations contributes to the trustworthiness of research as they form part of crystallisation (Maree, 2011). Over and above, field notes and observations can comprise validity, which often expresses how the researcher has influenced the focus of data interpretation (Waterman, 1998). As a research technique of collecting data, observations were conducted in the natural settings.

In order to observe schools, teachers and learners well, the researcher spent 30 days observing how teachers interact with learners, parents and other teachers. Five days were spent in each school, with the total numbers of 40 hours in each school. In total it was 240 hours. Observations were done in line with the NDBE policies which states that research should not interfere with teaching and learning. According to Marshall and Rossman (1994), observations rely on seeing and hearing whereas Leedy and Ormrod (2005) stated two types of interviews where in the process of seeing and hearing, the researcher can be a participant observer or a non-participant observer. For the purpose of this study, the researcher was a non-participant observer who just sat and noted the verbal and non-verbal expressions of the participants. When the researcher visited the schools, the schools surroundings were clean. The gardens were attended to except in two schools where the boreholes were not functioning because they were vandalised. Most importantly, teachers were in their classrooms teaching. The kitchen was clean and ready to serve the children during break. Above all, the number of schools showed an overall impression that they still follow health promotion activities.

Data were also collected through observation for the purpose of triangulation with other data collected for the study (Check & Schutt, 2012). According to Gibson and

Brown (2009), it has been suggested that as the data for the observation is being generated, it is the responsibility of the researcher to consider the implication of that data for research. This is done in comparison of the other collected data in the study. Teachers who were selected were observed in their classrooms as to how they promote health in their classrooms and the school as a whole. Creswell (2008) notes that observations can be deceiving since the participants can try to be awkward. The researcher had to establish her role in observations to suit the setting. Just like the interviews, the researcher needed to establish a process to observe (see appendix F). This process as outlined by Creswell (2008:223) includes the following:

- Select a site to be observed;
- At the site select who or what to be observed;
- Determine your role as an observer;
- Conduct multiple observations over time; and
- After observing, slowly withdraw from the site.

The observation process listed above assisted the researcher to note down the relevant information related to the research question as and when participants were observed in their settings. I precisely observed the authentic involvements that occurred within the environment. That was the physical environment that covered the classrooms, kitchen, and ablution blocks; the social environment, which covered the different relationships and the interactions between teachers, parents as well as the learners; and the general functioning of the school.

In addition to that, I was present when they had health promotion activities because teachers indicated that health promotion in school has no place in the curriculum. Therefore, they had to do that after school. It gave me the opportunity to observe how they do it. Neuman (1997) and Check and Schutt (2012) commented that for one to gain experience on what is going on in school, the researcher will have to pay attention to what is happening in a school both socially and in the physical surrounding. This assisted because in the afternoon, when teachers were interacting with learners, teachers or parents, they were flexible and not conscious of the researcher's presence. Gibson and Brown (2009) assert that interactions and actions can also be observed in outside of the classrooms whenever opportunities arose.

After each observation, I withdrew slowly from the activity having made some notes about the activity. This helped me to gain a better understanding of the factors in the settings that have an influence in the promotion of health in schools. The checklist was used to substantiate the observations in schools and forty hours were spent in each school. In addition, as such, I had a better understanding of why things were happening the way they were.

4.8.3.3 Document analysis

According to Henning *et al*., (2011), document analysis entails scrutinising of the relevant documents, which can be important sources of information. Generally, sources are classified into primary and secondary sources, where the primary sources are in a written form of the researchers' personal experience and observations and secondary sources result from the documents other than the original source (Mouton, 2001; Neuman, 2011).

The analysis of documents was an additional method that was used for data collection in this research because documents are useful sources of evidence for qualitative research (Kelly, 2006). Document analysis was useful to validate data collected through interviews and observations (Gibson & Brown, 2009) and to shed the light on the topic of research. In addition, documents shed light on the phenomenon being investigated since they involve the scrutiny of the relevant documents that can possibly be the right source of information (Henning *et al*., 2011) and they may include published and unpublished, admin documents, newspaper articles that may be original documents.

However, the researcher had to be vigilant and selective when using those documents since not everything was suitable for the research study (Henning, van Rensburg & Smith, 2004). The documents, which were analysed, included the diagnostic assessment document, evaluation document and the implementation document (see Appendix G). It was also useful to go through the documents when participants could not possibly recall the details of their experience since the inception of health promotion in their schools.

For the purpose of recording data when analysing the documents, the following strategies were applied:

- Are the health promotion and related documents available in LO/LS teachers files?
- How was the information descended to the teachers?
- Are there strategies in place to involve teachers?
- How was the interaction and developments during the course of the programme?
- How many workshops and meetings were conducted to sensitise teachers about the HPS concept?
- Duration of in-service training for teachers?
- The implementation programme?
- The development of LTSM for teachers and learners?; and
- The evaluation of the program after the three years term?

In the process of seeking relevant documents in schools, the ISHP was not found in all schools and some other sensitive documents were not accessible because they contain confidential information. However, the limitations with regard to the use of documents is incomplete of many reports and historical documents where there are gaps that cannot be filled in any other way to address the research question (Creswell, 2009).

Moreover, the documents were used to verify the data collected through focus group interviews and observations. Each data source contains its own strength and weakness where the strength of one procedure can compensate the weakness of the other (Patton, 2002).

4.8.2 Data analysis

According to Holliday (2002), qualitative data analysis is regarded as the process where meaning is obtained from the data collection phase. It is used to transform data gathered through interviews, observations and document analysis into an answer to the original research question (McMillan & Schumacher, 2001).

Qualitative data analysis requires of the researcher in the first place to organise, arrange and to prepare data systematically in the form of writing and to classify it into themes and categories (Creswell, 2009).

In order to analyse the data thoroughly, the researcher had to engage more reading using the field notes collected during interviews and observations and made use of colour codes by highlighting corresponding responses in particular colours. In order to develop themes and categories, the similarities and differences as well as unique findings were identified (Creswell, 2009). Similarly, there are data analysis steps as outlined by Creswell (2010:60) which are consistent with phenomenological practice. These steps are:

- bracketing the researchers own experiences for the purpose of taking a fresh approach to the data;
- becoming more familiar with the data by reading the transcripts;
- identifying important statements which indicate the experience of participants about the phenomenon;
- developing clusters of themes from the statements;
- writing in verbatim the description of what the participants experienced; and
- writing about the crux, which describes the common experiences of participants.

Most of all, the researcher determines different themes and categories on the role of teachers as promoters of health in schools. The themes were used to formulate guidelines for teachers as promoters of health in schools. Additionally, data were double-checked against the literature to regulate trustworthiness of the study. A group of three teachers in each school were asked open-ended questions and the questions asked in the focus group interviews were the following:

- *How would you describe the role of the school in society?*
- *What would you say is the role of the teacher in the classroom/school?*
- *What are your views on health and the promotion of health in schools?*
- *What are your views on the health promoting school as such?*
- *In your opinion, how do you think teachers can promote health in school?*
- *As a Life Orientation/ Life Skills teacher, how do you promote health in your pedagogical practice?*
- *Are there any barriers, which hinder you from promoting health in the classroom/school? What are they?*

- *In what ways do you counteract/overcome these barriers in the promotion of health in the classroom/school?*
- *Is there anything that you would like to add on in terms of the promotion of health in the classroom/school?*

4.9 RIGOUR IN QUALITATIVE RESEARCH

Rigour in qualitative research is an attempt to make "data and explanatory schemes as public and replicable as possible" (Anfara, Brown & Mangione, 2002). An essential process to ensure rigour in qualitative research is by constantly evaluating the quality of the data throughout the research process (Rule & John, 2011). In addition, it is critical to create rigour for readers to choose for themselves whether findings are credible are not.

4.9.1 Trustworthiness

According to Roux (2013), it is very important in qualitative research to ensure trustworthiness since it is based on determining whether the findings are accurate or not (Creswell, 2009). To judge trustworthiness in qualitative research, the following criteria issues were addressed: credibility, transferability, dependability, and conformability (Shenton, 2004), as well as authenticity. In a way, trustworthiness as a method was used to ensure rigour in qualitative research without compromising its relevance to the research. The findings of the study were actual issues regarding the role of teachers as promoters of health in the schools. In the next section, the issues of trustworthiness are discussed in detail.

4.9.1.1 Credibility

Credibility in qualitative research is regarded as the ability of the researcher to demonstrate the sustained period of time while engaging with the participants to provide evidence by utilising different sources and methods (Guba & Lincoln, 1994). To ensure credibility, prior to data saturation, the researcher conducted focus group interviews with the teachers in the selected schools who have been serving the school since the inception of health promotion programme in schools. Again, to ensure credibility, the researcher spent more time in school with the participants to allow them to get used to the researcher as well as to gain trust and confidence.

According to Mertens (1998), credibility seeks to ensure correspondence between the ways the researchers depict their standpoints and the way the participants essentially perceived social paradigms. Before data collection process began, the researcher familiarised herself with the participating schools. In total, the researcher spent three days per week in each school with the participants to allow them space to build trust and confidence.

Interviews were transcribed using verbatim data transcriptions for the purpose of drawing reliable conclusion. Raw data are included (in Appendix H) in order to provide a trail of evidence (Cohen & Morrison, 2006).

Member checking is one of the most important strategies to ensure credibility. This implies that participants were given a chance to correct the interpretation of the study (Lincoln & Guba, 1985; Creswell & Miller, 2000). Before the final compilation of the study, the teachers who participated in the study were allowed to do member checks on the results. Again, the researcher gave the details of how member checks altered the data (McMillan & Schumacher, 2010).

4.9.1.2 Transferability

Literally, transferability means the extent in which the findings can be applied in any other setting (Guba & Lincoln, 1994; 1985). This was in line with the provision of thick description regarding the process of data collection with the intention to allow someone to do transfer in different context as well as different groups (Robson, 2011). Research was done in six HPS in the Gauteng Province.

4.9.1.3 Dependability

The extent of which the same findings could be repeated if the same instruments were simulated with similar respondents under similar conditions is called dependability (Creswell, 2003). Given the benefit of doubt, HPS in Gauteng share the same sentiments. The overlapping methods can be used as a more direct method. In this instance, the researcher used the interviews, observations, as well as the document analysis to understand the role of teachers as promoters of health in schools.

On the qualitative component of this study, dependability was used instead of reliability (Lincoln & Guba, 1985; Creswell, 2014) because dependability in this study ensured that the processes were reported thoroughly. Research design, data collection and data analysis processes were described thoroughly. According Mouton (2011), dependability makes it easier for the future researcher to replicate the same work even though the purpose is not to get the same results.

4.9.1.4 Confirmability

According to Guba and Lincoln (1994), the extent to which the findings are free from bias is called confirmability. The data collection process allowed the researcher to record personal attitudes and emotions that could affect the researcher as well as the participants by keeping the field journal.

4.9.1.5 Authenticity

In qualitative research, the true description of people, events and places as well as their interconnection is called authenticity. To enhance authenticity, the researcher asked the participants to validate the identified themes and to ensure that their perceptions would be correctly understood, well captured and reported (Denzin & Lincoln, 2005). This was represented through the ability of the researcher, who reported a situation through the eyes of participants.

4.10 TRIANGULATION

Triangulation may involve the use of different methods such as individual interview, focus groups and observations which forms a major data collection strategy, especially in the qualitative research (Shenton, 2004). In addition, the focus group and individual interviews, although they are interviews of some kind, still tend to suffer from methodological limitations. This study made use of focus group interviews, documents analysis as well as observations to obtain a variety of information from the participants (Okeke & Van Wyk, 2015).

4.11 ETHICAL CONSIDERATIONS

The study ensured that ethics in the data collection process was adhered to. Cohen *et al.,* (2007) refer to ethics as human conduct in line with the goodness of certain actions, bad or good motives and the ending of such motives. Babbie and Mouton

(2007) indicate that ethics arises basically because of the interaction between the researcher who is trying to search for the truth as well as the participant from whom the truth is attained. According to Mouton (2001), “the ethics of science concerns what is wrong and what is right in the conduct of research”. Individuals who can make mistakes (Leedy & Ormrod, 2001) do bearing in my mind that research, there must be ethical guidelines which De Vos, Delport, Fouchè, and Strydom (2011) indicated that they serve as standard and a basis, which the researcher had to evaluate his own conduct.

In addition, McMillan and Schumacher (2001:420) indicated how qualitative researchers should be sensitive when it comes to ethical principles basically because of their research topic, face-to-face data collection with participants. Mouton (2001) recorded that ethical issues occur from the interaction with human beings. Therefore, the researcher had to adhere to the following principles of research:

4.11.1 Permission to conduct research

The issue of gatekeepers when it comes to research is very important. There is a need to respect the research setting in terms of requesting for the permission to the relevant official personnel to conduct research (Creswell, 2008). In this study, permission to conduct research was requested from the Ethics Committee of the Faculty of Education Sciences, North-West University. It was also requested from the GDE to conduct research from the identified HPS. The North-West University’s Research Ethics Clearance process aims to protect the human subjects who participate in the research study against any harm.

The Ethics Clearance also ensures that research is of high quality by ensuring that the registered research students get ethics before they collect data in schools. For the researcher to obtain ethics clearance, the ethics application form was completed. There were a number of sections on issues of ethics to complete; the same applies to the Gauteng DBE Ethics form. To serve as a guide in the ethics application form, the abstract of the research proposal, which gave an outline on the main issues of the study, was attached. The outline incorporated background and purpose of the study; the research problem; methodology including data collection process and analysis.

Again, the ethics issues were clearly outlined in the informed consent, confidentiality, harm, voluntary participation, anonymity as well as the issues of access and permission. Letters were written to the directors of the districts where research in schools were due to be conducted. Similarly, permission letters for the principals as well teachers were included in the ethics application. After that the ethics clearance certificate was received, giving the researcher permission to collect data in the schools (see Appendix D). After receiving permission, the researcher visited schools to hand over letters of consent to the principals and the Life Orientation teachers.

4.11.2 Right to privacy and confidentiality

In research, participants have the right to privacy and confidentiality. Owing to the participants' exposure to known and unknown exposure, participants needed to be assured of confidentiality. According to Denzin and Lincoln (2005), personal data need to be secured and released as anonymous. This implies their background information such as personal information, names of institutions as well as any information, which can expose the participants, was displayed as anonymous.

Confidentiality serves as a means to keep faith with the participants (Babbie & Mouton, 2011). It meant that the information collected from the participants would not be shared with other people excerpt for the authorities who gave permission to the study. This was clearly explained on the letter to the participants that confidentiality would be upheld.

4.11.3 Participants' informed consent

According to Cohen *et al*. (2007), informed consent refers to the procedures wherein an individual decides whether to participate in research study or not. In conducting research, informed consent is the critical ethical issue, which means that participants knowingly give consent with a clear mind. According to Leedy and Ormrod (2004), participants need to be informed about the nature of the study and a choice to participate or to withdraw. The study carefully considered the informed consent based on comprehension, voluntary participation, competence and full information.

This implies the research aims as well as the methodology. In the process of research, participants were reminded of their right to withdraw at any stage. Denzin and Lincoln

(2005) indicate that participants need to participate voluntarily without being coerced and this must be based on transparency in the information provided by the researcher. In addition to voluntary participation, Babbie and Mouton (2011) indicate that it requires someone's time and energy. Cohen *et al*., (2007) pointed out that-risks are encountered voluntarily and knowingly.

On that note, the researcher explained what voluntary participation means to the participants. Participants were also asked to give their consent to be interviewed, observed and consulted with regard to the accuracy of the interviews. Most importantly, they were assured that the voice recordings were to be accessed by the researcher and the supervisor and were going to be kept away for a period of seven years, and then after that it was going to be destroyed.

4.11.4 Participants' protection from harm

The study maintained the aspect of possible harm to the participants because safety of participants was crucial in research. Leedy and Ormrod (2005) suggest that physical and emotional risks involved in the study should not be greater than risks, which participants experience in their daily lives. In addition, McMillan and Schumacher (2010) assert that the researcher should be responsible in protecting the rights and welfare of the participants. Hence, the researcher needed to ensure the safety of participants.

The researcher ensured that the interview questions posed to the participants were neither sensitive, embarrassing nor demeaning (Babbie & Mouton, 2011). Over and above, the study followed the principle not to harm that considers the human dignity, worthiness and uniqueness of each participant in research (Creswell, 2009). Therefore, the study ensured that the results were honestly reported from the data collected in the field.

4.11.5 Beneficence

Beneficence refers to the benefits of which the study can bring as well as to the beneficiaries (Cohen *et al*., 2007). The researcher clearly indicated to the participants that the study was for educational purposes. Hence, the study deliberated on the issue

of beneficence. Again, they study pointed out professional benefit on health promotion for teachers and teachers as promoters of health.

4.11.6 Anonymity

The study guaranteed the anonymity of participants whereby their identities were not revealed such that their names and addresses were identified as pseudonyms (Cohen *et al*., 2007).

4.11.7 Access and acceptance to the schools

Access and acceptance to the schools where research is to be conducted is fundamental for the accomplishment of the study. As stated by Cohen *et al*., (2007), it is important for the researcher to achieve benevolence and mutual aid of the institution where research is to be conducted. Considering that there are officials in the national, provincial, districts, as well as schools, it was seen as important to follow protocol since obtaining access to schools is not a right for the researcher.

Permission had to be sought in the study from the District directors at each of the sampled districts (See Appendix C). Each letter was furnished with the research proposal, letters seeking permission to schools as well as the general information about interviews. The letters also explained the purpose of the study as well as the benefits to the schools. Voluntary to participation was also indicated in the letters. Permission letters clearly stated how research was supposed to be conducted at schools, such as no interruption of school programmes.

The permission letters from the Province and the District were used to negotiate with principals of the schools to conduct research in their schools. Owing to the difficulty in accessing principals through the landline telephones, which were sometimes incorrect, or not functioning at all, the letters had to be delivered by the researcher to schools. The principals facilitated access to their teachers and agreed with the researcher on the date and time to collect data in their schools.

The aims of the study, objectives, and data collection procedures along with the researchers' expectations were thoroughly explained by the researcher. To ensure

consent from the participants, the researcher made sure that they have all completed and signed the consent form.

4.12 CONCLUSION

The chapter on research and methodology focused on the elements that give an understanding as to how data were utilised in this research study. All elements that give value to the methodology in research were described in full as to how they are going to be applied in line with the research paradigm, which is phenomenology.

The next chapter is going to present the empirical research. The findings of the study were discussed in detail, with the basis on the data analysis. Data were also compared with the literature review and the theoretical framework to determine the relevancy in research.

CHAPTER 5

PRESENTATION AND DISCUSSION OF THE FINDINGS: THE ROLE OF THE TEACHER AS A PROMOTER OF HEALTH IN THE GAUTENG PROVINCE OF SOUTH AFRICA

5.1 INTRODUCTION

The main purpose of this study was to investigate how teachers conceptualise their roles as promoters of health in the schools. This chapter presents and discusses the findings from the empirical investigation. The empirical research was built on the HPS project that was funded by JICA to improve hygiene and sanitation in the Gauteng Province schools. The selected schools were no fee schools found in the previously disadvantaged communities. These schools are referred to as quintile 1 and 3 (schools where learners do not pay school fee and which qualify to be funded by the DBE for all their educational services (SASA, 1996).

More details about the background of HPS in the Gauteng Province have been detailed in section (2.4.2). Health promotion in the Gauteng schools was introduced in 2006. JICA, in partnership with the DBE, DoH and the DSD collaborated to promote health in schools. The role of each department in the national, provincial and district level was discussed in detail in Table 2.5 and the section that followed it.

Nineteen teachers from six schools and one principal participated in the study in answering semi-structured focus group interview questions, which lasted for an hour each. Only two participants among the 19 participants were males while the rest were females. The study developed categories from which themes were ultimately established. Eight themes from nine questions were compacted from the collected data, which will be presented with verbatim quotes from the participants.

5.2 PROFILES OF SCHOOLS AND PARTICIPANTS

This section presented the profiles of the participating schools as well as the participants. The profile of schools and participants were not given in detail because they did not have impact on the findings.

5.2.1 Profile of participating schools

Six primary schools were sampled based on the criteria discussed in Chapter 4. The sampled schools were primary schools and their profiles are indicated in Table 5.1.

Table 5.1: Profiles of participating schools

School	Quintile	Type	No fee	Enrolment	Teachers	Teachers learner ratio	LOLT	Financial status	Curriculum
School 1	1	Urban	Yes	1889	44	1:55	V/E	21	R-7
School 2	1	Urban	Yes	1196	37	1:35	T/E	21	R-7
School 3	3	Urban	Yes	409	8	1:30	T/E	21	R-7
School 4	1	Urban	Yes	958	24	1: 44	P/E	21	R-7
School 5	1	Urban	Yes	1469	36	1: 33	S/E	21	R-7
School 6	1	Urban	Yes	667	17	1: 28	S/E	21	R-7

The six schools where interviews were conducted were quintile 1 and 3 schools. The latter were in an urban area mostly in the Gauteng North, Tshwane East, Tshwane South, as well as Tshwane West. The enrolment varied depending on the community where the school is situated. This has an effect on the teacher learner ration because some schools have overcrowded classrooms. The Language of Learning and Teaching (LoLT) also varies depending on the cultural group surrounding the school, such as Sepedi and English, Shangaan and English as well Venda and English. These primary schools cater for Grade R-7 Curriculum.

5.2.2 Teachers profile

To gain more information with regard to the participants' profile their information was divided into sections.

5.2.2.1 Participants' age

Table 5.2 indicates the age distribution of teachers. It has been designed not to specifically present the participants' ages. However, the majority of teachers are between the ages of 43 and 51 as well as between 36 to 42.

Table 5.2: Participants' age

Participants' age			
Age range	36-42	43-45	46-51
N	4	6	10

5.2.2.2 Participants' gender, subject, phase and grade

Table 5.3 indicated the gender of all the teachers who were interviewed in the HPS. Almost all participants were females who were teaching Life Skills and Life Orientation in the Foundation Phase and Senior Phase respectively. The highest number is that of female teachers who are teaching Life Skills in the Foundation Phase. Only three teachers were teaching Life Orientation in Grade 7.

Table 5.3: Participants' gender, subject, phase, and grade

Participants' gender, subject, phase and grade							
Gender		**Subject**		**Phase**		**Grade**	
Male	Female	Life Skills	Life Orientation	Foundation	Senior	3	7
3	17*	13	7	13	7	13	7

*In school number two, there were extra two participants instead of three participants

5.2.2.3 Participants' educational qualifications

Table 5.4 presented the qualification of participants. In most cases, the participants have gone beyond the entry Diploma in the primary school to postgraduate qualification in education. However, their qualifications do not resemble in anyway how they understand their role as promoters of health in schools.

Table 5.4: Participants' educational qualification

Participants educational qualifications			
3 year Teachers Diploma	**4 year Teachers Diploma**	**First Degree**	**Post graduate qualification**
13	7	5	5

5.2.2.4 Position of participants in school

Table 5.5 presents the positions held by participants in schools. These positions range from post level 1 to the principal post. The investigations in this study revealed that although participants held various positions at schools, this does not distinguish the experience they have towards their roles as promoters of health in schools.

Table 5.5: Position of participants in school

Position of participants in school				
Post level 1	**Principal**	**Deputy principal**	**Head of Department**	**School Based Support Team**
12	1	2	2	3

5.3 DATA ANALYSIS

The responses, which are going to be presented in this section, were derived from the focus group interviews and analysis of documents. Further information was obtained through observation. Unfortunately, there were no documents found in the sixth school since the office and few other classrooms were burned down during service delivery strikes in the community. Participants who participated in the research included the Life Orientation/Life Skills teachers, HPS coordinators, as well as one principal who were part of the project when it began. In school number (two), there were more than three participants because the principal and the health coordinator volunteered to be part of the interviews.

Initially, I thought the presence of the principal would jeopardise the focus group interview processes. However, as the focus group interviews went on, I realised that they work collectively as a team, with the principal in the lead. That was clear because during the duration observation in that school, one could see that all members of the school were committed in promoting health in school, and not only Life Skills or Life Orientation teachers. They were all committed to the course of promoting health in school. One other thing was that the school mentioned above was also set as a benchmark for other HPS, which were part of the project with JICA and the three departments because it possesses the qualities of HPS.

The following section will present the data obtained during the qualitative stage of data collection process. To validate the process, the themes and sub-themes that emerged from the data collection were provided as well as the extracts that were taken from the interview transcriptions.

However, it should be noted that the responses in data analysis was highly interrelated in responses. The participants' comments would be familiar to more than one theme. Therefore, direct quotations from the interviews, observation and the documents analysed was presented in *italics*. The emergent themes and sub-themes are presented in Table 5.6.

Table 5.6: Themes and sub-themes emerging from the empirical study

Emerging themes	Sub-themes
1. Build partnership with parents and the community to promote health.	Involve the community to promote health. Educate the society on how to promote health. Give support to the society. Engage parents in school activities that promote health. Communicate with parents about health issues.
2. Promote learner health and well-being.	Teach about health issues. A custodian of multiple roles. Teach about moral behaviour that promotes health. Role model behaviour that promotes health.
3. Responsibility of school health services.	Health sector concept. Education has no role to play in health promotion. Teachers are not equipped to promote health in schools. Health promotion is subject based. Health promotion is an extra burden in the curriculum. There is a need for collaboration in the departments to promote health.
4. To build capacity for teachers and learners in the	To provide healthy environment for learning. To promote health from within the school. To provide resources. To promote hygiene.

promotion of health in schools.	There is a need for support from the departments and other stakeholders.
5. Addressing factors which affect teaching and learning.	To teach learners about body development. Teach knowledge about HIV. Teach learners about hygiene. Teach learners to stay away from substance abuse. Teach about nutrition and healthy food.
6. Support and sustainability of the promotion of health in schools.	Violence in the community and at home. Teachers are not ready to promote health. Teachers are frustrated. Lack of community involvement. Unclear involvement by the DBE. Lack of parental involvement. Lack of resources to promote health. Health promotion is not aligned to the school curriculum.
7. Leadership and management of health promotion in schools.	The provision of resources that promotes health. Parental/community involvement. Need for health promotion training from the DBE. To align health promotion with the curriculum.
8. The need to promote health and well-being for teachers.	The DBE needs to be more involved in health promotion in schools. Proposal for the entire schools in the Gauteng Province to be health promoting. Request for the provision of health services for teachers by the DBE. A need for teachers to be trained in health promotion. Approach health promotion from schools (a bottom-up approach).

5.3.1 Analysis and discussion of findings

The analysis of data are presented and discussed according to the identified themes of how teachers conceptualise their roles as promoters of health in the schools.

5.3.1.1 Build partnership with parents and the community to promote health

Participants were asked how they would describe the role of the school in a society? This question focuses on how best the school can engage the school community, which is the society in terms of their involvement in promoting the health of their children. In particular, the following sub-themes emerged:

- **Involve the community to promote health**

The first thing identified by the participants was that the school does not exist in isolation, the society is involved, and the participants stated the following:

> *"Mam I believe the role of the school in a society in the first place would be to involve the community. We cannot work together with parents if we do not understand each other. They need to know what is happening in the school"* **(Line 6-7).**
>
> "*I can say in our school we invite parents in the beginning of the year and explain our expectation from them"* **(L519-520).**
>
> *"…. the best practice is the question of the school taking education as a societal priority…"* **(Line 245)**
>
> *"The role of the school I can say is to involve the community where it exists. Mam there are so many challenges in this community, which cannot be resolved by the school alone. But I believe if we involve the community it will work so perfectly for us and the learners"* **(*Line* 828-830).**
>
> *"Our role is to involve parents in everything we do*" **(Line 1063).** *"The school can in a way involve parents in matters of their children health. We cannot do it alone*" **(Line 1277-1278).** "*You have to start at health and health starts where at home*" **(Line 1064).**

- **Educate the society on how to promote health**

The participants indicated that educating the society is crucial. They commented as follows:

"The best role we can play as a school is when we educate the society through learners. We teach the children who then was share with the parents at home" **(Line 523-524).**

"… Our society is dying because of the lack of knowledge. If you ask me, where do they get knowledge? Honestly speaking knowledge is acquired at school. So as a school our role would be to educate the society through our children" **(Line 1279-1280).**

Participants confirmed that education is the key to unlock the society. They commented as follows:

"…Education is the key to unlock any society from the lack of knowledge they have" **(Line 834).** *"As a school I believe through education we can liberate the society"* **(Line 246).** "*Through the education from the school, the community is changing its lifestyle bit by bit. It's a process though"* **(Line 1283-1284).**

- **Give support to the society**

Participants saw giving support to the society as crucial. The following comments confirm this assertion:

"I want to believe that there is much we can do for our society. We can give them support" **(Line 10-11).**

"Our role as the school I believe it is to give support to parents and learners collectively. You will remember that we have parents who are partially illiterate; those who cannot support their children with homework. We need to support them in order to support their children" **(Line 526-529).**

"*For parents to be able to support us as school, I think our role would be to give them support in terms of giving children who do not have food to eat before they begin with the school day so that they can learn well like others"* **(Line1066-1068).**

The issue of support was emphasised as follows:

"Our role is to support, and support and again support our society. Teachers of today have relaxed so much that we even forget our main responsibilities that it is to support. We have that platform to teach and enforce health issues in school which therefore, children can share with their parents in the society" **(Line 1286-1289).**

"… Our role as teaching practitioners is to support the society in its endeavour to acquire healthy lifestyle. You will understand that the school has a great influence in the society. Schools can uplift or destroy the society if there is no support" **(Line 835-837).**

- **Engage parents in school activities which promote health**

Participants understood that the school could play a huge role in the society in a number of ways. These include the following:

"As a school, we can have meetings where we invite parents to come and attend so that they understand that they are our partners in education especially in terms of health issues" **(Line 839-841).**

"I have seen meetings changing the perception we have about our parents". The more we explain about the importance of not giving sweets to the children when they come to school, the more we have less problems of children who are hyperactive and that is because when we invited them they come" **(Line 843- 846).**

It was further confirmed the following:

"*The school can also promote health by inviting parents to seminars or workshops about health issues which affect children's learning. If we are serious about this, I think we could have achieved so much. We could have had a generation of promoters of health in the community"* **(Line 530-533).**

"I can say the best way to capture the society is through seminars where they are empowered with knowledge. Do you still remember the time we had a workshop about eating healthy food? Many parents indicated that they would just give anything to the children irrespective of the benefit in their children's health" **(Line 1075-1078).**

- **Communicate with parents about health issues**

Participants stated the importance of communication as follows:

"In essence our role is to communicate our vision as the school to the parents who was then share with the society at large" **(Line 540-541).**

"I think communication is the key to any partnership. By virtue of the fact that we are teaching the children from this community, that means we cannot exclude this community when it comes to communicating the danger of using

drugs, how to manage sugar diabetes, how to treat HIV/AIDS patients. Information such as this, need to be communicated by the school. Either through the school health nurse or psychologist assigned by the department" **(Line 1292- 1296).**

"*Yes, I agree communication is the key which also determine the response of the society on health issues. Look, we are a primary school. Before we came here, the situation was hopeless. Young girls were pregnant at an early age, and many parents were HIV positive. But since we started communicating with the society through workshops, things are better now*" **(1298-1302).**

Participants in their response believed there is great need for the school to play its role within the society. This was attested by (Marx *et al*., 1998; Renwick, 2006) that schools need to engage the society, since there are health challenges affecting learners which cannot be solved by schools alone (Kickbush, 2003; Mohamed, 2015). The health promotion in schools framework highly considers community participation within the health promoting school (WHO, 1996; Kwatubana, 2014) because this is where the school and many health challenges come from. In this instance, the term society, community and parents were used interchangeably since they mean more or less the same thing in the school context. Majority of people in the community are parents with learners in the school and the fact that the SGB allows parents whose children are at school to participate in the school's activities. From observations it was clear that schools want to build partnership with parents because some of these parents were helping in gardening, cooking and the cleaning of classrooms and toilets.

Literature review indicates that schools were best settings (Jourdan *et al*., 2010; St Leger, 1998) to promote health and to prevent health challenges. The understanding was that the community needs to join hands with the teachers to help learners to learn better in schools.

As part of involving the community, participants indicated the need to understand each other, parents and teachers in particular, in terms of their *modus operandi* (Mohamed, 2015, Jourdan *et al*., 2016). The relationship between the systems is very important to promote health in schools (Stacks, 2005). The relationship between the micro system and the meso system is crucial for the development of learners in schools,

especially when it comes to health issues experienced by learners. Teachers are aware that they need to *have meetings* wherein they can share their expectation from parents. From observation some parents did not respond to the teachers call for a meeting. Many schools have a challenge that parents are not actively involved (Clelland *et al*., 2013). Themes from observations and documents analysis indicated that parent/ community involvement in the promotion of health for learners is a critical challenge. From the theoretical point of view, the home plays a critical role in the health and learning of their children.

Bronfenbrenner's ecological framework (1979) regard the family, the society as the closest institution in the development of the child, and anything that contradicts the development of the child within this setting affects the school as well. Teachers argue that what they are teaching in the classroom is not applied at home because they realise that learners knowledge has increased whereas the behaviour of learners remain a challenge (Atkinson & Nitzke, 2001; Warren, Henry, Lightowler, Bradshaw & Perwaiz, 2003). It seems as if the relationship between home and schools is not strong to promote the health of learners. Teachers understanding of changing the community, however should focus on reimagining their roles to infiltrate the community to an extent that what they are teaching in schools is also applied at home and within the community.

Teachers believe that parents and the community at large need to know what is happening at school because *education is a societal matter and it should be prioritised as such.* Although teachers' understanding is that the community need to be involved, they fail to understand how the community can be involved in the matters concerning learning (Mohamed, 2015; Viig *et al*., 2010). Schools do not exist in isolation; they exist within the society that can help to *resolve many challenges* in the community (Barton & Drake, 2002).

The teachers understanding of how parents should be involved sounds to be one-way (Mashau, 2011). Schools believe it has to benefit the school when parents are supporting teachers in school. This is where research indicates the failure and a gap in involving parents to participate in the promotion of health in schools. Mohamed (2015) indicated that such an involvement is just a token kind of. The mistake that the

schools often commit is to involve parents in a way they find it proper for themselves (Mashau, 2011). Often schools use the same strategies for all parents regardless of their needs, economic status and individual experiences (Hornby & Witte, 2010), and that continues to give schools challenges when it comes to parental involvement in a HPS. Maybe teachers need to understand that parents are the primary teachers of their children and therefore health starts at home (Clelland *et al*., 2013). Research done by Mohamed (2015) indicated that there were factors that hinder parents from being involved, and these factors were mentioned as time, socio-economic status, literacy level as well as the work place. If these factors are not taken into consideration, there is a possibility that it can affect how parents can relate to school activities.

Communities where HPS took place in the Gauteng province were said to be disadvantaged communities where there is high unemployment rate, poverty, illiteracy, negligence as well as the prevalence of communicable disease such as HIV/AIDS (Sizanang Centre for Research and Development, 2006). The danger within the society is that it is *dying because of the lack of knowledge.* Therefore, the role of the school is significant to *educate the community* to understand the issues of health, which affect the society as well as the learners at school (Marx *et al*., 1998).

Teachers' role is to teach learners at school and they do not have much access to educate the community. Hence, the HPS approach focuses on the promotion of health, which takes place in schools, but has an influence in the community. It has to be understood that to change the *lifestyle* of the community is *a* process (Roux, 2013). Due to poverty and high rate of unemployment, what teachers were teaching in the classroom about health was hindered because for instance when they teach about drug abuse and the dangers of it, learners on the other hand they were exposed from their communities and homes to the abuse of drugs. Research done by Bezuidenhout (2006) found out that learners who were exposed to substance abuse could easily copy such behaviour without considering the effect of it in their lives.

It takes a great teacher to understand that it is possible for teachers to promote health in school. Teachers who have a better understanding of the health promotion and HPS concept (see Chapter 2), understood that it is a process which the community need

support from the school (Strydom, 2011). Parents in the community needed support from school as to what needs to be done. It has been mentioned that schools cannot do it alone and the same applies to the parents they *need support* from school (Meier & Lemmer, 2015). Teachers in their profession are *custodians of education* and it is through their capacity that they are obliged to give support to the community based on the needs (McNab *et al*., 2010; Strydom, 2011).

Parents needed support when it comes to *helping learners with homework* and with issues around nutrition so that learners can learn better. For the sake of the society to acquire healthy lifestyle, teachers needed to understand that they have a great influence in the society *(*Marx *et al*., 1998*)*. Giving support to parents on matters of health such as First Aid training, hygiene, nutrition as well as parenting skills is very important (Storbeck, 2009).

During the focus group interviews, teachers were able to understand that there is a need for the school to support parents; the schools need to *engage parents in various school activities in schools.* Research done by Viig *et al., (2010)* indicated that schools want to engage parents in the best possible way which benefit them, and that according to Mohamed (2015) is a token way of involvement which does not yield much. In this manner, schools can organise *workshops and seminars* to make parents aware of the various health issues learners' face in their day-to-day basis. Teachers indicated that learners used to eat unhealthy food and sweets because parents would just give anything to the children irrespective of the benefit in their children's health.

Nevertheless, since they have started inviting parents for meetings and workshops they have built a very good relationship, parents felt that they were part of the *school.* This says that parents are not hesitant to participate. However, the manner in which the school wants parents to be involved creates impressions that parents are not willing. Therefore, schools needs more training on how better they can involve parents not just as a token but also in a relationship where parents' contribution matters.

Teachers in their meetings with parents communicated that children are not supposed to eat unhealthy food and since that, parents knew that they now have more information about nutrition. Unless matters were communicated thoroughly between

the communities and schools, the dilemma of their relationship would always remain as it is to parents and schools. Marshark and Hauser (2013) highlight the importance of informing parents about school activities. Therefore, in conclusion to this question, the schools through their capacity they need to engage parents in ways, which benefit both schools and the society (Meier & Lemmer, 2015).

Programmes that were introduced in schools as well as the issues that were addressed in the curriculum if they were better communicated with parents and the community there is a possibility that it can curb some of these critical health issues. It was reported in school 6 that through the curriculum where learners were able to share their knowledge about communicable disease, the prevalence of HIV/AIDS in the community decreased.

5.3.1.2 Promote learner health and well being

Participants were asked what they would say **as the role of the teacher in the classroom/school?** A number of responses from the participants led to the following sub-themes.

- **Teach about health issues**

Participants indicated that they need to teach about health issue in their classrooms. One participant said the following:

> *"I can say my role is to teach children about health issues. I am Life Skills teacher in the Foundation Phase. I must teach them about those things"* **(Line 21-22).**

The teaching of health issues is attached to Life Skills in the classroom as the participant put it this way:

> *"Obviously the role of the teacher is to teach in the classroom, teaching about health issues in Life Skills"* **(Line 554-555).**

Their willingness to promote learners well-being also extend to the understanding of barriers to learning which affect learners in their learning. On participant said:

> *"As teachers we are concerned about how our children learn. For instance, if the school health nurse visited our school and discovered that some children*

have problems, which affect their learning. Problems such as poor eye sight, hearing, and we want to know how we can help" **(Line 557-560).**

In teaching about health issues, the participants also added the issue of passing knowledge and skills as follows:

"*I think again our role as teachers in the classroom is to pass knowledge about health to children so they can share it with their families. Think about the knowledge about HIV/AIDS, children will know that we are not supposed to discriminate people who are affected as well as how to take care of the sick person. I think it is important that we do that because many children are also taking care of their parents who are sick, especially those who are HIV positive"* **(Line 562- 567).**

- **A custodian of multiple roles**

In a number of ways, participants explained their roles in the classroom in terms of multiple roles that are not part of their roles. They defined their roles as follows:

"… where an educator is not only a teacher in the classroom. You are a mother in the classroom, you are a father, a doctor, you also play a very pastoral role even outside the school environment" **(Line 264-266).**

Their roles were further clarified in a sense that learners will be able to share their challenges with the teachers

"It can also make them free to can discuss their problems with the teachers. What they are facing at home, whether they slept hungry yesterday or they were alone" **(Line 29-31).**

The multiple roles came about because of the challenges that teachers face as they are working with children in schools. Some of these challenges as participants mentioned them were

"*Over a number of times. We have tried to communicate with parents about the challenges their children are facing here at school, but the response is none. And because we work with these children day in and day out, we cannot ignore they problems"* **(Line 574-576).**

Almost all schools indicated their kind of multiple roles in a similar manner

"*I can say a role of a teacher in the classroom it is just a huge, huge, huge work because firstly a teacher is a mother is a I can mention many sorts of professions. Above all teaching is a mother of all professions, because if you can observe, I am a Foundation Phase teacher, who is responsible for the class*

teaching. I become all these other professions although I am not qualified to do so. When a child is sick in the class, I am the nearest person to that child, if a child has emotional problems I am right there. In other words, in the classroom environment, I am the first person to know the difficulty of a child and from there the process of support by other stakeholders can begin…" **(Line 856-863).**

- **Teach about moral behaviour which promotes health**

Participants were able to indicate that in their role in the classroom, they also teach children morals.

"We are also teaching the respect. Take care of the environment they are living in" **(Line 33).** "… *I believe morals are important. Once you teach a child about morals, you shall have won the world"* ***(Line 35-36).***

"The role of the teacher is to teach positive morals and values about health and hygiene" ***(Line 270-271).***

"…*and another point is like she just mentioned the values, those of love, caring and self-respect, cleanliness. It has gone through the other generations…they still take care of the school. They care about the school, they come over during holidays, clean classrooms, clean the windows…. Just to keep our school clean and healthy"* **(Line 273-276).**

- **Role model behaviour which promote health**

Participants also indicated the need to model behaviour in the classroom to show how modelling of behaviour can do to learners even when they are no longer part of the school. One participant indicated the frequent visit of learners who are in other schools by saying:

"Some of them those that would left last year; every time before they go home they would come and via the school to their homes to show that you know what the school is so closest to their hearts. They would wish that even other schools, the middle schools, the high schools where they would be going perhaps it would be like this and when I look at them I can see that you know these learners really love their school, these learners really love their teachers. The manner in which the teachers have modelled themselves whilst they were

teaching them it means they end up like them so much that they seem to be their fathers and their mothers" **(Line 278-284).**

In the process of modelling behaviour, teachers are aware that there are children who are neglected from their families.

"For children who seem to be neglected we can try and show them some love by drawing them closer to us as teachers maybe there would be some changes in the way how they behave and see things" **(Line 600-602).**

The role of the teacher was emphasised to say *"…..a teacher plays a very important role because the learner will see you as their role model"* **(Line 1122).**

"As teachers we do it in many ways. Such as cleaning our classrooms by making sure that papers are thrown in the bin, picking papers in the school yard after each break as well washing hands" **(Line 1336-1338).**

- **To teach about hygiene**

The issue of hygiene that was mentioned in question four was brought back in question five. Participants commented as follows:

"*In my classroom learners are encouraged to be clean*" **(Line 373).**

The teaching of hygiene extends to the classroom "Go back to the classrooms; we put basins next to every class. They know they must wash their hands before they get into the classroom after eating after lunch they must also go back wash their hands and keep clean and neat" **(Line 370-372).**

"My view is that schools can promote health for its children through teaching. It starts from even using the toilets, after using the toilets children must learn to wash their hands. Cleanliness is also problematic, the food are clean. Before they eat, they must wash their hands. After playing, they must wash their hands. They must keep themselves clean, so the books can also be clean. In total they was grow up being clean and also be able to eat clean food so less sickness and a healthy lifestyle" **(Line 1414- 1419).**

"Teach them how to wash their hands before they can eat" *we try to buy our own bath soap for the Foundation Phase before they can go to break they wash their hands. So we promote health a lot"* **(Line 108-110).**

"We teach them to wash their hands every time before they eat" **(Line 710).**

- **To prepare future health promoters**

Participants understood that HPS is a process to prepare children for future. They commented as follows:

> *"… preparing the learner for the future"* **(Line 112).**
>
> *"..not necessarily the curriculum"* **(Line 113).**
>
> *"Which is like we are preparing for the world when they go outside they know how to take care of themselves and also the surrounding"* **(Line 118-119).**
>
> *"Teach them to be better people for future"* **(Line 120).**
>
> "So we really *play a very very important role for these learners because what we have planted they'll use that in many years to come"* ***(Line 1199-1200)***
>
> *"Ja I think you have said it all but as a teacher as we have our lessons in the class especially in the Life Skills they are involved in how to teach a learner to be healthy. Those lessons are talking about those things they have learnt"* **(Line 1421-1423).**

- **To teach about healthy food and physical activity**

Participants understood that they could promote health in the school as they teach. They commented as follows:

> "*I am able to pass that needed education to children. Taking care of their bodies, their development, and the right food to eat. You will remember that here we have many children who suffer with nutrition issues. Either skinny or obese, some of them they do not get healthy food and some of them are eating junk food which is not healthy at all. For example when I am teaching about food, we have the food group chart where they learn about different types of food and how they help us. The time when we are learning about food, I also ask them to bring healthy food just to link this knowledge to their homes. And that is where I am able to see if the child's family can afford healthy food or not"* ***(Line 701-708)***
>
> *"We also do a lot of physical activities outside the classroom to keep them healthy"* **(Line 375).**

"Then again when coming to their part of physical training and performing art then we teach them how to do warm up do physical exercise to stay healthy" **(Line 927-928).**

- **To take care of the environment**

The issue of an environment, which was brought in question four also, appeared again in question 5 where participants indicated how they teach children how to take care of the environment. Participants commented as follows:

"If you have gone around our school you would have realised that in our school we promote health in anyway. We have gardens, the yard is clean, there are benches where children can rest during break" ***(Line 375-378).***

"We teach them to take care of their classrooms and their rooms at home" ***(Line 711).***

"…caring for the environment is taught at school. As teachers, we do it in many ways. Such as cleaning our classrooms by making sure that papers are thrown in the bin, picking papers in the school yard after each break as well washing hands" **(Line 1426-1429)**.

The purpose of using the Bronfenbrenner's ecological framework in this study was to promote the health of learners in schools through teachers. Hence, teachers need to understand that their roles to engage the society will be strengthened when they continue to execute their duty of teaching children in the classroom/school. Teachers are known to be confined in the classroom where they teach, and when the focus of the roles is moving away from the classroom to the wholes school community teachers find it hard to adjust their roles (Donald *et al*., 2002; Kwatubana, 2018), especially their understanding on the concept of health. Above all teachers in their pedagogical practice they promote the health of learners within their classrooms.

The focus group interviews were done with Life Orientation/Life Skills teachers, and they defined their roles in the classroom as to develop personal health skills to the learners by teaching about health issues. Teachers mainly teach health promotion through health topics. The researcher observed the classes where teachers were teaching Life Orientation or Life Skills in their classrooms. Most of the topics that were addressed in the classrooms were aligned with health promotion. These topics were

body development, hygiene, the danger of using substance abuse, nutrition and HIV/AIDS. The researcher was not aware if whether the topics were arranged for the researcher to see if whether they were promoting health or it was part of the themes to be discussed for term three. Although they understand that they are Life Orientation/Life Skills teachers, their roles in the classroom were not only confined to the curriculum (Preiser *et al*., 2014; St Leger, 2000). Their roles in the classroom were also defined by their experiences in the classroom. Basically, their role is to teach about health issues, which are within their Annual Teaching Plan (ATP). Anything above their roles in the classroom was perceived as too much work (Preiser *et al*., 2014).

This goes along with their understanding of how they should play their roles as promoters of health in the classroom. Quite often, teachers do not see themselves doing anything apart from their role in the classroom of *teaching about HIV/AIDS*. However, in the classroom they were also worried about learners who experience barriers to learning such as *ADD, hearing, poor eyesight.* They needed to know how they *can help* the learners within their classrooms (Sizanang Centre for Research and Development, 2006). Teachers' role in the promotion of health in the classroom covered screening of barriers to learning (DBE, 2014), but because they were not skilled enough they wanted to rely on the school health nurses who only screen health barriers (Kwatubana, 2018). The ISHP (2012) and the SIAS (2014) confirms the roles of school health nurses as to screen learners who have such barriers in the classroom. Irrespective of the challenges teachers were facing in terms of health promotion in schools, there were visible signs that showed improved skills, knowledge and attitude of both teachers and learners. When teachers visited the bathrooms, they wash their hand after using the bathrooms. This was observed even before they could eat they washed their hands. Learners and teachers strived to keep their classrooms and schoolyard clean. Learners whose parents were HIV positive showed great understanding on how to take care of their parents.

The need for teachers to know can also translate to the fact that the role of the school health services within the school which is also to give advice on health issues as such is not offered to teachers hence they raise frustrations such as these. The positive

aspect is that they can do their responsibilities to a certain level and even beyond as they also indicate that they are custodians of multiple roles. In the absence of permanent health professionals in the school (Kwatubana & Kheswa, 2014), teachers felt the need to step in and do some of the roles which are not in their profession. Due to the nature of learners within these communities teachers find themselves counselling learners with emotional problems, being mothers to some learners, playing pastoral roles, being social workers, nurses, doctors, transporter telecommunication and so forth (Mohamed, 2015).

Policies in education do not acknowledge teachers roles as such, although this is what teachers are confronted with on a daily basis to an extent that they can use their resources without compensation. This proves their sense of self-efficacy because they identify and remove conditions that reinforce powerlessness. Odora-Hoppers (2001), on the concept of empowerment, reinforces that people cannot be preoccupied by what they do not have but instead teachers should appreciate the fact that they can be innovative and creative.

Like the teacher in one of the observation theme where learners who are troubled at home were drawn closer to the teacher and at the end it helped the learners to behave well after all. Some teachers reported to be using their own money, their cell phones, and their cars to attend to the immediate needs of learners in their classroom. It has been reported in the ISHP (2012) and Kwatubana and Kheswa (2014) that there is a high shortage of health professionals and that has an impact in the schools to such a point when they are invited they took long or they never reach schools in time. Teachers agree that their roles are multiple in nature and they cannot wait for the nurses to help the learners (Mohamed, 2015).

The support to be given by the SBST was not mentioned that much by all teachers excerpt for one school, even though it has been indicated in the execution of support within the school that teachers will get support from them (DBE, 2014). The researcher is not aware of whether is it the lack of knowledge or they are just being ignorant. But overall, it explains that SBST's in schools are dysfunctional hence their support to the teachers was not mentioned. The multiple problems learners face in the classroom gives teachers the edge to help learners right there although the policy does not allow

them to do so, *they have pressure to help children to learn*. Teachers agree that they do not understand some health problems learners' face in the classroom; therefore, they would like to know better.

In the document analysis, the baseline study for health promotion indicated the quest for teachers to know and understand what HPS entails and how they can help learners with barriers to learning (Sizanang Centre for Research and Development, 2006), and they find it difficult. It can be said that the roles and responsibilities and departments of departments in all levels in Table 2.4 could not prepare teachers in terms of understanding their roles as promoters of health in schools. The DoH (2011) guidelines for school health nurse indicate that the nurses will also guide and advice teachers with regard to chronic illnesses that they encounter in the classroom. However, participants in one school gave an example of an *epilepsy* case they were not preview to; they boy passed on at school and they *wished they would have known better* how to help the boy.

This one case and others made teachers to understand that to some extent promoting health in schools cannot be in the hands of the health professionals only, there is a need to know and understand these barriers. This set the tone to say the HPS need to be inclusive in its nature to allow teachers to have basic knowledge about barriers to learning which affect children in and outside the classroom.

According to South African Council of Teachers (SACE, 2011) the roles of teachers are not anything but to teach in the classroom. It is understandable that they need to stick to their roles of teaching but the changing times (Chrono system) does not allow them to be complacent with what they know, they need to move to influence not only one learner but to influence all learners at once and to a certain extent to influence the society (Marx *et al*., 1998).

On the same note of trying to help learners, teachers sometimes are confused by what is suggested in policies. The roll out plan in the SIAS (2014) policy indicates that teachers will also have to administer deworming to the learners (see Paragraph 3.4.3). Many teachers were worried that this is not their role; they were not hired to be health practitioners. They indicated lack of training and to say the policy changes anytime

without their knowledge the only thing they do is to comply. Learners are sexually abused from home and teachers are not allowed to check the child because the policy does not allow them to do so.

Teachers need to understand that their role is not confined to curriculum only, as it has been indicated in Chapter 1 (see 1.7.2) they need to respond to the needs of the learners holistically, and that include learners physical health, emotional health, intellectual health and spiritual health in their classrooms (Jourdan, 2016; Mohamed, 2015). Lastly, teachers felt powerless and they could not do otherwise which is a total different perspective from what teachers are expected to do in a HPS where their roles are overall. The HPS concept aims for empowerment where teachers should be empowered and believe that what they do can contribute (Odora-Hoppers, 2001) to the well-being of learners.

The aim of health promoting school is to change learners' behaviour either through teaching or from what they observe teachers doing or not doing; that is an informal curriculum, which encourages positive health behaviour (Renwick, 2006; Strydom, 2011). Morals have been indicated as one of the most important tool to change behaviour of learners like teaching them *about respect, caring for the environment, cleanliness, and hygiene*. In schools where teachers' behaviour in terms of promoting health was positive learners seemed to follow what their teachers were doing. Moreover, it can be said that in one way or the other they were promoting health.

Over and above teachers, also demonstrate positive behaviour to their learners as they model what they expect from their learners. In two schools where they do not have problems with littering, teachers indicated that they *do not pass a paper,* they pick it up and that makes their learners to do the same. Through observations in schools where teachers were positive about health promotion learners seemed to be happy and cooperative in terms of how they keep their classrooms and school clean.

For the school to promote health from within it needs teachers who understand the health promoting school concepts and how they can promote health in schools. As it was indicated in the research done by St Leger (1998; 2000) teachers understanding is critical for the promotion of health in schools. With the multiple understanding of

health promotion as the provision of school health services by the health professionals, teachers find it so hard to define how they can promote health in schools, excerpt for *teaching*. However, they used the knowledge they have which was based in the teaching of Life Orientation in the classroom (Strydom, 2011). As always the focused on the teaching of hygiene, empowering learners to be future health promoters, teaching learners about body development and caring for the environment. Up to this far one can understand that teachers' responses were around hygiene, environment, body development and preparing learners for future.

In the schools where research was conducted, there were challenges of overcrowding, outbreak of diseases communities and many challenges facing the learners at schools. Yet the focus was meant to address hygiene issues. Teachers reported teaching learners to wash their hands before and after eating, wash their hands after visiting the toilet. Through teachers innovation in school 4 they have moved from washing hands in basins to avoid re-infection to washing their hands with soap in running taps. For the teachers, teaching hygiene in that manner was critical since many sicknesses could be prevented and therefore less sick children in their classrooms.

For teachers teaching about hygiene was not meant for the learners in the classroom or covering the *curriculum* only but it extended to *prepare learners to be future health promoters*. This was also confirmed by a research done by Ntagungira (2014) and Mohamed (2015). The basics of hygiene also enabled learners to understand how they need to take care of themselves and their environment when it comes to what they eat and their body development. Teachers understood that teaching learners about health issues was not a once off thing, but it was something they can use for a lifetime to improve their lives, their families' lives and those of their communities.

With the understanding that health promotion is a process schools should continue to strive to promote healthy environment. It was reported that it is difficult to encourage learners to keep the school environment clean if their community is not appealing at all. In School 1 teachers complained about the state of their physical environment where littering was a problem. The aim of health promotion is to promote healthy behaviour among learners (Donald *et al*., 2010). For that, reason teachers in their

capacity tried to promote hygiene by encouraging a clean environment as they discourage littering, but within the community there were a lot of unhygienic activities happening.

It can be said that in the process of promoting health as a school as such, it was not easy to penetrate the community because schools could only control what is happening within their parameters. But it was a different thing to school 2, 4 and 5 where they engage the community, littering was very minimal because all members of the school community were aware of their physical environment that it is the responsibility for all to keep it clean, and not the Life Orientation or environmental committee.

Most of the learners in quintile 1 & 3 schools suffered from malnutrition which hinders their learning or some were obese because they were eating junk food. However, through teaching in the classroom where learners could gain knowledge about healthy and unhealthy food teachers indicated that learners were seen eating healthy food. There were also National School Nutrition Program (NSNP) where the feeding scheme enabled learners to receive food at schools and to have their own gardens at home where teachers who resides around in the community were invited by the learners to visit their homes to see the gardens they have started at home. Life Orientation/Life Skills encouraged learners to do physical activities at all times in and outside the school to keep fit and healthy.

Based on the South African health promoting school framework (How…..to implementers of HPS, 2011) which covers the physical environment of the school, many schools were seen with vegetable gardens as well as the indigenous tree gardens. Schools maintained the cleanliness of the yard by making sure that they have the environmental committee that looks after the physical environment of the school. The school buildings were still in good conditions excerpt for school 3, that showed signs of dilapidation and school 6 where the admin block and few classes were torched during service delivery strike.

Schools 4 and 5, which were benchmarks for HPS, encouraged learners to use water sparingly and to utilise squeeze bottles.

In school 1 and 3 they had a challenge that they did not have water in their premises because the water pump were stolen and that had an effect concerning hygiene in

terms of washing hands before and after eating as well as coming back from the toilet. In school 4, they moved from using basins when washing hands to using taps. When the researcher enquired, the teacher said they were trying to eliminate further infection as learners would use dirty water repeatedly. The toilets in most schools were clean.

In school 1, they struggled with littering in the schoolyard because they assert not to have dustbins where they can throw the rubbles. However, in school 2 and 5 teachers indicated that for the environment to be clean, they also model good behaviour. It is either they pick papers together with the learners or they do not pass the paper when they see it on the ground. Since the schools in this research were quintile 1 and 3, they received money from the DBE that is used for maintenance. Others claimed that they receive it very late and that it was not enough to keep their schools clean since they can only use it where they needed it the most. In school 5, they have projects and fundraisings, which were communicated to parents, and they were able to buy what they needed in order to improve the physical environment of the school.

It is not stipulated in the CAPS Curriculum that learners should clean the physical environment outside. However, learners in school 4 together with the environment committee were seen taking care of their school environment every morning and after each break meanwhile some of them would come earlier to make sure the schoolyard is clean and also their homework and projects were completed. In school 4 they indicated that they also recycle everything and the researcher was shown an area where they throw their rubbles which they call a “decompose house”.

Teachers were struggling with learners who showed various barriers to learning. Moreover, with time and help from other stakeholders teachers were able to understand how to work with various learners without trying to change them but focus on making sure that they learn in an environment, which is supportive and conducive for learning.

Although not all teachers were familiar with the components of a HPS as it was outlined in the conceptual framework (see 2.4), through their direct engagement with the school health professionals they were more proactive to health challenges than being reactive. Learners who were experiencing barriers to learning were attended to, and

that lowered stress from the teachers because they knew what to do even before it could happen.

As the observation continues in schools, teachers in these schools were interacting very well with learners, other staff members in school, the general staff as well as the parents. During focus group interviews in school 1 when it was break time, three girls entered the office where interviews were taking place unaware that they were not supposed to enter. Later on when they left, the teacher explained that those learners were children at-risk from their homes and they were giving teachers difficult time in the classroom. However, the teacher decided to keep them closer and listen to them.

The teacher reported enormous changes because they felt loved and accepted and that was their turning point to good behaviour in the class because they did not want to lose their relationship with the teacher. In general, the social environment within the schools was good. This was highly expressed in school 4 where they indicated that they have a very close-knit relationship with each other. They indicated that they support one another in times when someone's relative pass on they give each other support like family. It might have happened that they might have hidden some behaviour but for the longest time ever when the researcher was in school that was observed on a daily basis.

Due to the changes in the social environment of the school, many learners developed a feeling of being secured and belonging to the school. A number of teachers indicated that majority of children came from broken homes where they were being cared for by parents who are unemployed and some are dependent on drugs and alcohol, cared for by guardians, and some were child-headed families. Teachers took it upon themselves to teach the children how to take care of themselves and their surroundings.

In all schools, the neediest children would receive school uniform through the help from the DSD and some would also receive food parcels and vegetables from the school's vegetable garden.

Throughout the project many learners academic performance improved basically because there was a total support from all stakeholders at once. A collective support from the DoH, Basic Education, the DSD as well as the NGO'S enabled learners who were struggling to learn due to various health issues such as ear infection, vision, asthma, hyperactivity, absenteeism due to illness and substance abuse.

From the observation, health promotion has led to improved staff morale, which saw teachers moving from high absenteeism rate, beating children, not doing their work to highly committed teachers. Although health promotion seem to be demanding but teachers who were able to acknowledge the impact of the program on their health as well as their influence on children and the parents they continue to collaborate even when the directives of health promotion in schools seem to be lost.

During breaks the researcher would be out observing how teachers supervise the learners.

Finally, teachers were able to see learners who were more calm and happy to be at school. That alone has eliminated emotional and behavioural problems, which hinders learners from learning in and out of the class. However, biggest challenge for all six schools was their relationship with the parents which was not good at all. Mostly parents were defined as young, negligence and careless. During the interviews, teachers were complaining about how parents take care of their children. The researcher sensed that teachers were still struggling as to how they can involve parents.

5.3.1.3 Responsibility of school health services

Participants were asked what their views are **on health and the promotion of health in schools?** This question seeks to investigate the teachers' understanding of health and the promotion of health in schools. The subthemes that emerged from this question were:

- **Health sector concept**

Teacher's views with regard to health and the promotion of health in schools, was understood as a concept that can only be associated to health institutions or health professionals. This was clear when the participant indicated that,

> *"However, one can say it is mainly a concept by the department of health. It's meant for nurses and doctors"* **(Line 40-41).**
>
> "*In my understanding I think health and health promotion in school has to do with health professionals. Like when the school health nurse would visit our school for screening of children"* **(Line 291-293).**

This was further clarified in terms of what is done specifically by those who were trained to do so:

> *"…but there are those health issues which requires health professionals knowledge"* **(Line 295)**
>
> *"At some point the giving out of whatever tablet even medicines to be given to learners by teachers was stopped and to me that was a right thing to do. To say since we are not doctors, we are not nurses and we are not trained in that field. Am how would you know if a learner is sick and you give Panado, and Panado will be the right pill or tablet for the child? And to me I don't know how I'll be correct to say cause it seriously defies logic that teaching practitioners, I mean teaching personnel must then give medication to learners, deworming and that is being rolled out"* **(Line 297-303).**

- **Education has no role to play in health promotion**

From the perception that it is a health concept, one participant aired a critical concern that teachers would not be suitable to work on health matters as this can land them in a big trouble as follows:

> "*But seriously am of the view that at some point it needs to be challenged in the sense that we are not health practitioners but teaching practitioners"* **(Line 305-306)***.*
>
> *"Poor teacher does not even know the medical procedures, how things are supposed to be done and it becomes a problem"* **(Line 308-309).**

"Perhaps if it is piloted I would be glad if I can be invited in one of the meetings or the workshops, just perhaps to air my own personal point of view to say I'm not for that., because I'm seeing teachers being taken to very very serious criminal charges for giving learners pills, tablets or whatever kind of medicine other than the one that we are used to take the child into the principal's office or the administration call the parents or the schools take the learners to the hospital as easy as all where a learner was be receiving a proper medical attention, unlike giving just anybody giving the medicines which are not right for the learners or for the kids" **(Line 310-317).**

The concern was further elaborated by a participant who indicated that their teacher union would not support the idea that they are involved in health issues as follows:

"We are not allowed by our unions even to give medication such as Panado when a learner has a head ache. Because our unions will not allow us to do that" **(Line 1154-1155).**

- **Teachers are not equipped to promote health in schools**

Participants raised the concern of lack of training as follows:

"I understand that if it is done at school it can be very influential to the children themselves as well as the community where they live, but the problem as teachers we are not trained" **(Line 43-44).**

"…*us as teachers we do not have any training in the health promotion in school"* ***(Line 611).***

A further concern with regard to training

*"…was more focused on the barriers to learning where teachers do not have much information on what to do in the class. "I thought maybe they can also help us as teachers, because we spend more time with children but we do not have any training whatsoever" You know what? As teachers we are faced with the dilemma of teaching children who have serious learning challenges, but we do not know how to help a child whose epileptic, whose diabetic, who's having serious health challenges which affect learning"***(Line 319-323).**

Moreover, the participant is aware that if teachers could have basic training in health issues, it can be of a good course.

"*Maybe that can help. We wait for a long time for health professionals to come here at school, but if we have some light I think we can contribute positively"* **(Line 325-326).**

- **Health promotion is subject based**

Participants' understanding of health promotion is that it is based in a particular subject.

"I think right now the subject which strongly promotes health is Life Skills" **(Line 49)**

"If here at school we can teach our learners through Life Orientation and Life Skills in the Foundation Phase I can tell we can win the battle in our communities" **(Line 880-881)**.

"…we are able to teach children in Life Skills about health issues" **(Line 1375-1376)**

- **Health promotion is an extra burden in the curriculum**

The perception of teachers is that it is an extra burden.

"But my main problem is that it could be an extra burden on teachers. Teaching in the classroom, being outside in the garden, on the other hand attending to parents" **(Line 333-334).**

"To help us to understand the concept of health better, right from the start they should have collaborated. 'Cause what I see is that the health department is dominant and the basic education is not strong, there is a missing link. It is like there is no link, because it is not included in our curriculum" **(Line 1143-1146).**

There is also a concern about time where the participant said:

"We are always in loggerheads because they will just drop here and say today we are going to give you pills but they did not look at our time tables, look at our programmes how are they going to disturb us that day" **(Line 1148-1150).**

Over and above, on top of the curriculum needs, the teaching of single topics would address perilous topics.

"By health issues I mean malnutrition, drugs, teenage pregnancy, STI's, diabetes, and infectious disease. We can promote health in school by trying to solve teenage pregnancy for example. By teaching that to have sex or unprotected sex they can become pregnant or have STI's" **(Line 24-27).**

- **There is a need for collaboration in the departments to promote health**

  "You know mam, with the mushrooming of diseases in our communities today I can say health and the promotion of health in school is very important because the school can influence the community in a big way through teaching we are able to reach to the whole community. Someone mentioned that when all stakeholders are involved within the school environment things are quicker and much easier. It is the school where all stakeholders can meet for the sake of school children" **(Line 883-888).**

  "But the challenge is that there is no clear demarcation as to how it can be done. Look in this project there are three departments which are involved. Only the department of health is responsible. The basic education is partially involved" **(Line 621-623).**

When further probed with regard to partial involvement the participant said:

"*It's partially because us as teachers we do not have any training in the health promotion in school. Even though we have serious problems which children are experiencing we cannot do much because we have no particular training in health issues excerpt for the fact that we teach Life Orientation of Life skills"* **(Line 625-628).**

Now that health promotion is done in schools, teachers are compelled to play their role. In this regard, their views on health and the promotion of health are very important. Hence, their views on health and the promotion of health in schools are explained as something to be done by health professionals.

When teachers were interviewed, their understanding confirmed that what is done in schools is under *school health services* by mentioning that health promotion in schools is a health concept, meaning that only the health professionals can promote health in schools in the sense that what they have observed since the inception of the HPS they have seen nurses running the health promotion in their schools by *screening* learners in the Foundation Phase as well as the administering HPV to Grade four learners. The ISHP (2012) projects are done by health professionals even though educational goals were clearly indicated. In the Baseline document analysis, it was indicated that the GDE was not aware of the health promotion project done in their schools (2006). In

addition to document analysis it was indicated that there is a lack of collaboration between the departments. This also speaks to the vision shared amongst these department about health in schools.

This could possibly be explained through observations that were done among teachers that confirmed that they were not prepared to deal with issues around health promotion excerpt for school health nurses who were screening the learners in their schools. On the documents analysis health professionals played a huge role in harmonising health issues in schools without the participation of teachers. Research done by Mohamed (2015) done confirm the importance of teacher readiness and the fact that there are also factors that can determine their readiness as it was indicated in section 3.4.1.

Teachers' role in health promotion in schools was not clearly stated and they continued to indicate that they do not contain the *knowledge* to provide health. One could suspect that the introduction of health promotion in schools was not fairly introduced. The document analysis in the evaluation report (2010) confirmed that although HPS approach has five components, teachers could not understand how they could fit in the components in their activities as they promote health. Their understanding of health was explained in medical terms where they would need to administer Panado to the learners and to give deworming pills. They continue to say they were not health practitioners.

In one school, the researcher observed few cases where teachers felt that they needed to act to promote the health of learners. There were three cases where the services of the school health services were needed desperately. The first case was of a boy who has been sick since the beginning of the year until when the educator with the permission from the principal took the boy to the clinic for medical attention. The other case was of a boy who was certified dead at school because of epilepsy. He had seizures and teachers were not aware of what to do. The last case was of a boy who broke his leg and the teacher had to call her paramedic brother who came to school to offer first aid to the boy before they could call the ambulance. The reason for calling the paramedic brother was that teachers were disappointed several times by the school health services response whenever they were called at school.

This perception is clearly underpinned by their understanding of health which was much isolated to education and of which the teachers were acknowledging that their *unions would not support*. The training of teachers is more focused on the learners in the classroom; hence they said they were not trained to promote health. In section 3.5 the needs of teachers for knowledge and skills reveals the importance for teachers to be trained to be promoters of health in schools. Research done by Tjomsland (2009), reveals that without proper training in health promotion it would not be easier for teachers to participate. From observation in schools teachers indicated that the training they have received was inadequate for them to promote health in schools.

At schools health promotion is addressed through Life Orientation/Life Skills subject where health issues were addressed according to different phases of education band (see section 3.7.1 in Table 3.1 & Table 3.2). Through observations in schools only Life Orientation teachers were the ones responsible for the promotion of health in schools. The HPS models in section 3.2 were all unified by the fact that there is formal curriculum in form of health education. Above all, the models address health topics which affect learners in schools and that could be done through subjects which are more health related. Both models have curriculum, teaching and learning as their components. Each country addresses health in schools depending on the national policies.

In the literature it was found that in Ireland health is a subject in its own right, whereas in other countries it was infused within other subjects; in France, it was placed as civic education where it focuses on health and citizenship and in Portugal it is considered personal education where the focus was on personal and social development (Jourdan *et al*., 2008). Depending on the importance of health promotion in school, the notional time on the CAPS document in South Africa concerning Life Orientation/ Life Skills is very much limited and in the Senior Phase (SP) and Further Education and Training (FTE) it is not used for promotional purposes. In schools teachers understand that only Life Orientation /Life Skills teachers are the ones who should be in the forefront of understanding and practicing health promotion in schools (Strydom, 2011). So, without much understanding of the health promoting school, the implication is that the whole school will find it hard to follow the health promotion initiatives in school.

Only if teachers could have a better understanding that HPS is not an *extra burden in the curriculum*, but it is what they do on a daily basis in their classroom and also at school. In the literature review research by Kremser (2011) indicated that in some cases principals reduce health promotion to mere activities which are assigned to particular teachers in schools. Bearing in mind that the findings by Fullan (2001) indicated that principals can serve as gate keepers who impede health promotion, the fact that health promotion could be seen as extra burden could not be overlooked even though all teachers can be promoters of health in schools because at some point they will have to meet with the parents and the community to discuss issues regarding learners. That is, they need to see that their classrooms are conducive for teaching and learning, they need to promote health for staff in terms of getting along with each other as members of staff, they need to promote the social environment in their classrooms by accommodating and giving support to all learners in their classrooms.

If teachers could have an understanding of policies which underpins health promotion in schools such as the SIAS (20, ISHP and Education White Paper 6 policy documents the fact that health promotion is an extra impediment could be minimised. Teachers in their classrooms they need to understand that learners have different learning styles and that they need to consider curriculum differentiation in their classrooms. What has been observed through in the classrooms was that teachers were finding it hard to accommodate all learners when they teach. Instead, teachers continued to use the same teaching strategy without much consideration of learners' barriers to learning. In the literature review Tomlinson (2001) considers that educators should be able to differentiate curriculum to cater for the diverse learners in their classrooms. One could say the reason why teachers find it hard to implement HPS could be that they perceive health from the deficit model instead of the socio ecological model which sees the development of learners as influenced by the environment where they live, play and work every day.

Above all through the engagement with the teachers, their understanding was that if really the collaboration of three sectors (education, health & social development department) as it has been indicated in the ISHP (2012), could function properly then the support of learners could be achieved. This was supported by the fact that during the program initiation all the departments were actively involved and they could see

the progress in their schools. Of course the training of teachers has been mentioned time and again because the teachers felt that they lack capacity in contributing their roles.

The collaboration of departments as indicated in the roles of departments in Table 2.4 seemed to fail teachers in their roles as promoters of health. Starting from the National departments; the Department of Health's role was to coordinate the implementation school health policy in schools and to conduct capacity building of both health professionals and educators. In the literature review the findings by Kwatubana & Kheswa (2014) indicated that in some schools the reception of health professionals in schools was poor and in some other schools they could not receive accommodation as it has been indicated to be the role of the DBE to link school health nurses and teachers in schools as well as to make the environment for screening of learners available.

Findings from the baseline document of the interviews that were conducted with the national and provincial departments revealed the following:

- National Department of Health (DoH)

The national DoH defines HPS in the context of promoting healthy lifestyle and to decrease the burden of disease in South Africa (DoH, 2011). The Department's approach is aligned with the WHO's model. Teachers were expected to facilitate the learning process by monitoring the progress of learners. The challenges within the department were the lack of shared vision within the department, coordination and collaboration with other departments as well securing enough capacity, interest and commitment.

- National Department of Basic Education (DBE)

What is of interest by the Department of Education was that it has affirmed that all schools should become HPS by promoting healthy lifestyle. The department made it clear that schools are not necessarily labelled as HPS However they are centres of support that provides care and not merely for educational purposes. It has been stated that within the National curriculum, health promotion forms part of the Life Orientation.

The Directorate ‘Health and Education’ said to be currently realigning themselves towards the five health promotion elements for the purpose of addressing health and wellness issues in schools. In schools, the SBST was said to be involved at a school level. The constraining factors within the department were:

- Lack of human resources
- Insufficient financial resources
- Time constraints
- Ensuring continued collaboration and coordination.

In conclusion to the National DBE interviews conducted by Sizanang Centre for Development and Research (2006) it was noted that the department was not formally informed about the pilot study which was done in Gauteng and did not have the complete details of the health promotion program which was launched.

- The Provincial Department of Health (DoH)

The long-term goal of the department of health was to develop all primary schools into HPS by playing a less role and encourages schools to take ownership and sustain the program.

- The Provincial Department of Basic Education (DBE)

The vision of the Provincial DBE is to provide teaching and learning environments that are suitable for learning as well as to address barriers to learning. “Banapele” was launched as a school enrichment programme aimed at addressing the opportunities and challenges by ensuring that the most needy schools receive the full basket of services such as exemption of school fees, school uniform, referral to social grants, nutrition etc. The Provincial DBE considers the DBST as the first line of support although the provincial department is responsible for developing teaching and learning material. The constraining factors as follows:

- lack of capacity;
- the late transfer of the budget;
- lack of clear targets;
- lack of coordination and collaboration, and
- overcoming procedural and intergovernmental system barriers.

From the baseline document analysis the teachers' understanding and awareness with regard to the HPS concept was not discussed at all, but it was mentioned that majority of teachers were aware of the concept, excerpt for few who were not aware of the concept. Those who indicated they were aware, when they were further requested if whether they understand the five components of HPS, none of them were able to name five components of HPS, correctly. None of the five components was specifically referred to.

Teachers' attitude towards the HPS program was motivated by the fact that other stakeholders will need to be involved and not by their own self-efficacy. However, those who indicated the negative attitude mentioned the lack of involvement by parents, communities not aware, learners who have no pride in their environment and that there was no co-operation among the staff and that they felt everything was given to teachers without support.

Teachers' understanding of the concept was very limited to factors such as limiting unhealthy conditions, school health services, and school nutrition program. The findings about teachers' perception on health promotion indicated a high percentage of 94% teachers that felt that it was not implemented because there was lack of facilities, experiences of poor management, time constraints, lack of coordination of activities among stakeholders. Health related topics were used to address health issues. Nevertheless, lack of community involvement, socio pathological ills, school environment and teachers who have lack of knowledge was seen as a challenge. Likewise, there was lack of dedication, team spirit and the feeling that the Department's expectations were high.

Above all the school environment in a number of schools was not in good condition as the toilets were dirty and far away, kitchen were not equipped, classrooms were overcrowded and non to unsafe playgrounds (Sizanang Centre for Research and Development, 2006).

The lack of collaboration in the provincial level was found when during interviews teachers indicated that health professionals visit schools and interfere with curriculum and do not take into considerations the educational goals, whereas both provincial

departments were supposed to develop a schedule for school health activities. Within the department of education in the province the mobilisation of teachers, learners, parents, school governing bodies and the community did not seem to materialise because only teachers and learners were aware of how they could promote health, whereas the school governing body and the community were not aware of such. In school 5 they had a challenge that needed water for gardening and other hygiene matters, but they were advised to use less water. The role of both provincial and district departments were to advocate with relevant local government on water supply and sanitation in schools. Lack of collaboration within the departments affects how teachers can promote health in schools and consequently affects learners indirectly.

In all the schools where data was collected, their understanding about HPS was based on physical health issues. Immediately when HPS was mentioned, they would reminisce about the initial stage of the health promotion in their schools where all health professionals were there regularly to check on learners who have barriers to learning. From the doctors, nurses, psychologist, therapists, and social workers were all attending to the learners holistically. From the teachers views this was excellent because now they were not struggling to assess learners until they find support at a later stage when a number of reports were submitted. The WHO (1996) acknowledges that there is an extricable link between learners' health and their ability to learn.

Learners who were partially sighted were reported to receive assistive devices as well as those with hearing problems were receiving hearing aids. Many teachers in schools were saying that they wish health professionals could be in their schools permanently because they could see the connection between health of learners and their academic achievements. By the time when the researcher was collecting data, none of the stakeholders mentioned in this research were seen anywhere near schools.

Teachers were very concerned about how the health professionals respond to their challenges. They indicated that its either they respond later or they do not respond to the call at all. Only the police services were reported to be active whenever they were called in schools to come and investigate cases of weapons in schools and substance abuse. The school health nurses were only seen in schools once or twice per year

when they were administering the HPV vaccination and when there was an outbreak of disease.

Teachers grossly complaining about nurses visit which could just happen without much communication with schools and they indicated discontent on such initiative, because on that day their schedule was interrupted. When teachers were asked about the school nurse who was designated to their school they were not aware of such and that obviously meant that there was no proper understanding from the teachers side of what the health professional should do at school. In some instances, it was reported that the screening was not done at all in some schools and that certainly confirms the challenges, which were mentioned in the ISHP (2012) that there is a shortage of school health nurses.

The Constitution of South Africa (1996) declares that children have rights to receive PHC in all public health centres. In schools when learners were referred for further support in institution outside and far away from the school parents failed because some would claim not to have money to take them to the clinic or the hospital. It was reported in one school when there was a child who was sick since January until around June when the researcher visited the school.

In loco parentis, teachers took the child to the clinic for further attention because intervention from the school health nurse was not possible and the parents were not responding to pick the child to the clinic or hospital. In all schools, there is a sickbay where sick children are kept whilst they are waiting for the parents or guardian who will pick them up. With some children, they do not receive any further attention from parents and that is where learners' education is affected by their sickness.

All schools should be commended for the fact that they have a feeding scheme which helps to eliminate malnutrition and other diseases which were related to malnutrition. The meals were mostly stamp, beans and fish and then schools would supplement the feeding scheme meals by the vegetables they have in their gardens.

5.3.1.4 To build capacity for teachers and learners in the promotion of health in schools.

Participants were asked what their views were on the health promoting school as such? In this question, the sub-themes were as follows:

- **To provide healthy environment for learning**

The participants defined a health promoting school as follows:

> *"A health promoting school is a school which promotes health to its learners and the school community. That includes the parents, staff and the community at large. It is a school which looks after its health closely"* "…*This can mean that the environment is well taken care of, the children are receiving food, those who don't have uniform are receiving it through the Department of Social development and those who are sick are attended to so that they can learn properly"* **(Line 639-644)**.
>
> *"It is important to take care of the environment, such the environment must be welcoming to everybody and you come to school happy even the learners was come to school happy, yes"* **(Line 1158-1160).**

The participant who indicated their commitment in this manner heard the love of the school by teachers who are in the environment committee commented as follows:

> *"We come to school early and leave late. We want to make sure that everything is ready for tomorrow. We love our school. If you go to the kitchen, you see the environment inside. We don't want to see the lady came maybe with something which is dirty, we teach them to be healthy even where they cook their food they must be prepared or be healthy place"* **(Line 895-898)**.
>
> *"You can even check our time register we come early; we don't care about the overtime thing. But the well-being of our school is of utmost important"* **(Line 904-905).**

- **To promote health from within the school**

Again, the participants view the health promoting school:

> *"…here at school we try to teach them about being healthy"…. Now I know that health and education are together"* **(Line 60-61)**.

"*The health promoting school is good because we are able to teach children about health issues*" (**Line 342-343**).

"To add on what mam has said the children that we are teaching are positively or negatively affected by HIV from homes, the school and anybody else next to them. So if we promote health in our schools we will assist the learners who are affected or infected by HIV/AIDS without being absent at school" ***(Line 345-348)*** *"is a school which intensely looks after the health of its school through education"* ***(Line 646).***

- **To provide resources**

The participants stated that

"…*To promote health in a school is a good thing because look, here we give children food so that they learn better, our environment is clean and we also have a food garden"* **(Line 62-63).**

"*If a school has to be health promoting as such it means according to my view that it must be able to provide all the services for that particular school. That school must have its own school health nurse who is able to assess learners right there; it must have its own therapist right there, services of the psychologist and social workers must not take years to follow-up like what is happening now"* **(Line 65-69)**.

…"Like from the Non-Profit Organisation we get posters from Dettol, we pluck it up on our walls and then we teach them how to wash their hands before they can eat" **(Line 70-71)**.

"A health promoting school provide resources to ensure that health is promoted in schools" **(Line 1395-1396).**

- **To promote hygiene**

Besides the healthy environment and resources, participants also indicated other elements, which form part of a healthy school, and these were***:***

"Hygiene is important" ***(Line 81)*** *"I think if a school is health promoting then it is also aware of the challenges facing its community. Like here in Kgorong littering is the problem. You go around in this community it's like a rubbish dump. So no matter how much we try to teach the children not to litter they*

*still do" **(Line 82-85)** "…we've got this first aid kit" **(Line 86)** "because as a school we are able to deal with the problems within the school on our own utilising the services of the school health nurse who's situated here at school as well as the social worker and the psychologist. The time when this project was active most of the problems were attended on the spot because all the stakeholders were here" **(Line 349-352).***

- **The need for support from the departments and other stakeholders**

In the process of defining a HPS, participants indicated the need for support. Participants commented as follows:

> "*I think schools can do it alone if they have support from the province as well as the district*" **(Line 88-89).**
>
> *"…..also get support from non-profit organisation"* **(Line 93).**
>
> *However, the participant acknowledged a concern to say that health promoting school is in the hands of the Department of Health. "…biggest chunk of health is with the Department of Health and we do the basics"* **(Line 93-94)**.

Above all, the participants indicated that they are not sure about the line of responsibility between the departments and that there is a need for support. Participants commented as follows:

> *"….As a school if we have that knowledge then it was be easier to teach our learners" "But the problem is when all the services are decentralised according to levels of responsibility and departments in the government. The health department was do this, the social department was do this and the basic education will do this. At the end the school is not aware as to where to enquire about particular issues". … Teachers in our school have attended workshops and courses of HIV AIDS and they know exactly what to do. But it's not enough. I wish somebody can come and add to what we have learnt"* **(Line 354-360).**
>
> *"I think the health promoting school is very important because healthy children I think they learn better. For instance school health nurses they come and attend to sick children regularly and us as school we promote health through teaching in Life Orientation or Life Skills" **(Line 362-365).***

The definition of a HPS outlines it as a setting where all members work together to promote health and well-being of learners, teachers, general staff and the wider community. This is how the HPS program was done in the Gauteng Province where all the stakeholders were involved to promote the health of learners. Now that teachers were expected to define what each school has to do alone depending on its needs and context, teachers were able to say that HPS need to promote health in terms of building capacity for teachers.

Depending on the knowledge teachers had acquired, caring for the environment and capacity building emerged as the most outstanding features they think the HPS should be. Their perception as such includes both physical and social environment where the whole school community is cared for by taking care of the environment and caring for the needy learners. One of the HPS conceptual frameworks components includes the social and physical environment that it should be conducive for both teaching and learning (see section 2.4). One thing that was observed in all schools was that they were striving to maintain the environment. Schoolyards were clean and the classrooms were conducive for learning. Moreover, in some schools they struggled with littering because teachers indicated that they did not have dustbins to maintain cleanliness. In some schools they were able to organise the garbage in their school to a point wherein white papers were recycled with the recycling company and some garbage were stored in the decompose house. Teachers expressed love for their school by indicating that that they arrive early at school to make sure that the environment was clean and ready for the day. The building in some schools showed signs of worn out. Schools also took pride in the prizes that they have worn by caring for their schools. Above all there were vegetable gardens with vegetables. From the teachers explanation the vegetables were of great assistance because they were used to supplement nutrition and to give away to learners who were very disadvantaged in their homes.

The systemic barriers discussed in section (3.9.1) form part of a healthy environment because lack of resources, overcrowded classrooms, inflexible curriculum, lack of adequate training and teacher attitude could affect how teachers promote health in schools. In all schools there are learners who need the services of social workers who will assist them in getting food and school uniform. Research has confirmed that no education can be offered to learners who are hungry (Marx *et al*., 1998) and as such

there is a need to educate learners about various health issues and how they need to protect themselves. Many schools focus on HIV/AIDS as the health challenge which needs to be addressed in schools. There are schools which are within very difficult communities where the HPS is not known to the community and this is seen by the acts of vandalism which they experience every now and then.

But it is a different story for schools, which communicates and involves parents, since parents in these schools feel that the school belongs to them and that they also look after schools during school holidays. In school 2, 4 and 5 since they have involved the communities they haven't experienced vandalism by the community. So teaching the community is very important in a sense that it builds capacity by empowering the community to participate in building health promoting school. Communities in South Africa often go on strikes for service delivery to an extent that they can burn properties which are meant to develop their community. For example in school 6, three classrooms and an office were burnt down due to service delivery strike. The role of the provincial and district departments of education is to build capacity for schools and the community as seen in Table 2.4.

Inasmuch as the health promotion is a good program in schools the issue around building capacity among the teachers, parents and communities is very imperative for its success as stipulated in Table 2.4. In building capacity teachers mentioned the three most important things and they were visible in schools. In schools learners receive food from the feeding scheme; there were food gardens where vegetables were cultivated and hygiene was promoted very well. At some point learners also had their vegetable gardens at home. In building capacity teachers felt the need to have school health professionals' right in the school for the purpose of addressing health barriers experienced by learners immediately.

Teachers also indicated that they would love to promote health right from their schools hence they would need training on how to do it. The imperative was that although schools were in the former disadvantaged communities; their needs were a little bit different. The SIAS (2014) policy document and the DoH (2011) both intended to capacitate schools by making sure that schools were able to sustain health promotion in schools. From the observations in some schools some of the health promotion

activities were deteriorating basically because teachers were waiting for support from external stakeholders.

Bearing in mind that the school should influence the society; the issue of support cannot be ruled out in communities where there were challenges which affect schools. The challenges of littering, vandalism, substance abuse and the like could have serious implications in the lives of learners as it was indicated in section 3.9. Now that the schools did not have much control over the community, the support by the district or even the provincial department to penetrate the communities was seen as important.

This clearly confirmed that the integration and collaboration of services by stakeholders need to manifest within the school community to ensure that the promotion of health in schools was a successful story. The main challenge within schools to promote health as such was that they always wait for the district to transcend the decision down to schools like when they had to administer deworming pills as it has been indicated in the roll out plan by the SIAS policy (2014). Besides, schools struggle to understand the roles by the collaborating departments to an extent that there were so many things which were left unattended. There were health issues and social issues which could not be addressed by the schools; hence the relevant departments were not coming forth to give the needed support.

Teachers argued that if they could have received more training on how to promote health within their schools they could have done more as a school without waiting for the district to give directives. It was in this instance that in school 2 the principal proposed that health promotion should cover all the schools in the province and in school 6 teachers felt the need to take it to themselves because they realised that even people from the district were oblivious about the general concept of HPS and therefore it has affected district support because it would take a long time before they could reach the school to a point where teachers would use their resources to attend to learners experiencing barriers to learning.

At some point teachers in school 6 indicated lack of knowledge by the district officials, because when they visited their school they would only need issues within the

curriculum and nothing to do with health promotion in school. One could say lack of proper administration of health promotion from the province to the district has affected the functionality of the program within schools as it has been stipulated by research done by Kwatubana & Kheswa (2014).

5.3.1.5 Addressing factors which affect teaching and learning

Participants were asked how they promote health in their pedagogical practice as Life Orientation/ Life Skills teachers? The responses to the question above were summarised under the following themes:

- **To teach learners about body development**

Participants commented as follows:

> *In their pedagogical practice, participants indicated how they promote health. "…they are being taught how to take care of themselves when they menstruate, puberty what is happening when you are on that stage, you know a lot of things"* **(Line 124-125).**
>
> "*In grade 3, learners are taught about body development*" **(Line 714).**
>
> "*For example I can teach them about the birds. How they developed from eggs to a big chicken*" **(Line 716-171)**.
>
> *"You see Life Skills is an important subject because you teach learners the physical development now they are changing. These learners have to know their physical development"* **(Line 1203-1205)**.
>
> *"Let's say for example if you teach children to take care of their bodies. It's something which they can learn here at school and share it with the community at large"* ***(Line 948-949).***

- **Teach knowledge about HIV**

Through teaching, knowledge about communicable disease is imparted. Participants commented as follows:

> "*When teaching about health, knowledge about HIV is very important*" **(Line 382).**
>
> *"I think we teach them about HIV/AIDS. This is the biggest problem in this community"* **(Line 727).**

The way HIV is understood in our communities is different from what our learners learn here at school. They know that you don't have to discriminate those who are HIV; they also know that you cannot touch someone's blood. Where do they get that? It's through education which is done by teachers on a daily basis" **(Line 954-958).**

"….They will understand that if you have unprotected sex you will have possibly STI's, HIV or to be a victim of teenage pregnancy. I think through the teaching of Life skills in schools learners understand the precautions around their health" **(Line 960-962)**.

"They have a very good knowledge about HIV & AIDS. So their attitude has changed as well" **(Line 1445-1446).**

- **Teach learners to stay away from substance abuse**

The participants indicated that through the curriculum they are able to reach out to learners in the classroom as they teach. Participants commented as follows:

"*I teach Life Orientation in Grade 7. So I teach them to stay away from drugs. See what "nyaope" (it is a local drug made out heroin, detergents and ARV's (Antiretroviral) is doing to our community. It's sad*" **(Line 391-393).**

"We are teachers in classes when I teach them about substance abuse, I also make it practical. The other day on my way to school, I met a learner holding a beer bottle. When I enquired, I find out that the learner was sent by the parent to buy it. I reminded the learner of what I have taught them about substance abuse. But you have to be careful outside there" **(Line 1212-1215).**

Participants expressed their challenges when they teach about substance abuse. They commented as follows:

"We teach them to stay away from drugs and alcohol. But parents are using those things" **(Line 719)**.

"*Some they sell from their houses as a means to sustain their families so that makes it difficult to deal with it. We can see that it's destroying this community but anyway what can we do?"* **(Line 724-725)**

- **Teach about nutrition and healthy food**

Participants indicated how they influence learners on what to eat when they are teaching. Participants commented as follows:

> "*We teach them about the importance of nutrition. We often encourage them to eat a health balanced diet*" **(Line 384).**
>
> "*We teach them to eat healthy food and not the bunny chow. They eat all sorts of food which is not healthy*" **(Line 730- 731).**
>
> *"…it's about nutrition, children are served with porridge in the morning, if it's about gardening the school have a garden where vegetables are planted by learners"* **(Line 964-965).**
>
> *"We try to incorporate the SNP (School Nutrition Program) and food gardening through the issuing of food parcels to take home vegetables, to take home sometimes on Friday. But it is still not enough, because they would just eat for the weekend, and what happens during the week"* **(Line 386-389).**

Teachers were aware of the fact that there are health issues that affect learning in the classroom; hence they took it upon themselves to address those issues in the curriculum which affect learning. It has to be understood, that although teachers were expected to demonstrate their pedagogical practice on how they apply the teaching strategies and the teaching styles to promote health to those learners who were experiencing barriers to learning as well as to differentiate the curriculum; none of the teachers in these interviews were able to demonstrate such knowledge and during observations in the classrooms none of the teachers ever used that.

It could be said that the documents analysis as well did not have anything specific to address as to how teachers can promote health in the classroom when they teach. All the responses were around the health promotion activities that were demonstrated when teachers were introduced to health promotion program in schools. These activities were hygiene, nutrition and caring for the physical environment.

It only tells that although the health promoting school model in South Africa contains curriculum teaching and learning as one of its components (ISHP, 2012), the focus of it in these schools was not basically on teachers and the curriculum as such. The findings in the HPS models revealed that it is the responsibility of each country and schools as to how health promotion can be catered in schools. The Evaluation

document (2010) on the document analysis indicated that schools were still waiting for the curriculum material although only gardening books for the foundation, intermediate and senior phase were the only LTSM (Learning and Teaching Support Material) found in schools.

The absence of LTSM which ties the whole school curriculum with health promotion in schools was also confirmed by a teacher in school 6 who indicated that when district officials visit their school they need only curriculum report and not health promotion report and as such the roles of district in coordinating the schedule proved not to be fulfilled. Depending on how teachers see themselves as Life Orientation/Life Skills teachers in the classrooms, still their responses were based on health promotion activities such as:

Life Orientation/Life Skills gave teachers a good platform where they could address the issues of body development to learners starting from the Foundation Phase where they learn about how to take care of themselves in the morning before they go to school and how they developed as children to the stage where they are. This transcends to learners in the Senior Phase where they go deeper in the understanding of their bodies where teachers would explain about puberty stage. The findings in the literature review by Viig *et al*., (2010) and St Leger (1998) indicated that health promotion was done in schools through the teaching of health topics. Although teachers in school 3, 5 and 6 indicated the difficulty of teaching learners about body development they tried their best to explain it in a way which children could understand. This was also associated to the teachers' cultural background where teaching about body development to children was a taboo to talk about. In school 2 the teacher indicated how body development was taught without tempering with the learners age and cultural beliefs.

Due to the fact that a number of learners were HIV/AIDS orphans who were taken care of by foster parents, many teachers stressed on issues around sexuality, HIV/AIDS and teenage pregnancy. HIV was among the most topics taught in schools as it has been indicated in the literature review by Stewart-Brown (2006) Teachers were confident that what they were teaching children at school about the communicable disease was far much apart from the knowledge which the community has. The

literature review findings revealed that children were affected by HIV/AIDS especially when all parents passed on because of it (Basaza & Kaija, 2002), and the community as well as the family would reject them to a point where they end up as child-headed family (Ritchter, 2004). From the literature review, teachers acknowledged that learners had more information on HIV/AIDS and they were able to disseminate that to the community. Teachers also made use of the HIV/AIDS policy to provide more information to the learners.

As part of driving learners away from their community practices where in all schools substance abuse was a serious challenge where majority of learners were at-risk from their homes and communities, teachers seriously addressed the danger of using drugs. The finding by Wevers (2012) has proven that learners are using drugs at an early age. In and around these schools there was this common drug called “Nyaope” which was destroying the lives of families. Teachers were able to tackle that in terms of teaching in the classroom about the dangers of substance abuse, although parents of the learners were engaged in the consumption of substance or using the substance to sustain their families.

This was reported to be the challenge by schools because that was sending a contradicting message to learners as well as the schools. In school 5 teachers indicated that learners in their school knew that none of them drink alcohol or smoke cigarette because they have a designated area for smoking and even when they had a trip with learners none of the teachers would do such things in front of learners. In school 2 there were signs everywhere to discourage the use of substance abuse. In a way the schools were not only focusing on formal curriculum in the classroom but they also infused and encouraged informal curriculum to enforce what they teach in the classroom.

As one of the objectives of the health promotion in schools was to make sure that all children could learn provided they were receiving support. The National School Nutrition Policy was used by teachers as a document to promote nutrition in schools. Many children who suffered malnutrition because of the circumstances at home and in the community were being given soft porridge before they began with their lessons in the morning and lunch in all schools as it was indicated in the National School

Nutrition Policy (1994) program document. Moreover, the challenge around nutrition was that the food was not always enough since they only have it at school. After school it was supposed to be the responsibility of the parents whom were under poverty and unemployment.

Even though the DoH (2011) planned that schools should be able to sustain health promotion activities. Moreover the lack of resources in terms of food for learners proved to be beyond what schools could do, but something which could be done by the DSD. Through gardening LTSM learners were taught about the importance of nutrition and to have their own gardens at home and to sustain their families by providing vegetables to supplement their meals. In schools 2 and 4 teachers indicated that they supplement what they receive from the NSNP by adding the vegetables they have planted in their gardens. It was also reported that learners have started their own gardens at home.

Through teaching about communicable diseases and other health promoting topics, there were changes that were clearly observed in learners regarding their behaviour as well as their awareness on health issues. In Life Orientation, learners were able to understand how HIV is contracted and how to prevent it. In particular, they understood that they cannot touch someone's blood and that they cannot discriminate people who are HIV positive. Children who were asthmatic, diabetic and those who were epileptic knew how to take care of themselves.

Learners showed more discipline in terms of how they engaged in learning and doing their schoolwork. From the teachers report there was a high rate of school attendance and less absenteeism. It was through teaching and learning that learners were able to understand issues around body development. Teachers in school 2 and 6 indicated that they present lessons about body development as they are. They said "I call a spade a spade", meaning that when it comes to body development in the Foundation Phase they address it according to the age of the children and in grade seven when they address physical development for the boys and girls, they talk about developing hair in private parts and menstruation for girls. One teacher in school 2 believes that education about health can liberate the society.

This was observed in school 6 where the teacher indicated that before the school was there, there was a high pregnancy rate as well as HIV/AIDS. The teacher indicated that but since they started talking about unprotected sex and the danger of it, many children started to be cautious. By the time when data was collected, the teacher indicated that the challenge has been reduced but they have many children in the community who are orphans due to the prevalence of HIV/AIDS in the community.

Throughout all observations, the researcher was longing to see how teachers in their pedagogical practice accommodate learners who have barriers to learning. Teachers are not familiar with the policies and also the issue of curriculum differentiation when it comes to the promotion of health for learners as per the SIAS (2014) policy and the Education White Paper 6 (2001). Throughout the observations, teachers did not indicate if they still have in-services training which are aligned to health promotion in schools, excerpt for only 2, 4 and 5 schools where they still have their in-house training in health promotion.

Teachers use the formal curriculum in the classroom where learners were made aware of many health issues in their lives and in the community. They were made aware of the concern of the community about substance abuse such as alcohol and a drug called “nyaope”. In the teachers’ explanation, many children were coming from broken families where substance abuse was a problem. This was seen when some children would come to school dirty and when they were asked about their parents, they would say they were drunk. The same applies with the substance abuse some parents were reported to be selling drugs for survival. One teacher indicated in the focus group interviews that she met a child holding beer and she engaged the child on what they have learnt in the classroom about alcohol and its consequences. Right there the teacher took the alcohol; send the child to call the parent and the issue was resolves right there.

That shows that the formal curriculum was linked with the informal curriculum where application was done as this showed that the curriculum was designed to approach health issues in a holistic to an extent that learners theoretical understanding was improved (WHO, 1996). In one school, there is a designated area where teachers would use as a smoking area. In another school the teacher indicated that learners in their school know that their teachers do not smoke or drink. According to WHO (1996)

for teachers to be key health promoters in school they need to be thoroughly prepared for their roles at school and also in the community where they can engage parents in what learners do in the classrooms, and that helps learners in their school not to be involved in any substance abuse.

The personal health skills were not applicable to learners only; it also assisted the teachers to be more conscious in and around their environment. During observations in some schools, teachers confessed that they were able to apply what they teach learners to their life experiences and also in their families. The obstacles were parents' attitude in the community who refuses to abstain from their behaviour, which does not promote health.

As part of promoting healthy curriculum on the part of nutrition, teachers reported that parents gained knowledge where they were able to follow the rules in the preparation of a healthy meal. The researcher had an opportunity to visit all nutrition sites and observe parents serving children and also when children were eating. In school 2 and 4, there was a designated area where learners can sit down and eat healthy meals. In addition, before they could do that learners would do what they were taught in the classroom; that is washing their hands before they could eat and after they have eaten, which is part of the formal curriculum.

5.3.1.6 Support and sustainability of the promotion of health in schools

Participants were asked if whether there were any barriers that hinder them from promoting health in the classroom/school. Themes that emerged under this question were**:**

- **Violence in the community and at home**

Participants stated violence as one of the barriers that hinders the promotion of health in schools. They commented as follows:

> *"Or sometimes they have fought. Someone is in jail"* **(Line 149).** *"This community is full of violence. You cannot travel here in the evening, even during the day"* **(Line 150-151).**
>
> *"As teachers in the classroom we can also teach them conflict resolution skills. Cause there is a lot of fighting in this community. Mostly criminal activities are*

here, domestic violence is common. So we experience children who beat others because that is what they observed from their homes as well as in the community. The father when he is drunk he would beat the mother" **(Line 568-572).**

"*You will remember that children always copy anything good or bad. If what they see at home is bad behaviour such as domestic violence, substance abuse, sexual abuse, us as teachers we have to turn that around"* ***(Line 607-609).***

"A burning issue to me is that the community is very violent and negligence" ***(Line766).***

"Mam there is too much violence in our community" ***(Line 1461).***

"These children observe abuse at home, parents are always fighting, there are gangsters in our community. It's not safe" (**Line 1463**).

"Yes they always fight" (**Line 1466**).

- **Teachers are not ready to promote health.**

As the participants continued to share barriers that hinder them from promoting health in school, their state of readiness as promoters of health in schools was shared. Participants commented as follows:

> *"So how are we going to promote health?"(**Line 139**). "We don't know what to do"* (**Line 405**).
>
> *"We cannot do thing things on our own. Here we are expected to be promoters. How are we going to do that? All we know is that we are teachers"* (**Line 509-510**).
>
> "*Us as teachers we do not have any training in the health promotion in school"* (**Line 611**).
>
> "*Although my knowledge about health in school is limited to physical health"* (**Line 612**).
>
> "Mam I don't think we are ready by now to promote health in schools" (**Line 1475**).
>
> "Yes, but I don't think we are ready" (**Line 1477**).
>
> "We try our best you see. But the feeling I have is that it is not yet the right thing" (**Line 1478**).
>
> "I think teaching in the classroom is ok for me. This health promoting thing is complicated" (**Line 1480**).

- **Teachers are frustrated**

Participants shared their frustrations with regard to their roles as promoters of health in schools. They commented as follows:

> "…*we are not very sure if what we are doing is doing something to the community*" **(Line 543).**
>
> "*We often try to connect with the community but as you know how our communities are, we doubt if what we are doing is correct"* **(Line 254-255).**

In addition, other participants echoed their sentiments regarding their role to the community as they said:

> *"The changing communities make it hard if what we are doing as a school is helping anyhow. Our communities are so diverse in a way"* **(Line 257-258).**
>
> *"With all ills in our communities we fail to connect in a big way"* **(Line 13-14).**

"Like today a child came today and she was not feeling good in her private part. It was like you know we couldn't help the child because we cannot check her because the policy does not allow us to do that. She said when she urinates it was painful. This is a grade 2 child, she couldn't walk properly. What do I do as a teacher? In my opinion I think health in school is crucial as well as the promotion of health in school. But the challenge is that there is no clear demarcation as to how it can be done" **(Line 582-587).**

- **Lack of community involvement**

Participants indicated the lack of community involvement as one of the barrier. They commented as follows:

"The community where we are is not supportive. You heard about the vandalism issue where the people in the community can come and steal even the feeding scheme food… Therefore it means that for that month it will be a struggle" **(Line 737-739).**

"The other challenge is the use of substance abuse here in this community. At school, we are teaching that it is not healthy to use drugs, but at home, one parent is using them, either alcohol. Sometimes these children are sent to buy alcohol. I am not sure if whether are they aware of the notice that it is not for sale to people younger than 18. With drugs, children are useful careers because they cannot be suspected easily. It is heart breaking to see the community being destroyed from the roots. We teach them not to try substances because they destroy lives. But at home it's a different message" **(Line 742-748).**

- **Unclear involvement by the Department of Basic Education (DBE)**

According to the participants, support from the education department seems to be at its lowest. They commented as follows:

"Look in this project there are three departments which are involved. Only the Department of Health is responsible, the [Department of] Basic Education is partially involved. It's partially because us as teachers we do not have any training in the health promotion in school. Even though we have serious problems which children are experiencing we cannot do much because we

have no particular training in health issues excerpt for the fact that we teach Life Orientation or Life skills" **(Line 748-755).**

"Mam I think we are not getting support from the district. When they come, they only concentrate on the curriculum. They don't care about this health promotion. So I think it's a problem" **(Line 132-134).**

"It is a problem mam. The only thing they want is what we do in the classroom. That tells me there is a problem. I question their support so to say" **(Line 136-137).**

"I think this project is a Provincial thing. Even today as I am speaking mam we have not received the curriculum material. So how are we going to promote health?" **(Line 138-139).**

"Yes mam. I think the support we get from the department is not enough. We are not sure if whether what we are doing is right or not? Since JICA left we do not see any progress like before. We don't know what to do" **(Line 403-405).**

- **Lack of parental involvement**

Participants cited parental involvement as one of the barriers. They commented as follows:

"….this is a very poor community, where you find that a child doesn't brush the teeth" **(Line 141).**

"even bathing" **(Line 143).**

"the child's clothes itself is dirty. On a Monday, on a Monday (stressing the point) it's sad" **(Line 144-145).**

"I don't think it's the poorness of them (parents). Even they are irresponsible. Because some of them they drink. Some of them they work very late they come back home very late, meaning the parents" **(Line 154-156)**.

The participant continued to say:

"You give them uniform today, tomorrow it's not there. I don't know if they sell or what" ***(Line 157).***

When the participant was probed further if whether they were winning with regard to the issue of parental involvement, the participant said:

"It's a losing battle" "our school is situated in a community that is less fortunate and that hinders the teaching of health in the classroom as these are not practicable. "….cultural background of a learner plays a vital role as not every

learner believes in the same things that are taught. This is also affected by the belief from different families" **(Line 406-409)**.

- **Lack of resources to promote health**

They commented as follows:

"We have BMW which is assisting with us with Technology and in that projects we also involve a-a learners, teachers and teachers and then we are also hands on with ABI which is recycling, cleaning the environment. We also hands on with "Batsha le metse" water and sanitation project which teaches children to take care of water to learn how to wash their hands, to know the importance of water" **(Line 417-421).**

"Ya I think the barriers, like mam said the water. That's one of them because if you don't have water you cannot clean the toilets, you cannot clean the classroom" **(Line 165-166)**.

"*Then other thing if we can get enough dustbin where they can make those cleans one's for each grade (she wanted to say recycling) and then they know when it's after break there is a bin next to our class we put the papers there"* **(Line 183-185).**

I addition to the resources, the lack of human resource was mentioned as well as the resources which were to be delivered in schools. "To reach to a point where the psychologist is involved you might have done a lot of admin work which gives evidence about the child. And that is very difficult on the side of teachers to do that and that means children can be neglected for a long time. The other difficult thing is that even when the whole process of intervention has been done, the referral services become difficult and that applies to placement of learners in a particular school" **(Line 759- 764).**

"late delivery" **(Line 992).**

- **Health promotion is not aligned to the school curriculum**

HPS for teachers is seen as something that is not closely linked to the curriculum as a whole, However it is seen as follows:

> *"For me is just a lot of paper work. The way teachers are handling curriculum delivery sometimes it sort of take you from the target. Management encourages us to be in the classroom and less outside". On the other hand life skills was seen as a vehicle which drives health promotion within the curriculum"* **(Line 1507-1510).**

To some participants although HPS is not aligned to the curriculum. They commented as follows:

> *"It is helping because mostly health issues are addressed. Issues such as; HIV/AIDS, hygiene, nutrition and many other issues"* **(Line 1512-1513).**
>
> *"Can you see the system we are using is not like the oldest one? Because with that, you were able to install the knowledge to a learner. In the morning, I must wake up, open the windows, brush my teeth wash my body. The day will pass be unable to see your class"* **(Line 1524-1526).**

Although schools were trying their best to promote health in schools, the issues of support and sustainability were critical in the promotion of health in schools as a goal of the DoH (2011) to sustain health in schools. It was indicated several times that all stakeholders were fully involved in the promotion of health in schools even when the roles of the teachers were not clear. The literature findings revealed that holistic programmes that continued for a longer period tend to be more successful, than targeted interventions that were more time limited (Quirke, 2015). The difficulty faced by teachers though was that health promotion in schools was meant for certain period of time and that it was funded by an international organisation (Sizanang Centre for Research and Development, 2007).

The project in the Gauteng Province was funded by JICA and it was meant for three years. After three years when JICA pulled out, that is where teachers felt that there was a lack of support from the remaining structures and stakeholders. The main barrier to promote health in schools is the lack of support. Support from the Gauteng DBE, Health and Social Development as well as the community and the sustainability of

health in schools. The findings by Freire (1972) indicated that projects which are supported by external agencies are difficult to sustain afterwards. This was also confirmed by Mohamed (2015).

One of the barriers which teachers were worried about at school and in their classroom was the issue of violence in the community, which often manifest at school. Where learners would fight or bully other children. This would have been triggered by what they observe at home where parents would fight each other (see section 3.9). The use of substance abuse in the community as well as any kind of abuse has been reported in a number of schools where some learners would show signs of sexual abuse. The unfortunate thing would be that teachers were not able to investigate further but to report the issue either to social worker assigned for the school. Teachers reported that other stakeholders would take time to attend to the matter and sometimes they could not find any feedback.

Teachers' knowledge about health promotion was limited to physical health (Mashau, 2011). Hence they continued to indicate that they lack a proper training on how to promote health in schools. Health promotion by teachers in school was seen as something complicated to be done by teachers. In a number of responses teachers felt that they were not ready to promote health in schools. The research done by Quirke (2015) confirmed that support is one of the barriers that can affect teacher readiness in the promotion of health in schools.

In school 5 they shared their frustration because they were literally using the municipality water where the bill was paid by the DBE to maintain their garden. They were advised to use less water because their bill was too high. This totally rejects the roles of the provincial and district authority to advocate with the local government on water supply and sanitation (see Table 2.4) and it has affected the hygiene practice of the school. During the time of the interviews they were engaging the Department to provide a borehole for them to make it easier to continue with their daily activities. Teachers also indicated their frustrations in terms of how they should work with the community as they were not sure if they were doing the right thing. Table 2.4 indicated that the community will be equipped to understand issues around health promotion to make it easier to be involved (DoH, 2011). However, during the interviews teachers

indicated their difficulty in involving them. Clelland *et al*., (2013) highlighted that teachers always get frustrated often when they do not how to involve parents in the community. From the researcher's observation, teachers showed signs of frustration. Teachers' expressions indicated that they did not know what to do concerning health promotion in school excerpt for gardening and hygiene issues. Even though teachers were willing to promote health, there were not receiving proper support from the district. In two schools, the borehole thermostat was stolen and in some cases, the usage of water was restricted. Above all, they indicated the frustration in terms of working with parents and the community at large.

Within the community there were a number of activities which were not supportive of HPS such as vandalism, substance abuse, and children negligence and violence (see section 3.9). What was taught in schools was not what the community was teaching its children. To a certain extent food from the feeding scheme was stolen over and over again and that had an effect on the nutrition at school. From the researcher's observation, partnership with schools and the community was encouraged to ensure sustainability of health promotion within the school although it was hard for schools to do so. As part of health promotion framework to empower the community, in all schools, members of the community were involved in the community projects such as the feeding scheme, where they cook for school children without any earnings; gardening where they work in the garden and receive some vegetables to feed their families and the Extended Public Works Programme (EPWP) programme where the community members were working in schools but get earnings from the Department of Public Works. Involving parents in the school projects was done to eliminate poverty and unemployment within the community. What teachers find so hard was to listen to the needs of the community and how they would like them to be involved.

Most teachers were hesitant when it comes to involving the community, because they doubted if whether parents would promote the goals of the school. In this regard, teachers were not aware where and when they should draw a line. Teachers in schools were aware that the involvement of the parents is key to the success of a health promoting school. In school 4 and 5, teachers indicated that in the beginning of every year they have meetings that are scheduled to inform parents about the school's expectation with regard to the issues of health, which affect children. Although it is

very important for parents to be involved, teachers find it difficult to involve parents fully in school activities and projects.

Besides the changes in the community, there were also some challenges which were experienced and that include difficulty in establishing new links with the NGO's besides BMW, Dettol, "Batsha le metse project" (Youth and Water project) which have been partnering with the schools since the inception of health promotion in schools. There were schools that were in impoverished areas where community participation in schools was lacking. The community in school 1 and 3 instead of protecting their schools, it was reported that there were serious cases of vandalism where feeding scheme food was stolen several times.
Some teachers indicated that the health promotion project was disengaged before they could understand their roles. The SIAS policy and the ISHP (2012) indicated how the three departments get to be involved in the promotion of health in schools and that was not taking place during the time when the teachers were interviewed. One of the purposes of promoting health in schools was to develop the LTSM. It was indicated a number of times in the evaluation document that they would and they were going to develop LTSM.

The final evaluation report document indicated that there were no LTSM materials produced (2010). None of the report ever indicated that material for teaching and learning for HPS were produced and they were utilised in schools. This could be the general approach of the program where it was too wide and that the main focus was on health issues which required medical attention (Quirke, 2015).

The only LTSM (Learning and Teaching Support Material) which the researcher could get hold of from the schools was the Basic School Gardening: Teachers Manual. It is the output of the project and it forms part of the LTSM which were produced for the purpose of empowering schools in the knowledge and skill of producing vegetables which then will be used to supplement nutrition at schools as well as to provide for learners from poor background. This document is aligned with all the learners' books (Basic School Gardening: Learners Activity book. Foundation phase; Basic School Gardening: Learners Activity book. Intermediate phase and Basic School Gardening: Learners Activity book. Senior Phase) which provides knowledge in gardening. All

teachers in all six schools registered their dissatisfaction regarding the support they received from the province, district and the community. It was observed in some schools wherein the gardens were without vegetables or there were no resources to do gardening. This lack of collaboration was seen when the health professionals would visit the school (Kwatubana & Kheswa, 2014) once in a while or when there is an outbreak of a disease in the province and when the health professionals would come and disrupt the school program without negotiating with the schools.

Their role of giving advice to schools was not seen (Renwick, 2006). And to an extent this lack of collaboration makes teachers not to be comfortable to participate in the promotion of health because it did not count as part of the curriculum. They indicated that when the district officials visited their schools, they did not take cognisance of HPS programmes in schools. Now that Life Orientation was used as a vehicle to promote health in schools, there were two things which could also contribute in the lack of support from officials and also from teachers themselves. The first one was the time allocated in the classroom was very little and that Life Orientation was not a promotional subject even in the Further Education and Training (CAPS, 2012).

Poor support from the provincial and district officials in the DBE did not only affect the teachers in schools it has also affected parents (Mohammed, 2015), and one could understand that if teachers were incompetent about their roles how then could parents have confidence to be involved in such a program Mashau (2011). In two schools where they practice the activities of HPS it was reported that parents were helping on the feeding scheme, gardening and cleaning of the classrooms. However teachers were failing to give parents an opportunity to say how they would like to contribute and before they could do that it could be fitting that they would be trained by schools to have a better understanding (see 3.9.2.1).

Participants indicated there was a lack of resources to promote health. These resources according to (Kwatubana & Kheswa, 2014; ISHP, 2012; DoH, 2011, Mohamed, 2015) are human and capital resources. Some schools were reported to have challenges with water that seemed to affect the health of learners, since the routine of washing hands before they could eat or coming back from bathrooms was not possible because of lack of water which at two schools where the community was

not involved it was reported that the thermostat of the borehole was stolen. The principal and the SMT were regarded as the resource for health promotion in schools (Quirke, 2015). But in this case due to the management's lack of understanding teachers find it hard to promote health in schools (Shung-King, 2013; Kwatubana & Kheswa, 2014).

Teachers indicated another barrier as the disintegration of HPS from the entire curriculum. Teachers also complained on the fact that when district officials conduct their visit in schools they do not care about what they are doing in HPS, their focus is on curriculum and nothing else (Kwatubana, 2018). The rigid and inflexible curriculum and its inability to cater for learners complete health did not contribute in the promotion of health in schools (Ntagungira, 2014). The integration of HPS activities and the entire curriculum was still much lacking and they wondered how it could be done. The findings by Quirke (2015) indicated that teachers struggle to integrate health promotion and the curriculum. In Table 2.5 the roles of the national, provincial as well as the district is to ensure that there is time allocation for extra-curricular activities for the implementation of health promotion and health education.

The only time they have at school was when they were in the classroom and again they saw HPS as something additional to their role of teaching (Weare, 2000). Many issues are handled by stakeholders outside the schools such as health professionals, Department of Agricultural and the NGO's.

5.3.1.7 Leadership and management of health promotion in schools

Participants were asked: In what ways do you counteract/overcome these barriers in the promotion of health in the classroom/school? The following sub-themes emerged:

- **The provision of resources that promotes health**

Participants noted that the solution could be brought about if there are resources available to promote health. They commented as follows:

> *"For now I don't think we will overcome this thing unless if we have a necessary equipment, like water and then we have people who can come and just address the kids because we always do that"* **(Line 208-210).**
>
> *"To save water, we encourage them (learners) to use squeeze bottles instead of running taps"* **(Line 459).**
>
> *"I think we need human resources to provide support on how we as teachers can promote health for the success of our school"* ***(Line 212-213)***
>
> *"Just to add on that we also need the teaching material for that matter. Since they promise to develop material we are still waiting"* **(Line 214-215).**
>
> *"Our schools are very poor we need support on the resources we can use to promote health"* **(Line 461- 462).**
>
> "*Doing health promotion without the relevant resources is a challenge. I can say we need the resources"* **(Line 1013-1014).**
>
> *"I understand we are not health practitioners, but with the little support in terms of resources I think we can try our best"* **(Line 1229-1230).**
>
> *To mitigate the challenges experienced by feeding schemes and to supplement nutrition, which is part of the health promoting school framework in Gauteng, participants have their own way to support learners. "We try to incorporate the SNP (School Nutrition Program) and food gardening through the issuing of food parcels to take home, vegetables to take home sometimes on Friday. But it is still not enough, because they would just eat for the weekend, and what happens during the week"* **(Line 463-466).**
>
> "*We go outside and then they borrow us 1kg of rice, borrow us 2.5 of maize-meal when the delivery comes we will send them back. It is how we overcome. When our garden is flourishing, it helps us a lot because we forget about our neighbours. Carrots we pick from the garden"* **(Line 1017-1020).**

- **Parental/ Community involvement**

Participants called for the involvement of parents. They commented as follows:

> *"If we were working together with parents things gonna be simple….."* (**Line 217)*.***
>
> *"We need the community on board"* **(Line 467)**.
>
> *"I think with regard to parents who are negligence we try to invite them to meetings, even one on one kind of meetings to show them the importance of caring for their children. For those living with their grandparents who cannot help with homework; we advise them to find someone to help"* **(Line 790-793).**

And in case where the school experiences urgent medical attention where a learner is in a critical condition the school gives support. They commented as follows:

> *"Mam if the case is very urgent we, we step-in as the school"* ***(Line 1023).***
>
> *"Communications at all times whether its good or bad"* **(Line 1232).**
>
> *"The issue of vandalism we try to involve the police to educate the community about that"* **(Line 795-796)*.***

- **Need for health promotion training from the Department of Basic Education (DBE)**

The issues of training were mentioned as a way to overcome the barriers that hinder the promotion of health in school. They commented as follows:

> *"We need training, that's all"* **(Line 219).**
>
> *"I would suggest serious training from the department because as far as I remember, the project collapsed still at its infancy. I cannot tell if whether I am a health promoter or not. Because it is all about nurses and nurses"* **(Line 469-471).**
>
> *"I support what mam said, we really need training"* **(Line 475).**
>
> *"The most important thing we need as teachers is to be fully trained that we can take our responsibilities seriously. The only thing I know about health promoting schools is hygiene, environment and partnership with the community, nothing more"* **(Line 803-805).**

"You can say that again. We need to know how we can work in harmony with the community. So we need training since we sometimes differ with parents" **(Line 806-807).**

"I think if we are to promote health in school as teachers, we need training by the DBE. Remember we are teaching practitioners. We are not familiar with the health concept" **(Line 1024-1026).**

"I think we would be grateful to know that there is a health promoting school training somewhere. We could see that it is good to promote health in school. Our school is better than before and if we can all be trained I am telling you our school would be in the better than it is" **(Line 1234-1237).**

- **To align health promotion with the curriculum**

The participants also raised the alignment of curriculum to health promotion. They commented as follows:

"I think health promoting school need to be integrated with the whole school curriculum and not an extra task for teachers" **(Line 220-221).**

"I have a feeling that health promoting school cannot be addressed through Life Orientation only, everybody must be involved" **(Line 477-478).**

"You are right; remember it was only Life Orientation teachers who were attending the meetings with the stakeholders" **(Line 479-480).**

"For me before I saw it happening because I had a lot of meetings from 2009 since the inception of the HPS with a lot of stakeholders I didn't understand what was happening. I thought maybe it was the clinic which was coming but now what I have learnt is that it is the stakeholders responsibility; The Social Development, the Health Department, Education Department, and other stakeholders like companies like Agricultural they have to come together to promote the health for the livelihood of everybody in the school and take it out into the community so that they must be at the same level" **(Line 1549-1555).**

"I think if the department can really manage the program and take leadership and reduce this paperwork. We are doing too much paper work" **(Line 1556-1557).**

"Let's say if we have to sustain what we got from JICA. Then that means that we have to do that even during school hours cause that is what we need to do with the children during school time. So, in my opinion I think it was supposed

to be infused within the curriculum so that it cannot be seen as something that is out there. Now the problem is that if we do that during school hours, then it's like we are abandoning our classes, abandoning our job to teach. Thinking about that sometimes demoralises us" **(Line 1559-1564).**

Teachers were aware that on the barriers, which they were experiencing there was supposed to be a solution for health promotion to be successful. As such, they mentioned the following issues that required attention.

The findings in the literature review indicated that resources were very important in the promotion of health (Mohamed, 2015). In the first place, teachers mentioned that they needed resources that promote health. Since they have gardens in their schools, they indicated that they need water to promote health in issues of gardening and hygiene. Without water, they indicated that it would be hard to promote health. This was experienced by school 1 and 3 where the pump was stolen and they were not able to have running water to use in their toilets and to use for their gardens. From the observations in these two schools there were no vegetables in their gardens.

The same expression of water was shared by school 5 where they indicated that from the district they were requested to use less water in their health promotion activities. Table 2.5 indicated that national and the provincial departments of health and education will have to advocate with relevant local government on the matters regarding resources (DoH, 2011). So, as a way to overcome the usage of water in school 4 and 5 they encouraged learners to use squeeze bottles for drinking water. However, in school 4 they discouraged the use of basins for water to wash hands since they indicated that they would like to avoid the spread of contagious diseases. From the researchers' observation, there were signs of lack of resources ranging from human to capital resources. Teachers indicated that there was no one showing them what to do as teachers in terms of promoting health in schools, and that has caused them a lot of strain because they were expected to promote health but without resources to do so. In some schools, it was indicated that they lacked resources such as water mainly used for hygiene purposes, dustbins and community stakeholders who can support schools in their endeavour to promote health in schools.

In terms of food they indicated that they supplement what they have received from the Nutrition program by the vegetables they have in their gardens and sometimes if the delivery was late they borrow from the neighbouring school basically because they want to teach learners who are not hungry. The findings revealed that there could be no education, that can be offered to hungry children (Leahy *et al*., 2016; Sawaya, 2006).

Moreover, teachers indicated that most of their challenges could be mitigated by human resources that could help in the support for teachers as promoters of health in schools (see 2.9.2). In the document analysis, it has been indicated that there was a lack of shared vision between the participating departments (education, health and social development) and that led to poor leadership in terms of administration. This has been observed when the researcher requested for the information in the development of health promotion in schools in the Gauteng DBE; such information was not available. The findings revealed that effective leadership and management were the essential requirements for quality education and school development (Bush, 2007).

A lack of collaboration and coordination between the departments had a serious implication in how teachers can promote health in schools. A research done by Mohlabi *et al*., (2010) in Mpumalanga and Gauteng schools indicated that collaboration between the departments were a challenging effect in the promotion of health in schools. The collaboration between the departments lacked the ability to provide enough resources and understanding to schools (Mohamed, 2015). This was also confirmed by Kwatubana & Kheswa (2014), in their research that resources were a problem in the promotion of health in schools. To break down their challenges, teachers indicated if they could receive support from the principal as well as the management team, it could make their participation a lot easier, because due to lack of understanding they were not receiving much support from them, whereas Mohamed (2015) indicated that the involvement of principal is very important in the provision of resources to promote health in schools.

In school 4 and 5 teachers praised the support they received from their principals where the principal in school 4 would go an extra mile to get food for the learners and

even to visit those who are sick to ensure that they receive full support from school. In school 3 teachers indicated that health promotion was known to few teachers whom the principal had chosen and in school 6 teachers indicated that they were not receiving any support from the principal. There were resources which they needed but the principal was not providing such. In all schools they requested the support of the principal, the SMT, the SBST as well as the DSBT, but it was very minimal.

From the observation there were no LTSM that teachers could use in their classrooms to teach health promotion. This has been confirmed in the document analysis where the issue of LTSM was reported not to be available. Teachers indicated that if the resources could be available it will help in the understanding and delivery of health in their school.

The issue of the involvement of parents and the community in supporting what schools were doing in the promotion of health was a critical issue (Mohammed, 2015), hence teachers stressed that communication with parents was very important. Teachers indicated that in cases where learners were taken care of by their grandparents, it would be ideal to get someone who will assist in home works. It was also indicated that the school will act in *loco parentis* in case where the case was critical. Over and above, the teachers indicated that they need parents and the community on board as it would be the solution to many of the health problems in schools and at the community. The findings revealed that parents were critical for the promotion of health in schools, However schools find it difficult to involve them (Mohammed, 2015). Mohamed suggested that it could be the negative factors they could have experienced during their school time (Mohamed, 2015). In the findings McNab (2009) revealed that parents of learners who experience barriers to learning were critical for educational change process.

In a number of responses teachers indicated that there was a need for training for teachers from the DBE. The literature review findings revealed there was a need for training (Mohamed, 2015). The document analysis indicated that training has been done to prepare teachers to be promoters of health. Moreover, teachers indicated that the training was inadequate for them to promote health. Again, the document indicated that the training was done to sustain health promotion by schools (DoH, 2011). The

request by teachers for training confirmed that indeed there was a need for training of teachers by the DBE.

The lack of support from the principals, School Management Team, SBST as well as the DBST was seen as the lack of proper training from the DBE where all structures were not effective in the promotion of health in schools (see Table 2.5). The document analysis in the Baseline study in 2006 indicated that the Gauteng DBE was not aware of the health promotion in schools program and that had an impact in how the department would capacitate its structures in the promotion of health in schools. The need for training was a genuine concern for teachers which would require a serious attention.

Apart from the training in health promotion which the teachers would require so much, it was also indicated that there was a need for alignment of the whole school curriculum with the health promotion program. The idea of Life Orientation/Life Skills teachers to be called promoters of health was critical for the promotion of health in the whole school, however it was suggested that all teachers need to be involved. The issue of infusing health promotion to the curriculum was not there basically because district officials in their visit they would only request for curriculum work and exclude what teachers were doing as health promotion in the classroom. The findings in Table 2.5 revealed that there would be an infusion of health promotion activities to curriculum.

Apart from that teachers indicated that there was too much administration instead of supporting the learners. This was said because teachers indicated that they have to complete SNA1 form and SNA2 forms to show that they support learners in their classrooms (DBE, 2014). But, there was a need to align what they were doing in the classroom as health promotion to the total curriculum. This would include the curriculum differentiation and the understanding of health issues in and around school. The HPS Models (HPS) did not specifically indicate the infusion of health promotion in the curriculum. However, health promotion was done according to the needs of each country.

5.3.1.8 The need to promote health and well-being for teachers

Participants were asked if there was anything that they would like to add on in terms of the promotion of health in the classroom/school? The sub-themes that emerged were:

- **The DBE to be more involved in health promotion in schools**

In addition to anything that the participants would like to add regarding health promotion in schools, the following suggestions were made:

"If the government can make road show for the communities" **(Line 228).**

"Government can stop providing things for free" **(Line 229)."**

"*I believe that if the government can take the lead and show teachers how they need to be involved in the promotion of health I think teachers can also have confidence in doing so because then the government would be hands on"* (**Line 812-814).**

"*The health concept is critical in school especially because the DBE is silent about it. What we see it's the nurses who are coming for screening of learners. We do not know what to do"* **(Line 1243-1245).**

"*What we need is the Department of basic education to lead this program fully"* **(Line 1033).**

- **Proposal for the entire schools in the Gauteng Province to be health promoting**

The benefits of health promoting school seen from one of the bench mark school participant is that if maybe. They commented as follows:

> *"The entire provincial schools could be given an opportunity, perhaps through meetings and workshops and involvement that everybody, everybody takes it up because it improves the general lives of the teachers, the parents and the entire community at large. And it has some influences in the community as it has some influences in the school"* **(Line 485-488).**

In addition another participant suggest that if all the services were provided literally in schools like before the school was going to benefit. She commented as follows:

"My view is that it can be a good thing provided we all have the services around here at school" **(Line 230-231).**

Owing to positive results of what a health promoting school can do in schools and in the community, this participant put a very strong suggestion. She commented as follows:

"I don't know where it has ended. But if it could be re-started all over again, and I have an opportunity to be invited into the meeting or the workshop I was then request whosoever being in charge to say can't we make this to be a provincial thing?" **(Line 490-492)**

Although the participant is leading a school, which is very successful in terms of HPS, the participant is pleading that this should be rolled out in the whole province for teachers to learn from each other. In other words, schools should work together towards a better state of their being. They commented as follows:

"And so that we do not compete in a way. But we take whatever that is a good practice across, the province and across the schools. whatever we experience let the learners just next door experience the same and we all become health promoting schools because these are the things that we need as we need an oxygen" **(Line 494-497).**

- **Request for the provision of health services for teachers by the DBE**

Teachers acknowledged that although HPS programme is designed to promote the health of learners in schools they also need support in order to be productive. Their understanding is that if they are healthy physically and emotionally they are an important asset to the school. In their words they said:

"I think the department need to take its teachers seriously by providing health services in school. I mean for teachers as well" (**Line 233-234).**

"I agree with the previous speaker because sometimes we have our own problems. How do you think we can cope in the classrooms" **(Line 235-236).**

"I think the department need to think about us as teachers. We do have problems of our own. The fact that we are teaching children about health doesn't mean that we are aware ourselves. How many teachers who are resigning because of stress? You know mam that we earn less and if they are just throwing their programmes how do we cope? We will be absent every now

and then. But if the government is uplifting our health, I am telling we will be happy teachers who are able to influence the learners in our classrooms" **(Line 499-504).**

"We need awareness programme, our morale is down mam. Teaching has lost its value I must say. We cannot do thing things on our own. Here we are expected to be promoters. How are we going to do that? All we know is that we are teachers" **(Line 508-510).**

"I would like to add something which was not asked, and that is the health and well-being of teachers. No one is worried about our health. As long as the learners are excelling academically the department is satisfied. Teachers are the ones who have many problems" **(Line 1035-1037).**

- **A need for teachers to be trained in health promotion**

One participant felt that they still need more training on how they can promote health in schools and also to know how they can incorporate HPS into the curriculum. He commented as follows:

"As much as we are the health promoting pilot school, I feel we are not yet there. We still have challenges as to how can we incorporate health promoting school into our curriculum?" **(Line 1041-1043).**

A further sense of concern with regard to the training that was offered .They commented as follows:

"Again mam, I think we need clear guidelines with regard to the smooth running of the health promoting school program. These people I think they feel that they have trained us and it is enough we can run on our own. Honestly I feel we still need support to do things right and not touch and go kind of interaction. We used to have meetings in the earliest stages of this program. Before we know it mam, everything just collapses" **(Line 1047-1051).**

"We are a health promoting school we did not stop because JICA went away. We don't know what happened to the program, and no one came to us and told us what to do" **(Line 1262-1263).**

- **Approach health promotion from schools (a bottom-up approach)**

The willingness for teachers to take their roles as promoters of health in schools is also determined by the approach taken by the DBE. One participant said:

> *"I am not giving up but I mean there is nothing we can do everything comes from up there we only do what the policy say we must do. Mam you will understand that there are levels of authority and we are at the bottom of these levels. From National, Province, District, Cluster and schools"* (**Line 1267-1270**).
>
> *"…..But I think that before any program can be introduced in schools, people from the district need to listen to the teachers first or allow us to address the issues within our schools and then they can give us support from there" (***Line 818-820**).
>
> *"I agree. It has to begin with the teacher*" (**Line 822**).

In addition one participant showed great concern on how the project was run structurally. They commented as follows:

> *"Suppose they need to begin with the teachers and not from the Department. I mean from the top". …… Yes. That's what I mean. They bring their programmes after that you don't know much about the progress"* (**Line 1053-1055**).

For the promotion of health to be possible in schools, it has to begin with the promotion of health for teachers (Marx *et al*., 1998). Health promotion for teachers is critical in the whole school. However it was imperative for teachers to promote health alone and by themselves, therefore they needed support from the higher authority (Quirke, 2015); starting from the department to the principals. From what teachers observed it was noted that in addition to what they have mentioned before during the interviews, the issues of concern were mentioned again, and these issues were:

The manner in which health promotion was practiced in schools was quite confusing for teachers, because it all they could see was the school health nurses who were coming for screening of learners and nothing more (Kwatubana & Kheswa, 2014). The DBE was perceived as silent, because according to the teachers as it has already been indicated they lacked training from the department (Kwatubana, 2014).

To promote the health of teachers it was noted that through meetings and workshops where teachers would voice their opinion with regard to health promotion in their

schools would in a way promote their health as well. For schools where teachers were observing the benefits of health promotion it was suggested that to solve some of these problems, it would be ideal for all schools in the GDE to copy the good practice from each other where teachers could learn from the neighbouring schools. The document analysis indicated that the aim of HPS in the Gauteng Province was to ensure that all schools should become health promoting even though the aims were not achieved (Evaluation document, 2010).

Health promotion in schools is done to promote the health of learners and teachers as well (WHO, 2006). However, in many instance it is the promotion of learners' health that was taken into consideration. However, this could not be possible if health services for teachers were not taken care of. This includes the need for teachers to promote health in schools. Their understanding of health concepts; as well as their own health is important if they have to promote the health of learners in schools (Marx *et al*., 1998). Due to a load of work many teachers find themselves stressed and sometimes they were found to be absent many times as they try to attend to their own health (Renwick, 2006; Quirke, 215). The suggestion was that it would be ideal to have health service providers within the schools so that teachers could access the services without any absenteeism from school.

The health promoting school conceptual framework described in this study did not have the element of health promotion for staff. The same applies with the Gauteng HPS model did not have promotion for staff. Moreover, this is the critical component since it focused specifically on teachers. This component covers things such as in-service training, workshops, health, and well-being for teachers and professional development. From the literature and WHO's declaration the purpose of promoting health in schools is to promote health for learners as well as the school community. Moreover, according to the researchers view teachers' are main gatekeepers. Before any research could reach the learners, teachers need to be prepared mentally, emotionally and psychologically.

Teachers in these schools felt so helpless when it comes to how they can promote health without the health professionals or without JICA for that matter. Their frustration was felt when they shared experiences such as, when is JICA coming back, we are not health professionals, we did not receive much training, one school principal in

school 1 indicated that the aims and objectives of the program were lost right from the start because health aims and objectives were growing further away from each other to a point where it was confusing as to how it was supposed to be done.

Teachers indicated that the project was done within their schools but they did not understand their roles after all since people from outside, meaning people did everything from the province, district and other stakeholders. From what I have observed teachers seem to follow anything brought to them by the department without much understanding. Most of the teachers when they were engaged during informal discussion they indicated that the top-down model is not a good thing for schools, rather the province should work together with schools.

Teachers felt the need to have staff wellness programmes in their schools so that they can have access to health services as well. Their need for teacher's health promotion affirmed what Marx *et al*., (1998) confirm to say, "teachers and staff who are healthy, both emotionally and physically – are an invaluable asset to school". They continue to say not only to school but to the entire school community. One teacher said it is not a must but it is a right, bearing in mind that they work with learners, parents and the community. During the data collection period, in all HPS there were no services directed towards teacher wellness.

Above all, in school 1, 3 and 6 teachers indicated that they were not receiving any support from the principal. There was no time set aside to promote health outside the classroom and they lacked knowledge about the promotion of health in their classrooms.

Through the interviews, teachers indicated the need to be trained in health promotion so that they can understand their roles as promoters of health in schools. Besides the training of teachers as one of the benchmark requirements (see 2.10.5) Teachers acknowledged the little knowledge they had but they felt the need for more training so that they would be able to know how they would incorporate health promotion in their pedagogical practice (see 3.5). To this extent teachers were saying they were not yet ready to promote health However they would appreciate training in line to that. Hence, Mohamed (2015) indicated the importance of teacher readiness (see 3.4.1).

One pressing issue was the top down approach to health promotion where there was a role played by the national departments, provincial departments, district, cluster and to the schools (See table 2.5). Teachers indicated that it would be good that before any program was introduced in schools, people from the district should listen to the teachers first and allow them to address health issues within their school and from there they can give them the needed support, unlike to give support which is not aligned to the needs of the school.

Literature indicated that at some point the top-down approach leaves trail of poor management (Mohamed, 2015), whereas Fink and Stoll, (1998) indicated that it would work better if the larger system (national and provincial departments), would provide direction and support. Gleddie (2011) argued that both top-down or bottom-up processes are useful for the implementation of health promotion basically because the manner in which the program is coordinated and managed at a higher level is as important as the buy-in from everyone on the ground.

This suggestion came about because teachers noted that there have been so many programmes which were initiated in their schools but they did not have any idea about the sustainability of such programmes (Adelman & Taylor, 2003). The initiative to promote health in schools according to the DoH (2011) was to make sure that schools were able to run their own health issues and then receive support from all stakeholders (Quirke, 2015). The issues of sustainability did not happen in schools, hence the program has just collapsed and the teachers' role was not defined.

From the researchers observation, policies were not utilised very well in schools hence teachers find it hard to support learners in the classroom. The other difficulty was that teachers find it very hard to interpret and to implement the policy. Teachers agreed that policies guide how they should promote health in schools, but they did not have a better understanding.

5.4 IMPLICATIONS FOR HEALTH PROMOTION IN SCHOOLS

The promotion of health in schools is one thing that cannot be ignored anymore because the health of children is very important for their learning. The shift from an individual learner to focus on the settings where learners are developing has called for

the whole system of education to move towards the improvement of settings to building the capacity of teachers in schools. Through the HPS program the focus is on the components which can highly contribute on the health and well-being of learners. Most importantly the collaboration between the three Departments makes it easy to attend to the health needs of learners because of the shared responsibility. The shared responsibility among the stakeholders including the NGO does strengthen the activities which are done within schools.

Research has proven that schools are best settings to promote health in schools Jourdan *et al*., 2010a; St Leger, 1998) because this is where services are integrated and also the fact that schools can influence the community through children. In addition children who are in HPS are cared for by teachers who have an understanding that children‘s barriers to learning do not occur in isolation, multiple systems within their environment plays a role which can build or break their future. Schools which are health promoting respond to the challenges within their school community in a proactive manner because already they understand what needs to be done.

HPS success lies in the whole school development though where all staff members are participating to ensure that teaching and learning, school environment as well as community partnership were highly taken into consideration. The health promotion implication for teachers and learners were discussed below.

5.4.1 Implications for teachers

For the success of the HPS teachers need to be central in the program (St Leger, 1998). When the misconception about the understanding of health promoting school is cleared teachers begin to understand that although they are teaching practitioners they can still promote health in schools. Under the impression that teachers want to teach learners who are healthy they are willing to go an extra mile to ensure that the complete health of learners is achieved. In most cases research has indicated that often teachers are resistance to programmes which are brought for implementation in their school and they also display certain attitude which hampers the development of the program.

After a rigorous research on HPS research revealed that under normal circumstances when teachers are not familiar or when they do not see any educational benefit in the programme they tend to resist the initiative and at some point display some attitude towards the program. Hopefully when they see the benefits of the programme they become more resilient and ensure that they sustain the program even when it could mean that they do not have enough support and resources, and this has been observed in the successful pilot school where the researcher spent many hours of research within the schools and with the participants. Although in some schools they were indicating the need for restarting the health promotion in schools which was not possible at all because it was done and the schools were expected to maintain that. In these schools teachers were so excited about the health promotion programme and the changes they see in their schools.

Through the programme teachers' health was reported to have improved totally although this was done with little effort from both departments because their focus is not on teachers it is basically on learners. Before the initiation of the programme teachers were reported to be demoralised with the work environments where there was less teaching and learning resources, dilapidated classrooms which were also overcrowded as well as dirty school yards. But through the inception of the programme teachers are aware that the environment also contributes to the health of learners as well as theirs.

The nutrition programme which was initiated in quintile 1 & 3 where the surrounding communities were reported to be high on poverty and unemployment, teachers knew very well that learners who are hungry cannot learn well. So they made it to themselves that all learners should receive breakfast at school before they start with their classes and also receive lunch during breaks and in some schools learners who are very poor have been identified as the receivers of food parcels which were provided by the NGO'S within the community and some receive vegetables from their gardens.

Owing to low socio-economic status in the surrounding communities and the changes in the state of families where many children have single parent, or they were looked after by the guardians because they are orphans which in some instances also led to child-headed families, many children's behaviour was troublesome. But with the

support from teachers many children were reported to be happy and positive about the school. For the purpose of supporting learners, teachers were trying very hard to work with parents to build a positive relationship which ensures that learners are given full support.

Teachers esteem and self-efficacy were also boosted because now schools observed low absenteeism rate, less frustrated teachers, creative teachers, who now understand that learners barriers to learning are not only intrinsic, they are extrinsic as well. So they were careful on how they conduct themselves before the learners. In one school they indicated that their learners are not aware that there are teachers who smoke and drink, because they strive to model the desired behaviour to their learners.

Irrespective of the good things which were happening in schools there were also critical repercussions where teachers lacked knowledge and skills to continue with health promotion in schools. The pedagogy of health promotion in schools was not clearly put into practice. Teachers could only teach health topics which were said to be health promoting. To reach to all learners was difficult because teachers could not differentiate the curriculum. Above all, teachers find it hard to involve the community to promote health in school.

5.4.2 Implications for learners

The main purpose of the WHO to introduce health promotion in schools was to ensure that the complete health of learners is accomplished in a setting which promotes teaching and learning. Children in many countries and communities are faced with challenges which has affected their communities and that is a call for concern since it affects and create barriers to learning. Based on the theoretical framework which guided the study, the levels in the system of education can have a grievous effect in the teaching and learning of children in schools even though some levels could not be directly involved. For example failure of the National DBE to design clear policies which allows teachers to promote health of learners in schools could have a serious effect in the sense that teachers always follow the directives from the authorities.

The health promoting pilot schools were schools which were in impoverished communities where the socio-economic status of parents was at its lowest. So it can

be said that the socio-economic barriers could also be other reasons which might have contributed to learning. There are measures in place to assist learners who have been affected by these barriers, but in most cases it was not possible for parents to take their children in places where they have been referred to excerpt for the intervention by the school. It was reported in the interviews in three schools where they have indicated how they have intervened to make sure learners receive serious medical attention.

The collaboration between the three departments (Health, Basic Education and Social Development) compromises the health of learners in schools basically because their goals in promoting health are working in opposite direction. The DoH is dominant and its focus is on physical health and there are challenges with resources; lack of facilities and staff. Although it is stipulated in the DoH Guidelines for school health nurse of what needs to be done in schools, mostly screening and assessment are the only activities which are active.

In some cases there are schools which are never reached at all; meaning that learners who enter their first grade or phase are never assessed at all. With the DBE it has failed the learners dismally because only Life Orientation/Life Skills are ones expected to be promoters of health which is far different from what is to be the role of the National Department which is to mobilise teachers and the school community on the implementation of school health programmes.

From the intensive research which was done by Kwatubana and Kheswa (2014) there was a lack of linkages between the school health nurses and the teachers because there were no teachers available and they were not assisting in finding the accommodation for screening of learners.

Capacity building for both health professionals and teachers is still lacking. This is seen in how they interpret and understand health promotion and health promoting school concepts. From the education domain, health is mainly for health professionals or school health services whereas from the health domain is the absence or prevention of diseases. Therefore, this has created a huge gap in terms of how teachers can play their role as promoters of health in schools. This could have been aggravated by the

fact that the participants in the research could have indicated that the district official understanding about the HPS is implausible because in their visit they want nothing to do with HPS program but curriculum only.

One of the roles of the province and the district is to make provision for time allocation for extra-curricular activities for the implementation of health promotion and health education component of school health services package. The curriculum is rigid to allow health-promoting activities to flow in the school setting.

Above all, the health of learners in the HPS was reported to be thriving even though there are challenges that affect them directly and indirectly through the systems. Many learners were reported to be absent in a number of days away from school because of the home setting, sickness, and poverty. Since the inception of the HPS program in schools, less absenteeism was reported because of the nutrition program in schools where learners would receive breakfast in the morning and lunch during break time. Sick children were attended to because health professionals would give learners immediate attention they deserve and that learners who needed social workers' services were addressed. The social environment played a huge role in the complete health of learners although teachers were not aware that what they were doing was to promote health even when they are not health professionals.

In all schools the participants indicated that they play multiple roles to their learners. They indicated that they are social workers, nurses, psychologists and counsellors even though they were not trained to do so. But the nature of their work requires that they support learners. For example they indicated that they give uniform to the needy, bought specific pillows for those who have epilepsy, give food parcel, take some to the hospital in emergency even when their parents were not responding to the call; seek medical advice, counsel learners who are traumatised before they can get counselling from the professionals.

5.5 CONCLUSION

The purpose of the study was to investigate what could be the possible roles of teachers as promoters of health in schools. Through the interviews, documents analysis and observations, the practical implications of the HPS project was found to

be constructive basically because the pilot HPS were still holding on to what was implemented during the time when the project was active. The following fundamentals of a HPS were visible in a sense that these schools have feeding schemes which are running smoothly to feed all the children at school in order to eliminate learning barriers which can be caused by hunger and malnutrition and which can affect the health of children in a massive way.

The fundamentals of school health services were reported to be active especially at the initial stage of the HPS project because all stakeholders were actively involved in the project. Everything was receiving immediate attention. According to the participants in all schools this was the most important fundamental of a HPS because it is in their classrooms where they find it difficult to work with children who have health challenges which affect learning. In a number of responses the participant were showing their dissatisfaction with regard to the role of the school in the society. And to show that they were not sure of what the school can contribute in the promotion of health from school to the community, they were worried about their communities which are not responding to the call of health issues faced by children in the community.

The last fundamental which is the school environment, there was mixed feelings depending on the strength and the context where the school is. In some schools teachers acted as role models in keeping the school yard clean and in some schools teachers depended on the community to teach the children. Through observation the social environment could tell that the relationship between all staff members and the learners was favourable to learning.

In line with the definition of health promotion which articulates health as “a process of enabling people to increase control over and improve their health” and the definition of HPS which is “a school that constantly strengthens its capacity as a health settings for learning and working, where all members of the school community work together to provide learners with integrated and positive experiences and structures which promote and protect their health.

The fundamentals above confirmed the definitions of health. However, the sustainability of the project was not possible as the participants were raising concerns

on the resumption of health promotion because they were not aware of the direction which could be taken afterwards. And this is where the researcher would like to design a framework which schools can utilise for teachers to be promoters of health in schools.

The promotion of health in schools can be an excellent approach if it is thoroughly conceptualised by teachers and supported by all stakeholders within the school community. The success of the HPS lies in the understanding and support internally and externally. For the success of a health promoting school lies in the central government down to the district when the HPS concept is understood under the comprehensive elements of the health promoting school conceptual framework (school health policies, physical environment of the school, social environment of the school, community partnerships, personal links and school health services) and not necessarily meaning that teachers must be health practitioners. Teachers in their own capacity can be able to play their role to promote total health of learners. That is, emotionally, physically, spiritually, socially and psychologically.

The focus on the HPS pilot schools was on the disadvantaged schools where children experiences a number of health challenges in schools. However the paramount enemies of success in the HPS are the conceptualisation where the HPS activities (nutrition, gardening, and hygiene) are mistaken for HPS; lack of funding from the DBE; lack of support from all stakeholders, lack of integration into the curriculum, lack of collaboration by three departments.

One cannot shy away to mention that in South Africa the political framework might be the gate keeper of the success of HPS because the HPS approach is applied to redress the past inequalities and as such the resources to provide for schools are never enough, and also the top-down approach does not give allowance to the schools to focus on the needs of their school community, instead a uniform approach is given to all schools.

The understanding of health, in this case HPS is based on the physical health of learners, hence one element of HPS framework which is “School health services” is extremely elevated above other elements. A number of researches have proven that

the school is the best setting for health promotion, especially if the health of learners is attended to in a comprehensive manner which covers all the HPS elements.

Based on the findings of this research, teachers can play their role as promoters of health in school level if they are provided with support from all systems based on the Bronfenbrenner's ecological systems theory (micro, meso, exo, macro, and chrono system) and therefore the following recommendations which can also be applied anywhere else in schools in South Africa can be made basically because all schools need a crucial reform as well as to sustain themselves in terms of HPS.

The argument has to be well placed though that teachers are not health practitioners and their status quo will remain as teaching practitioners but a mere fact that they are in a position where they spend more influential hours with children in school, their roles cannot go unnoticed. Therefore teachers will need to increase their understanding of HPS; support from different levels in the system (microsystem, mesosystem, exosystem, macrosystem and chronosystem); to change their attitude towards health promoting school; to commit to the course of promoting health in school; professional development which will better equip them to promote health in school; to be skilled in order to draw their own policies which will respond to the needs of the school community; to understand the SIAS policy document, Education White Paper 6 as well as the ISHP and other related policies; to know when to consult the support system as advisors; to mobilise external support to serve as mentors, advisers, advocates guides and to give technical support; to build all teachers capacity in school; and to develop and to implement HPS related policies.

With the gaps in the understanding of the health promoting concept it is very important for teachers to understand their roles as promoters of health. From this research the understanding is that all teachers can promote the health of learners and not only Life Orientation/ Life Skills teachers. Based on the findings from this research the following section will design the framework for teachers to operate as promoters of health in schools.

CHAPTER 6
CONCLUSIONS, FRAMEWORK FOR TEACHERS AS PROMOTERS OF HEALTH, LIMITATIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The aim of this chapter is to draw conclusions based on the findings. This chapter will also propose a framework for teachers as promoters of health in schools. Above all, the limitations that hindered the study are discussed and the recommendations for further research are provided.

6.2 CONCLUSIONS

The section below will present conclusions drawn based on the findings from literature reviews and empirical investigation of the research study.

6.2.1 Conclusions from Chapter 2: Health and the promotion of health in schools

It has been accepted globally that schools are perfect settings to promote learners health. However, limited capacity, knowledge and skills as well as the resources often compromise the promotion of heath in schools. The promotion of health in schools is a process but not an end in itself. It is a radical movement that focuses on changing how people view health in schools. Health education has been taught in schools, even though the focus was on acquiring knowledge regarding health. However, the Ottawa Charter introduced the promotion of health in various settings such as hospitals, universities and other public places.

The promotion of health in schools was the initiative of the health department in the education domain. The settings' approach has been established under five components where the whole health of learners was set to be developed within the school setting. In schools, the concept has been introduced under the umbrella of Life Orientation/Life Skills subject where learners are taught about health issues.

The Bronfenbrenner's systems theory has been used as the lens to find out what could be the role of teachers as promoters of health in schools. The understanding of health,

promotion of health and HPS is that it is interwoven as the components within the system overlaps as they influence each other to promote health in schools. The health promotion framework served as a map that defined what could be the role of teachers in schools.

However, the biggest challenge was that health promotion in schools was not well understood by teachers, as it was perceived as the responsibility of the school health services where they visit schools for screening and assess learners' health. Instead of focusing overall school development, health promotion was addressed in the form of subjects such as Life Orientation/Life Skills, topic-based or programmes that focus on particular challenges in the community. There were barriers hindering the promotion of health in schools such as the family, school, and system of education, economic, and political. These barriers did not affect learners directly. However, they have affected how teachers should promote health in schools.

There was a gap in how teachers can be involved. Although collaboration of various departments and stakeholders was encouraged, there seemed to be inattention given by both health and education departments in particular. There was a lack of accountability as the programme went on, which compromised the sustainability of the health promotion programme. The involvement by outside agencies poses a challenge of sustainability by schools after their involvement, although the aim of the health department was to ensure that through teachers, schools were able to sustain health promotion activities.

6.2.2 Conclusions from Chapter 3: The teacher and the promotion of health in schools

It was clear that the teaching profession was changing rapidly and that requires the teachers to change the way they view their roles as promoters of health in schools. Teachers are the most valuable asset in schools. Lack of knowledge, skills and professional development hampers the involvement of teachers in schools. Teachers were known to be reluctant when they have to be involved in the HPS programmes as they view it as overload on the already overburdened curriculum. Research suggested that teachers participated only when the vision and mission of schools was aligned to education.

HPS models from various countries indicated that each country developed its programme depending on the culture and tradition of each country. Various components depending on the needs of each country were presented as framework. However, it can be said that there was no model that was perfect to be a sample model, which can be referred to other by other countries. It is very important for teachers to understand HPS as an integrated approach and not as mere activities because other than that, teachers can struggle to sustain the promotion of health in their schools.

The most important thing to remember was that health promotion is more settings-based rather than classroom-based. Schools in disadvantaged communities had challenges when they had to practice health promotion because the settings were not ready. Teachers were not trained and their role was not clearly stated; hence, they promoted health promotion activities such as nutrition, hygiene and gardening only. There was a need to build capacity for teachers so that all of them would be able to support all learners irrespective of whether they have barriers or not. Therefore, teachers needed to be empowered with health knowledge at all sensible times.

6.2.3 Conclusions on Chapter 5: presentation and discussion of the findings: the role of the teacher as a promoter of health in the Gauteng Province of South Africa

It can be concluded that health promotion cannot be left alone to LO/LS teachers only. It should be the issue for the whole school where teachers are empowered to be health promoters in schools. It is still a major challenge that teachers find it hard to involve the society in promoting health in schools, even though health promotion can become the nexus where schools and the community can work together. There was confusion as well as the misinterpretation of health concept and that can be ascribed to how the health promotion was presented to schools in Gauteng Province. Teachers only understood health promotion in terms of activities such as hygiene, nutrition and gardening and with a better understanding they need to cover all components to be able to promote health of learners holistically.

If teachers are not empowered to promote health in schools, there will always be a problem that teachers are not involved in the promotion health. The promotion of health by teachers in the classroom/school is necessary. Nevertheless, there is a need for proper training and the provision of resources for teachers to be able to promote health in schools. It has been suggested that health promotion in the Gauteng Province should be shared to all schools to promote good practice where schools would be encouraged to follow what is good. The social ills in the community needed to be addressed by school as a way to address the factors affecting teaching and learning.

For teachers to be able to sustain health promotion, the leadership and management of the school will need to be committed. Starting from the DBE to schools, there should be proper training of teachers, adequate resources and alignment of health promotion to the curriculum.

As it has already been mentioned, teachers are central to the promotion of health in schools. Hence, all stakeholders need to play their roles to ensure that teachers promote learners' health and well-being in schools. It has to be acknowledged that the health of teachers is critical as well for the purpose of promoting the health of learners in school.

6.3 BRONFENBRENNER'S ECOLOGICAL FRAMEWORK AND THE ROLE OF THE TEACHER AS A PROMOTER OF HEALTH IN SCHOOLS

For teachers to be promoters of health in schools, it was important in this study that the Bronfenbrenner's theoretical framework could be used to determine how systems affect how teachers can be promoters of health in schools.

The findings were consolidated within the theoretical framework as shown in the Figure 6.1 below.

Figure 6.1: The role of the teacher as a promoter of health viewed from the Bronfenbrenner's ecological model.



6.3.1 The microsystem

Microsystem refers to the immediate surrounding where there is direct contact with the child. This basically includes the home and the school. The findings in Chapter 5 revealed that there is a detrimental effect on the role of teachers as promoters of health in schools.

6.3.1.1 Frustrated teachers

The findings of the empirical study revealed that teachers are frustrated when it comes to their role as promoters of health in schools. Less information on how to promote health in schools was disseminated to teachers. This is clear when their understanding of health is explained in terms of health services because what they have observed was the health professionals who came and screen learners in the classrooms. Life Orientation/Life Skills teachers in their classrooms do health promotion. However, teachers do not understand that as teaching practitioners, they can promote health basically because the concept is not clear in the education domain. The findings revealed that teachers understand health promotion in terms of its activities (nutrition, hygiene, gardening). There are concerns that health promotion is an addition to an

already overburdened curriculum and that there is no support from the other stakeholders.

6.3.1.2 Lack of training

The findings revealed that although health promotion is good in schools, but teachers were not trained enough to understand what it entails (Kwatubana, 2014). A number of teachers were not trained to be promoters of health, except for Life Orientation/Life Skills teachers only. There was no in-service training for teachers; hence, during the interviews teachers were pleading for training in health promotion because they realised that they did not understand what to do. In the classroom, teachers were not able to apply teaching strategies or to differentiate curriculum in order to support learners with diverse barriers to learning in the classrooms. The findings also revealed that teachers find it hard to involve parents in the education of their children. Instead, they just call parents for meetings where they only inform them as how they would like them to be involved.

6.3.1.3 Lack of resources

Some of the challenges revealed by the findings were that there were no resources to promote health in schools. These resources range from human resources, finances, LTSM, and support from SGB, SBST and DBST. To begin with health professionals who were supposed to screen learners were not adequate to cover all schools within the period when they were supposed to screen or give any other services to the school. The schools indicated that when health professionals were invited at schools, they would not avail themselves.

All schools where research was conducted were quintile 1 and 3 (these are no fee schools) where they did not have funds at their disposal but they would receive services from the GDE. Apart from the funding they were receiving from the GDE, there were other needs, which were not provided. The SGB was not involved in health promotion and the same applies to the SMT and the DBST that were not supporting the teachers. It was found that the SMT and the principal could be the resource at school when they support the school in its initiative to promote health.

6.3.1.4 Lack of parental involvement

The findings revealed that parents are the primary teachers of their children. However, one of the challenges schools experienced was that parents were not involved except for cleaning, feeding scheme and gardening in some schools. Again, the findings revealed that when schools arrange for meetings, they were not considering other factors, which can have an effect if whether parents will be involved, or not. Illiterate parents find it difficult to go to school because they felt that there was nothing they would contribute. In some cases, it was parents' past experience at school and even the workplace, which have an effect on how they would be involved. Against this background, teachers did not know how they would involve parents besides informing them how they would like them to be involved.

6.3.1.5 Teachers not ready

The findings revealed that teachers were reluctant if they felt that they did not understand the health programmes in their school or else it was not linked to the educational goals. Although workshops and training of some kinds were done initially for teachers to understand health promotion in schools, they still indicated that they were not ready and they would need more training. Teachers' self-efficacy in terms of promoting health in school was undesirable.

6.3.1.6 Inflexible curriculum

The findings revealed that health and education were inextricable. However, in terms of promoting health, the curriculum seemed to be inflexible. The findings from empirical study discovered that only Life Orientation/Life Skills teachers were the ones promoting health in the pedagogical practice. Nevertheless, much was not happening because teachers did not know how to use different teaching strategies to support learners who have barriers to learning as well as to use curriculum differentiation. Health promotion in schools was viewed as an extra burden to curriculum. It only meant that it was promoted outside the curriculum scope. Hence, teachers felt that it was a burden. Teachers were able to say that because every time when officials from the district would visit, they would not like anything to do with health promotion but everything to do with the curriculum.

6.3.2 The mesosystem

The mesosystem refers to the relationship between two or more settings. In this case, this is where teachers are actively involved in the teaching of learners at school. This setting includes the home, school and the community surrounding the school. The factors affecting teachers on their role as promoters are discussed below.

6.3.2.1 Lack of relationship between school and parents

The findings revealed that the relationship between the school and home is crucial for teachers to be able to promote learners health in school. Parents are recognised as equal partners in education. The roles and responsibilities of parents could not be limited to fundraising and the attendance of meetings. However, the findings revealed that although schools are willing to involve parents there was no effort from schools to encourage parents to be involved. Lack of relationship between school and parents put more tension because what is taught in schools is not what parents are doing at home. In return, parents lack interest whenever they have to visit school.

6.3.2.2 Lack of collaboration between home and school

Schools did not know how to collaborate with parents although they wanted them to be involved. On the contrary, parents wanted to be involved; hence, there were parents who were involved in the feeding scheme and gardening, and even when parents were invited to clean the classrooms. The absence of parents in the education of their children put too much strain on teachers since they are supposed to be in the position of parents because whenever parents were called at school, they were not available. It can be said that both parents and school were willing to work together. However, there was a lack of constructive collaboration.

6.3.3 The exosystem

The exosystem refers to the structures that are within the school community, which are very important for teachers to promote health in schools. These structures are SMT, SBST, SGB as well as DBST. The commitment of these structures towards the promotion of health in schools can have a huge influence on how teachers promote health in schools.

6.3.3.1 Lack of commitment by the SMT

The principal together with the SMT are expected to take the lead in the promotion of health in schools. Moreover, the lack of commitment by the SMT in the promotion of health can have a potential to demoralise teachers in their efforts to promote health. The findings revealed that the principals and the SMT are the resources that should be the driving force behind programmes in schools. The empirical findings revealed that the SMT did not show any interest in health promotion hence they would expect teachers to be in their classrooms teaching. A mere fact that the SMT is not committed to health promotion, the findings revealed that it has caused the cascading effect on how teachers can promote health in schools. Hence, there were no systems in place to monitor the progress of health promotion in schools.

6.3.3.2 Dysfunctional SBST

The SBST is the most important structure in the support of learners who experience barriers to learning. The SBST is also responsible for the implementation of SIAS policy strategies with the view that meaningful support will be given to learners experiencing barriers to learning. The findings revealed that the SBST was dysfunctional in most schools. The only thing the SBST was doing was just the administration of learners who needed support by completing SNA1 forms, without giving these learners the support they really needed. The fact that the SBST was dysfunctional has affected how teachers could support learners in terms of promoting health. As a result, teachers did not understand their roles with regard to the SIAS strategy and HPS. The findings also revealed that the dysfunctionality of the SBST was as a result that the DBST was non-operational since it could not provide training and guidance to the SBST's in schools.

6.3.3.3 Lack of support from DBST

The role of the DBST is to ensure that HPS was implemented in schools. Through their specialised support services, the DBST was supposed to provide suitable practical orientated training for teachers in order to be able to understand health promotion in schools and their roles as well. The findings revealed that DBST was not structured and it lacked capacity to provide support to teachers with regard to the promotion of health in schools. It was reported that whenever they would visit schools, they would not require anything to do with health promotion but curriculum only. The

DBST contributed in a great deal on the teachers' lack of knowledge and skills in the promotion of health in schools.

6.3.3.4 Non-involvement of the SGB

The role of the SGB's in schools is to ensure that the school is governed properly and effectively by developing policies that were geared towards the promotion of health for all. The findings revealed that SGB's were not involved in anything to do with health promotion in schools. Hence, they were not mentioned anywhere throughout the interviews. SGB's have been entrusted with the finances and maintenance of the school properties and buildings. However, whenever schools needed resources or maintenance, they focused their attention on the district or provincial officials for the provision of such.

6.3.4 The macro system

The macro system refers to the broader context on which all other systems depend. This is where laws and policies that underpin health promotion in schools are produced. The macro system could be regarded as the higher authority in terms of giving directions as to what the provinces, district, schools, and teachers need to do to promote health in schools. The findings in the empirical study found out that there were important things of concern, which were mentioned below, which had an effect on the role of teachers as promoters of health in school.

6.3.4.1 Lack of collaboration between the departments

Health promotion is a concept, which has been developed from the DoH and adopted by the DBE. In order to ensure that these two departments were able to collaborate, the ISHP was a joint policy development by these departments. To ensure that learners' social needs were attended to the DSD also form part of the collaborating departments. The findings revealed that collaboration from the three departments was lacking. Rather the DoH has dominated the promotion of health in schools to such an extent that educational goals are not met.

Hence, teachers in schools indicated that health promotion in school has nothing to do with education. Furthermore, the findings revealed that health promotion was not aligned to the curriculum. Only the screening of health issues in schools was done.

However, teachers were not able to screen barriers to learning except for administering SNA1 forms. It was indicated that the main aim was to ensure that health services that were offered vertically were eliminated. The roles of the DoH and the DBE as it has been presented in Table 2.5 were not carried successfully because the departments were not collaborating in taking health to schools. Instead of collaboration, there is too much confusion on the side of teachers as to which department is responsible for which health activity.

6.3.4.2 No leadership and management of HP

Moving from the fact that there is a lack of collaboration from the departments in relation to the role of teachers as promoters of health in schools, the research findings revealed that there was literally no leadership and management of health promotion in schools. As it has already been mentioned above, the administration of health promotion in schools lacked the driving force from SMT, SGB, SBST, as well as the DBST. From all schools, teachers did not understand how health promotion was progressing although it was indicated that there was a Monitoring and Evaluation (M & E) tool that checked on the progress of health promotion in schools. From the document analysis, it was indicated that schools did not submit their report about health promotion because they did not know where to send their reports to.

6.3.4.3 Policies not aligned to curriculum

Policies are an essential tool to guide the implementation of any programme in school. Hence, the ISHP, SIAS and Education White Paper 6 were used to guide health promotion in schools. These policies are developed in the higher level in education where teachers do not have any control over. In other words these policies were developed through the top-down model of which teachers were to be in the last level where they have to apply the policies as they were. The research findings revealed that policies were not aligned to the curriculum, hence teachers found it difficult to promote their pedagogical practice in the support of learners who experience barriers to learning. The gap in the policies has affected how teachers could promote health in schools.

6.3.5 The Chronosystem

The chronosystem refers to the changes in times within all the systems over a period of time. In this study, Chronosystem has to do with the shift away from the provision of health separately from education as well as the changing times in terms of family structures where learners are cared for by care givers or they are just child-headed families. The research findings revealed that while promoting health in schools was the move to a right direction, the schools were not properly prepared to do that. Hence, the following discrepancies were identified:

- No preparation of teachers as promoters of health in schools;
- A gap in the policies where educational goals were not promoted in schools;
- Insufficient capacity building in all structures;
- Curriculum not aligned to the policies;
- Non-supportive structures in relation to the role of teachers as promoters of health in schools; and
- No monitoring of health promotion progress in schools.

Drawing from the findings in this study in relation to the Bronfenbrenner's theoretical framework, there were factors which had implicated what could be the role of teachers as promoters of health in schools. Therefore, it would be difficult for teachers to understand their roles as promoters of health. Bearing in mind that what occurred in the systems is something that teachers could not have changed in any way. Hence, it was suggested in the empirical study that a bottom up approach should be used as a means to empower teacher and to increase control in the roles as promoters of health in schools. The next section focused on the development of the proposed framework, which will enable teachers to be promoters of health in schools.

6.4 A FRAMEWORK FOR THE TEACHER AS A PROMOTER OF HEALTH IN SCHOOLS

The HPS pilot schools in the Gauteng Province of South Africa are more focused on three components of the health promoting school. The purpose why the pilot project was introduced in Gauteng Province cannot be set aside whilst there is a high prevalence of diseases due to overpopulation, which affect learners' health in schools. The HPS framework, which governs health promotion in South Africa has been displayed in Figure 3.5

The image of HPS framework as represented in figure 3.5 stipulates in the first place the curriculum, teaching and learning. Teachers do the coverage of the curriculum basically in the teaching of Life Orientation/Life Skills in the classrooms. One of the objectives of the HPS was to develop LTSM. From the document analysis, a review, which was done in 2010 report, indicated that LTSM were still due. In addition, from the observation, the only LTSM that were found in school 5 (DS5) were that of gardening where the teacher and learner guide were presented; other than that, the LTSM were never presented. Above all, teachers were using the Life Orientation/Life Skills material to teach matters about health in the school as well as in the classroom.

The second components in the framework indicate the school organisation, ethos and environment. The observations in most schools confirm that they were taking care of their physical environment that was visible by means of gardening where all schools have gardens wherein they have planted vegetables, herbs, flowers, or indigenous trees. Schools have three different types of gardens. In particular, the organisation and ethos of the school were not clearly emphasised although it was stated that the SBST were leading the HPS project (ISHP, 2012). Currently, what the researcher has observed was that the training of SBST was treated as an entity, which was not supporting the promotion of health in schools. The ethos of the school was not clearly defined as to how they were encouraged in order to promote health in schools.

The third component of the framework is the partnerships and services that were mainly stressed in how the school can provide links with the society. The external stakeholders such as the BMW provided with the seed to start the vegetable garden where few schools won in terms of how they were excelling in gardening. The members of the community who were cultivating the land in all six schools where some of the vegetables were given or sold to the society to supplement the meals also saw this partnership. The hidden elements within the model created a gap that would require to be closed by developing a framework, which can be used by teachers to further develop their role as promoters of health in schools. These elements as per the themes were obtained from the research cover all five components.

Therefore, to close the gap a framework was developed to ensure that each school was able to understand, carry and sustain its HPS activities from within, based on their needs assessments. These elements will not be presented in a particular order.

6.4.1 Proposed framework for teachers as promoters of health in schools

After an extensive research was conducted, the researcher proposes a framework in figure 6.2 that is guided by the Bronfenbrenner's theoretical framework (1992; 1994) and the WHO (1996) conceptual framework. The proposed framework is also informed by HPS approaches, strategies and practices, which have been suggested by different researchers (St Leger, 1998; Jourdan, 2016; Samdal & Rowling, 2013; Renwick, 2006; Samdal *et al*., 2010; Barnekow *et al*., 2006) who focused on the theory and policies of HPS. In South Africa, the ISHP, an introduction to the Policy on SIAS guided this study. Based on the empirical findings of the study the Gauteng HPS framework will be adapted and expanded to accommodate the roles of teachers as promoters of health in schools.

The proposed framework for teachers as promoters of health seeks to provide a structure through which teachers can promote their health, learners' health as well as the health of the community operating from schools as teaching practitioners. A brief description of the theoretical framework and the conceptual framework was done thoroughly in Chapter 2 (see 2.2.2 and 2 2 3).

6.4.2 The framework structure

The framework structure will be derived from the themes, which were defined in section 6.5.2 and the relationship between the themes in relation to the role of teachers as promoters of health has been discussed in section 6.5.4. On the bottom part of Figure 6.2, there is a HPS framework for teachers, which is central to the role of teachers as promoters of health in schools. This structure could serve as the first level of implementation, which can be utilised by the national, provincial and district to promote health in schools. The components carry the same weight. Nevertheless, the point of departure in the structure could be nothing specific since the needs of the school are not the same. Both components can serve as a point of departure.

Figure 6.2: Health Promoting School framework for teachers



6.4.2.1 Partnership with the community

For this framework, partnership with the community means how teachers include the community in the education of their children because of the influence that the school has in the community (Marx *et al*., 1998). This partnership should include the key role players in Figure 2.1, where key role players are encouraged to participate actively in the promotion of health in school. It has to be two-way communications, and be based on mutual relationship where all members are equal. Through teachers as key role players at school, the community can be involved in decision-making, involvement in school programmes, educational engagement, consultation promoting health in and outside the school through educational workshops, and seminars that are run from school.

6.4.2.2 Learners' well-being

In this framework, the learners' well-being embraces relations among learners themselves, learner-teacher relationship as well as the learner-parent relationship; moral behaviours; school and family support for child-headed and vulnerable children; creating substance free school setting. Promoting learners' psychological, social, emotional and physical health for the purpose of their well-being is essential. In

addition, moral responsibility as well as modelling of good behaviour by teachers should be encouraged.

6.4.2.3 School health services

In this framework, school health services mean the provision of health services by qualified health professionals through health and education as well as the screening and assessment of learners who experience challenges in their learning. Quirke (2015) argues teachers are gatekeepers in the HPS. Therefore, they are the first one to notice that a learner or the environment (home or school) needs health professionals' attention. This was mentioned in all schools where teachers defined themselves as multiple role players. In this framework, through the SIAS (2014, they were be able to give support to their learners by utilising the services of the PHC services which are within the district or the province. In addition, as part of applying health practices, teachers need to ensure that they build partnership with the health services providers and also have at their disposal first aid kit, sick bay for sick learners and to pay attention to minor injuries.

6.4.2.4 Capacity building

In this framework, capacity building for teachers means the empowerment of teachers to promote the health of learners in schools. This will be done by creating a healthy environment for teaching and learning in the classroom as well as in the school by ensuring the classroom is clean and conducive for learning. Through teaching, learners are empowered to take decisions that affect their health on a daily basis. Capacity building for learners will also mean that teachers will ensure that there are resources available to support the needs of learners. Over and above, teachers will need to be capacitated in terms of how they work with parents and members of the community as well as initiating partnerships with external stakeholders for the purpose of promoting health in school.

6.4.2.5 Teaching and learning

In this framework, teaching and learning cover how teachers address factors that affect teaching and learning in and out the classroom. In this instance, the "how" (pedagogy) of teaching was not addressed, only what is taught in the Life Orientation classroom. In their pedagogical practice, teachers will have to screen learners' barriers

to learning as well as to differentiate the curriculum for learners who have barriers to learning. Various teaching strategies and teaching styles will be utilised as well.

In the curriculum, the understanding of body development is taught as well as the unhealthy sexual behaviour, which can cause HIV/AIDS and other health needs. These needs range from the teaching of hygiene, nutrition, health knowledge, attitude and skills, as well as values and morals. Other factors include the coverage of communicable diseases and the danger of using substance abuse.

6.4.2.6 Sustainability of the programme

In this framework, sustainability covers the continuation of the programme by the schools themselves as this was the expectation by the DoH that schools must take over health promotion programme and consult health professional whenever they need their services. Teachers need to be empowered to sustain parental/ community involvement, resources and the curriculum on a daily basis. Depending on the needs of the school, teachers need to develop strategies to sustain health promotion in schools. Owing to the fact that barriers to learning which affect learning are not a once-off thing, it will require that teachers should be informed and on regular basis be informed about the new health challenges within their schools and communities.

6.4.2.7 Leadership and management of the programme

In this framework, leadership covers the development of resources in terms of empowering teachers to lead the HPS programme in schools where teachers will be able to lead various activities including the five components of HPS. Through the leadership of the principals and the SMT, teachers need to take leadership in directing the involvement of parents. The available resources as well as the curriculum in the classroom need to be managed by teachers in their classroom. Teachers on the micro level need to design policies that guide school health practices. Starting from what teachers could have recorded in their classroom/school as challenges and success, there should be leadership that ensures that there is provincial participation for all schools in the province. This can be done by schools that are in close proximity to each other when they share good practice in the promotion of health.

6.4.2.8 Health promotion for staff

In this framework, health promotion for staff or teachers covers the support from the government where there should be resources, which are supplied to schools so that teachers can implement health in schools without any difficulty. Support for teachers can be in a form where teachers within their schools are able to analyse their needs for support such as workshops, rigorous in-service training, professional development resources in terms of material and human capacity, and workload. Happy teachers equal to happy learners and this is possible when teachers are getting support from the partnering departments as well as the other stakeholder within the school community.

6.4.3 Relationship between the components of this framework

Based on the Bronfenbrenner's theory as well as the health promoting school conceptual framework, the research findings have indicated that there is a relationship between the components of the framework above. South Africa has adopted the HPS framework, which consists of three components, namely, Curriculum, teaching and learning; school organisation, ethos, and environment; partnership and services. However, the framework does not provide information as to how teachers can be directly involved as promoters of health in school except for assisting the school health nurses with accommodation for screening and learners profile whenever they visit schools. In the focus group interviews, teachers indicated their challenge of accessing the stakeholders for the purpose of rendering services as well as the lack of sustainability of health promotion in school because they have to wait for the directives from the DBE.

The designed framework for teachers gives clear responsibility of what teachers can do as promoters of health in schools. In the how to…for Implementers of HPS (2011) document, it has been clearly indicated that the approach is based on the principles that schools are more than just "classrooms and lessons". Therefore, teachers' role as promoters of health should go beyond walls of the school if teachers have to promote the health of learners. The presented framework concepts relationship is crucial for the teachers to understand. Although the relationship between the concepts will be discussed below, none of the concepts is important than the rest. It all depends on the needs of the school.

There is a close relationship between the levels in the Bronfenbrenner's theoretical framework. Teachers are found in the micro system level where they teach learners in school. In their role as promoters of health, they need to connect and build partnership with the parents as well as the community. Research has proven that the relationship between the home and school is crucial to promote the physical, emotional, social, and psychological health of learners. Marx *et al*. (1998) indicated that the school has the ability to influence the community to participate in the school health activities. In the interviews, it was indicated that parents were requested to assist in promoting the hygiene of the school by cleaning the classrooms and the toilets.

Some parents assisted in the gardens although in some cases they expected to receive incentive for such. Parents also helped in the feeding scheme where they cooked food for learners. Apart from what has been mentioned above, it was observed that teachers can connect better with parents and the community by giving parents enough space to be involved, and this could be done by reducing the barriers that contribute in the failure of parents to be involved.

Through the partnership between the school, parents/community, and other stakeholders in the school community (mesosystem), learners' well-being can be promoted as they collaborate in various activities. Health promotion is done within the school domain by the DoH. The SIAS policy (2014) document postulates that the role of school health professionals was to screen, teach health education and to give advice concerning health issues to schools. Teachers spend most of their time with children at school; hence they experience physical, emotional, social, and psychological challenges of the learners.

Because teachers do not have knowledge and skills to support learners with barriers to learning which are health-related, they are compelled to seek the school health services. This entails that the health professionals would screen the learners who have barriers as well as to give advice on what teachers can do further as a way to support learners in schools. Furthermore, teachers communicate with parents on the report from the health professionals where the learner can be referred further for support. This is where teachers would use the SN1 from with the assistance of the SBST.

Moreover, if the support provided is still lacking, the teacher together with the SBST would complete the SN2 form where the DBST will then be involved.

Research has indicated that teachers are not empowered to deal with many challenges faced by learners. Hence, various stakeholders could be involved to give support to the learners. Apparently, for teachers to be able to give support to the learners, they will need to be empowered with resources in the form of material and human capacity, as well as the LTSM. Through the school health services, they will have to be empowered with skills and knowledge on how to support learners with barriers to learning. Teachers need to be capacitated on how to work with parents/community, external stakeholders (exo system) and learners themselves.
The main aim of applying the HPS approach in schools was to ensure that teachers were able to influence the learners to live healthy lifestyles wherein hygiene, nutrition, body development, taking care of self, washing of hands were encouraged. In some instances, teachers will have to have workshops with the parents on the promotion of hygiene or healthy diet for learners. In some instances, teachers will have to liaise with the external stakeholders such as Dettol for hygiene purposes, BMW for seedlings, Batsha le metse (Youth and Water Project) for water purposes. Teachers' understanding of health, health promotion and HPS concepts can help to sustain the programme since they will be able to work with parents, learners as well as the external stakeholders.

As it has already been observed, no matter how much they can be enthusiastic, teachers cannot promote the health of learners alone. They need the leadership of the provincial departments, district officials, principals, SMT, SGB, DBST as well as the national DBE, DoH and DSD. Research has indicated that in schools where principals were involved, teachers experience huge success since they will be able to receive support from the principals in the form of resources, moral support as well as encouragement for the whole school development. It is necessary for teachers to receive support of HPS from the provincial department (macro system) where the issues of curriculum alignment can be dealt with down to the district.

Although it has been stipulated, in the DoH (2011) document that the National DBE will design the health promoting school's curriculum, which will then be facilitated down

to schools. However, failure to do so has affected the delivery of health activities by teachers to learners.

One critical thing, but then that was not taken into consideration was the health and well-being of teachers. Research has indicated that healthy teachers equal healthy learners (Marx *et al*., 1998). For teachers to be able to support learners and parents in school, their needs must be met first. These needs cover their emotional needs, knowledge and skills. Sometimes teachers were incorrectly considered to be reluctant and adamant to receive the programmes in schools. However, research has indicated that if they do not understand the importance of health promotion in schools and its benefits to education, they will be reluctant. However, if their needs are taken care of, they will be able to support learners with ease. Therefore, Figure 6.3 presents the framework designed for teachers will assist them to know that they have a role to play in the promotion of health for learners even though they are not health professionals.

Figure 6.3: Implementing the framework



6.4.4 Implementing the integrated health promoting schools (HPS) framework for teachers

Figure 6.3 implementing the framework is the second level of implementation, which will take place in schools. Teachers will need to understand how to implement the framework in the school and this will be presented below. Each school can decide on how they interact with the framework structure.

6.4.4.1 The role of the teacher in implementing the framework

The teacher is central in the implementation of the HPS framework. This is because the teacher is responsible for teaching in and outside the classroom where there are learners who experience barriers to learning. Again, it is the teacher's responsibility to make sure that the academic, physical, emotional, social, spiritual, and psychological health needs of learners are met. Therefore, the teacher will have to work with other staff members in the school. The SIAS policy, in its support guidelines, clearly indicates that parents of children who are in need of support need to be actively involved as equal partners with the teachers, school support team, which is called the SBST, in order to support the needs of learners in an integrated manner.

To ensure full support of learners, the teacher needs to collaborate with other teachers in the grade or phase. Collegiality is very crucial for the success of the HPS programme in school. The teacher also works with the professionals in the community for the purpose of awareness of communicable diseases, promotion of hygiene as well the dangers of using substance abuse. Most importantly, these professionals can be a multidisciplinary team that include nurses, social workers and the community. It has to be understood that each of these professionals have their specific roles to play in the school for the purpose of addressing health needs of learners. For example, the school health nurse will screen and assess learners who have health needs. The social worker will attend to the social needs of learners where those who do not have birth certificates or ID's are registered, and those who live in child-headed families are placed in foster care homes or those who need grant they are able to access it.

Beside the professionals in the community, the teacher can also collaborate with the general staff in the school to ensure that the physical environment of the school is

conducive for learning. In conclusion, the teacher can also work with the NGO's for the purpose of support with knowledge, skills and resources.

6.4.4.2 The role of the school community in implementing the framework

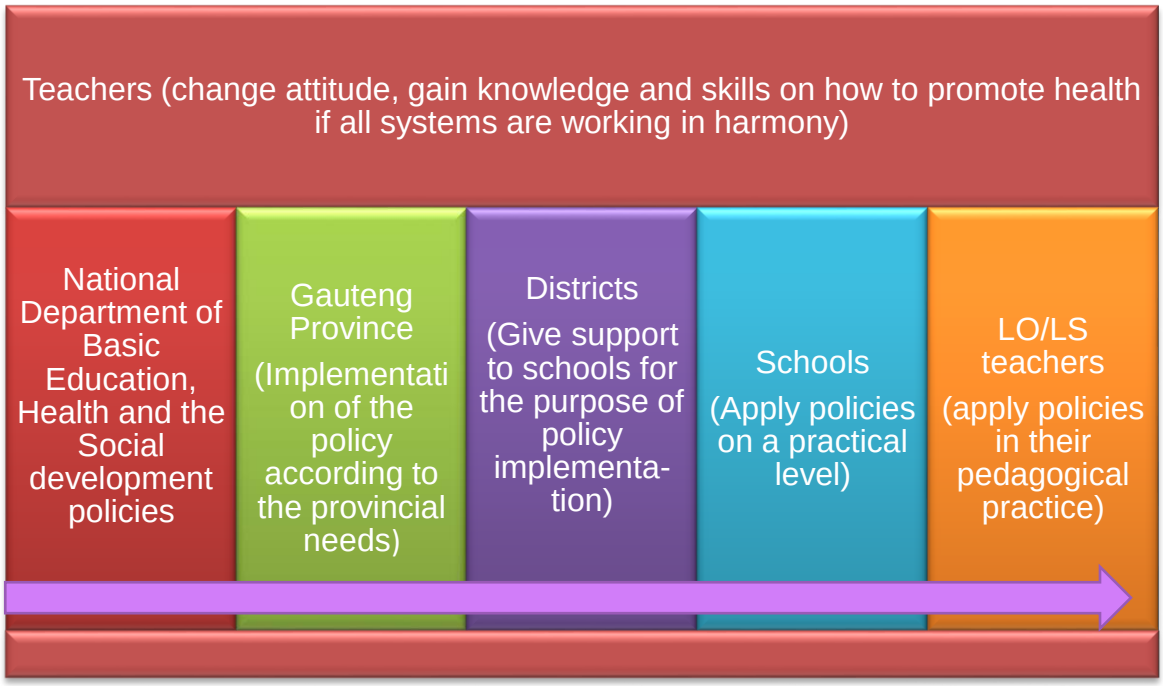
HPS in South Africa has adopted the top-down approach where it all starts from the national DBE, DoH and DSD to the schools where teachers are based. So this is where the school community, which includes the SBST, DBST, and other district officials, who are responsible for curriculum, services in schools and resource provision. The DBST is crucial for the implementation of the health promotion programme in schools.

For example, the DoH provides the necessary health services for learners as well as the teachers in the school. Support is given to schools by providing guidance on illness and health as well as health promotion. The DBE provides support in the implementation of the HPS programme in schools by ensuring that the district officials understand the goals of HPS in education. The DSD provides the necessary support given by social workers to schools. Since health promotion is not restricted to the three departments only, the Department of Correctional Services (DCS) can give support on issues such as the danger of substance abuse, crime and safety. This is done by educating the community to be free from such dangerous behaviour.

The ISHP, SIAS and the Guidelines on HPS advocate for the collaboration of stakeholders in schools. However, during the interviews, it has been mentioned that the collaboration of stakeholders is lacking. Therefore, it translates into the fact that teachers need to play their roles as promoters of health in schools by inviting the stakeholders in schools for training and advice.

At the end of it all, teachers are the implementers of the Health Promotion (HP) programmes in schools where learners can benefit directly or indirectly. Figure 6.5 will be used to illustrate how the systems can support teachers who then will directly support learners in the classroom as well as in the school.

Figure 6.4: Educational systems interaction



Based on the theoretical framework above, the illustration of educational systems as they operate in the development of learners has been presented in Figure 6.4 to show how the implementation of HP in schools can have an impact as to how teachers can be the promoters of health in schools.

Research in this study was conducted in the Gauteng Province, South Africa. Moreover, if teachers are working closely with each other in their schools and the district is giving them support, the whole school organisation is likely to benefit from the HPS initiative. Contrary would be the case where teachers are not getting any support in the promotion of health for learners at all; the circle of poverty and unemployment and all socio-pathological ills will be the vicious circle that continues to destroy communities (see the roles of the educational systems as it was presented in Table 2.5).

6.5 CONTRIBUTIONS OF THE STUDY

The study has contributed to the existing body of knowledge in terms of the theory, policy and practice and this has been outlined below.

6.5.1 Theory

The study has contributed towards the formulation of a framework for teachers as promoters of health in schools. The relationships between the systems can contribute towards the role of teachers as promoters of health. The HPS conceptual approach further gives emphasis to the role of teachers through its five components, namely, curriculum, teaching and learning; physical environment; social environment; school health services, personal links and community participation.

6.5.2 Policy

The study has contributed in this instance by identifying gaps in the policy. The policy, which guided this study, was the ISHP and the Policy on SIAS for the purpose of supporting learners' physical, emotional, psychological, spiritual, and social health. Nevertheless, none of the policies uses the HPS settings' approach in dealing with the health of learners. Only the school health services are central in schools and they emerge above the education sector in their activities. It could be said rather that the role of teachers as promoters of health was not clearly stated. However, with the teachers' framework, teachers will be able to promote health in schools.

The policies lack further pedagogy directives on how teachers can teach learners in the classroom; the integration of curriculum within all the subjects; whole school approach where all stakeholders are involved and not only Life Orientation/Life Skills teachers involved; lack of LTSM and lack of the defined role of teachers in the program. The researcher proposed a HPS framework for teachers that look at the wide components, which can be utilised by teachers to promote health of learners. Furthermore, the researcher designed the implementing framework that makes it easier for teachers to promote health across the school with other stakeholders. The researcher hopes the teachers will be able to apply the framework in their particular schools.

6.5.3 Practice

The study contributes to the practice in this manner:

- The recommended framework will be shared with the HPS.

- It is envisaged that the framework and the recommendations will serve as the guideline for teachers to apply their roles as promoters of health in schools.
- It is anticipated that the GDE will use the framework in its development of the policy and the districts will be able to support teachers in schools as promoters of health.
- It is anticipated that the study will influence practice in terms of how teachers will promote health in schools.

6.6 LIMITATIONS TO THE STUDY

Although the research was planned, organised and executed according to sound scientific principles, the following factors impacted negatively on the course of the project:

- Owing to the focus of this research, which was based in the Gauteng Province, South Africa, the findings of this study could not be generalised to include all the nine provinces in South Africa.
- The lack of collaboration between the Gauteng DoH, Gauteng DBE and the DSD compromised the study.
- Data were collected in the HPS pilot schools only.
- The unpredictability within the hustle and bustle of community life created special challenges that the researcher had to deal with. Some of these include political activities like street protesting and rivalry between political parties; boycotts and protesting activities against the local municipality; stay-away and other trade union actions; policing and searches that were done to uphold peace within the socially unstable parts of the communities.
- The researcher had some difficulty to access some of the schools. Although members of the management of certain schools were very helpful, others were not responding positively to the researcher's request to conduct interviews.
- To communicate with the schools was also a challenge. It took some time before a proper communication line was put into place. Schools had no functioning telephones or any other means of communication, which hampered the project. The private mobile phones of the principals were used since there was no other option. This was negotiated with the principals themselves.

- The absence of proper administration of the ISHP progress in the national and provincial level, in this case, Gauteng province also contributed negatively in the study.

6.7 RECOMMENDATIONS

While some success has been attained in promoting health of learners in disadvantaged schools in the Gauteng Province of South Africa through the DBE, DoH and the DSD, the results discussed in Chapter 5 raise a number of recommendations for the improvement of learners' health in schools. Without omission, teachers expressed how they promote health in schools and how they would like health promotion/HPS to be taken further for them to be promoters of health in schools. The following recommendations were found on the study aim to develop a HPS model that offers teachers with the opportunity to be involved in promoting health in schools. Recommendations for the study as well as recommendation for further study are stated below.

6.7.1 Recommendations for health promotion study

The Bronfenbrenner's ecological systems theory used in the study ensured that there is a better understanding of what teachers in the micro level can do to promote health after all systems roles and responsibilities were clarified.

Therefore, the following recommendations are made to the following:

6.7.1.1 The National Department of Basic Education (NDBE)

- The policies that underpin HPS in South Africa could not clearly define the role of a teacher as a promoter of health in school. Hence, teachers understood health promotion in school as an agenda of health professionals alone. Therefore, it is recommended that the national NDBE should embrace the HPS framework proposed for schools as a framework for teachers to be involved as promoters of health in schools. This should be done by revising the policy on health promotion in schools to accommodate the direct role of teachers as promoters of health.
- Throughout the literature review and empirical research, it was clear that there is a need for resources to promote health in schools. The national department as the provider of resources, decentralise resources to the provincial department through to schools. The recommendation therefore is that there should be a provision of resources and funding for building comprehensive and effective HPS.
- From the empirical study, it was clear that teachers were not that much familiar with the health promotion concept, but the health promotion activities were applied in schools. To ensure that teachers' understanding with regard to health promotion in schools, it is recommended that the national NDBE should mobilise teachers and the community on the implementation of school health programmes in schools.
- The health concept is a new phenomenon in the education domain. The NDoH dominated schools through its activities, which were clearly defined in the health policies. Their activities in schools were more focused on physical health, which could only be done by the health professionals. Research indicated that teachers' roles were not clear; hence, their relationship with school health nurses was reported to be minimal. It is recommended that the national NDBE should facilitate a better relationship between the teachers and school health nurses.
- Health promotion in the Gauteng Province of South Africa was meant to address health challenges in the Province since this has been the overcrowded province where there was a critical outbreak of communicable diseases that have affected communities and school-going children. In the empirical research, teachers indicated that they did not receive a thorough training as to how they can play their role as promoters of health in schools. Moreover, they indicated the need for

professional development in order to promote health. It is recommended that the national NDBE should provide professional training for teachers to promote health in schools.

- The lack of clear roles and better relationship between health professionals and schools has led to resistance in terms of accommodating health professionals whenever they would visit schools. Teachers indicated that health professionals would visit schools even when they did not arrange with the school, which then could cause the challenges of accommodation because they were not accommodated in school. It is recommended that the national NDBE should ensure there is accommodation for screening of learners in schools every time the health professionals would visit schools.
- Although throughout the research study it was clearly indicated that schools are the best setting for health promotion, there was no time set aside for teachers to promote health in school. In essence, the national curriculum could not set aside time for health promotion in schools. Teachers were expected to promote the curriculum that does not encourage health promotion in schools except for Life Orientation, which was only taught in the classroom. It is recommended that the national NDBE should provide time for health promotion in the national policy by aligning health promotion with the curriculum.
- From the onset of health promotion in the Gauteng Province of South Africa, the document analysis indicated that the national NDBE was not aware of the HPS project happening in the Province. Only the NDoH was active in terms of health promotion in schools. It is recommended that the national NDBE should collaborate with the NDoH in capacity building of teachers and health professionals.
- Research was done in disadvantaged schools under quintile 1 and 3, which relied on the NDBE for all services to be rendered in schools. However, schools indicated their difficulty in terms of acquiring services from the local government. One such example was the provision of water to promote hygiene and to water the vegetables, which then supplement nutrition. It is recommended that the national NDBE in its capacity should liaise with the relevant local government for services required by schools.

6.7.1.2 The National Department of Health (NDoH)

- Teachers perceived health promotion in schools as the responsibility of the national NDoH. Moreover, teachers expressed their concern when they could not see any direction in terms of how health promotion is run in schools. Health professionals would only be seen when the national NDoH would be addressing an outbreak of a disease in schools in the Province. However, when the health professionals were needed by schools to attend to critical cases regarding learners' health, they would not be available. In the ISHP and the Policy on SIAS, it was clearly indicated what the health professionals ought to do in schools; but it was not clear of what schools, teachers in particular could do. It is recommended that the national DBE should provide strategic direction in the implementation of school health programme in schools.
- From the empirical research, it was clear that the implementation of school health was not well coordinated from the policy point of view. The ISHP focused more on the prevention of diseases among schoolchildren and that has caused more confusion on the side of teachers since they do not know how to implement health promotion in schools. Learners are screened regularly in schools without much knowledge on the side of teachers of how they can promote health. It is recommended that the national NDoH should coordinate the implementation of school health policy in schools.
- From the empirical research, teachers indicated that there was a lack of leadership in terms of facilitating school health programmes. It was not clear as to how the school health programmes were integrated in school from the NDoH perspective. Therefore, it is recommended that the national NDoH should facilitate the integration of school health programmes that have an impact in the lives of learners in schools and not only visit school when there is an outbreak of disease but also give advice to schools as to how they can address health issues affecting learners.
- From the literature review, the implementation of health services in schools did not have any uniformity as to how it can be done. Different countries implemented school health services based on their needs analysis. The same applies with school health services in South Africa. Accordingly, different provinces implemented school health services differently since there was no standard set by the national NDoH. The benchmark schools in this research proposed that for

health promotion to be successful in the province, health promotion in schools should be implemented in all schools and neighbouring schools should copy the good practice of schools around them. It is recommended that the NDoH should ensure standardisation of implementation of school health services.

- The implementation of school health services in the Gauteng Province of South Africa only included few schools and in those schools only Life Orientation teachers were involved. The document analysis indicated that teachers were going to receive further training as well as the LTSM. During the interviews, teachers indicated the need for training on how to handle learners with barriers to learning. It is recommended that the national NDoH should develop orientation manual for school health services, which will be disseminated to schools for teachers to understand their roles as promoters of health in schools.
- One of the concerns with regard to health promotion in schools was that there was a lack of resources; both human and physical resources. In the ISHP, it was indicated that the school health nurses were not enough to render their services in schools because the ratio was just unreasonable. Besides the human resources, there was also a lack of transport to take the school health nurses from school A to school B. For school health services to be successful, it is recommended that the national NDoH should mobilise resources for the implementation of school health services in schools.
- The literature review and the empirical research indicated that there was a lack of accountability in terms of school health programmes in schools. From the document analysis, it was also indicated that although the report concerning school health progress was required, schools did not know where to submit the reports. Therefore, it is recommended that the national NDoH should monitor and evaluate the progress of school health in schools.

6.7.1.3 Provincial Department of Basic Education (PDBE)

- In Gauteng Province of South Africa, school health promotion was implemented in few schools used to pilot health in schools. These schools benefited from such initiative because they understood health promotion activities in their schools. They could see the difference between their school and those which are not health promoting. In addition, for the purpose of promoting health for all learners in the

province, they suggested that the provincial PDoH should see to it that all schools are health promoting. It is recommended that the Gauteng PDBE should ensure that all schools in the province adopt good practice in terms of health promotion.

- The literature review indicated that teachers could only participate if the school health goals are aligned with the educational goals. From the teachers' point of view, school health programmes were more focused on the physical health. Every time the school health nurses would visit the schools, teachers felt that they were interfering with school curriculum. This could have happened because there was no clear collaboration between the PDBE and the PDoH. It is recommended therefore that the PDBE should collaborate with the PDoH to develop a schedule for school health services to avoid confusion on the side of teachers as well as the school health nurses.
- It has been found that school health phenomenon is not well understood from both teachers, community, parents as well as learners. From the teachers' understanding, the community and parents did not understand what it means to be health promoting. This was shown when there were many complaints from schools on how parents respond to the invitation by the school to promote health. On the other hand, teachers did not understand how to involve parents. The PDBE should mobilise the teachers, community, parents, and learners on the implementation of school health programmes in school.
- Based on the findings, it was clear that health promotion was done with few teachers. The empirical research indicated that teachers lack capacity to sustain health promotion in schools. Therefore, it is recommended that the provincial DoH should conduct capacity building of both teachers on health promotion and education and first aid and not just the few.
- Concerns over the knowledge of health promotion by district officials have affected how teachers promote health in schools because every time the district officials would visit school, they would like nothing to do with health promotion but curriculum matters only. It could be understood from a point of view that district officials were not well conversed in health promotion issues in schools or they understood it from a Life Orientation point of view. It is recommended that the DBE should ensure that district officials are knowledgeable about HPS concept to avoid confusion when they visit schools but to support teachers in their endeavours.

6.7.1.4 Provincial Department of Health (PDoH)

- The provision of school health services has been dismally affected by the ratio of school health nurses to schools. Some schools could not be reached owing to the fact that school health nurses would be recalled from school. This continued to happen in the schools where research was done; every time when the teachers would require the services of the school health nurses, they were nowhere to be found. It is recommended that the PDoH should appoint adequate number of school health nurses to schools to ensure that schools are receiving proper attention and advice from the health professionals.
- Teachers showed concern regarding the visit of school health professionals who would just visit schools without any proper arrangement, but based on the outbreak of disease in the Province. This was done without any consultation with the NDBE, which would then liaise with the districts to schools. It is therefore recommended that the PDoH in the province should collaborate with the PDBE in the development of a proper school visit schedule, which would ensure that there is no interruption of the school programme.
- Because of the understanding by schools as well as the community that health promotion is done by health professionals alone, supervision on the side of education domain was lacking. Teachers confirmed that screening was not regularly done like in the beginning of health promotion project in the province. They also indicated that they do not know how the health programme was concluded since they were still waiting to continue. Therefore, it is recommended that the provincial PDoH should conduct proper supervision.
- Research has proven the importance of meetings with the stakeholders in the promotion of health in schools. As part of leadership by the PDoH, it is recommended that it should convene school health meetings in the provincial level with relevant structures to check on the progress of health promotion in the province.

6.7.1.5 District Department of Basic Education (DDBE)

- From teachers' experience with the district officials, it was clear that they were not aware of what school health means and how it was supposed to be done in school.

Schools showed the need to be trained in the understanding of health promotion. However, the officials showed lack of knowledge when they visited schools because their focus was on the curriculum issues. It is recommended that the district DDBE should ensure that schools know, understand and be able to implement ISHP and SIAS policy documents. This should be done by giving continuous support to the teachers by the district officials.

- The dilemma on how teachers can be promoters of health in schools was found to be caused by the lack of support from the district officials and that they were not involved. It is recommended that the district officials should be fully involved and have a better understanding of the HPS concept to ensure smooth implementation in schools where teachers could also find it easier to play their roles as promoters of health in schools.
- The issue of the lack of capacity in terms of health professionals who can attend to learners health in schools as soon as they were identified was found to be disruptive. It took much time for health professionals to attend to such cases and to some cases there was no feedback. Teachers also suggested that it would be very practical if schools could have health professionals in their premises for the purpose of attending to learners with barriers to learning as they manifest. Based on the fact that there is a lack of human resources, it is recommended therefore that each district should be resourced with school health professionals who will be able to cater for the schools under their care whenever they need support not only when they have scheduled visits to schools.

6.7.1.6 District Department of Health (DDoH)

- The issue of collaboration between health and education officials was mentioned repeatedly to show the importance of it. In some schools, teachers were not aware if whether they have as school health nurse who is responsible for their school. In the SIAS policy document, it has been indicated that health professionals would advise schools with regard to barriers to learning, which affect some learners in schools. However, this has been affected by the fact that school health teams were not collaborating with teachers in schools. It is therefore recommended that the district DDoH should appoint school health teams, which collaborate with schools and other stakeholders.

- The study findings revealed that there was lack of communication between the leadership of school health programmes in the district and inadequate resources to promote health in schools. The referral system for those learners who needed further attention in health institution did not receive the attention it deserves. It is recommended that the district DDoH should strengthen school health existing system in terms of communication, resources, transport, and proper referral system.

6.7.1.7 Teacher training institutions

- Without much accountability in the province in terms of school health programmes, it would be difficult for the new teachers entering the teaching profession to understand what health promotion is and what needs to be done to promote health of learners in schools. It is recommended that teacher-training institutions should ensure that courses are designed for student teachers to be trained in health promotion in schools.
- It was discovered that not all teachers were trained as promoters of health in schools. Throughout the study, teachers indicated that they needed training for them to be able to know how to promote health in schools. To ensure that all teachers were trained in health promotion, it is recommended that the teacher training institution should develop short learning programmes for in-service teacher training.

6.7.1.8 Schools (School Management Team)

- Research findings indicated that the principal and the SMTs can serve as the resource for school health promotion because of the power, authority, leadership, and vision that they possess. They could have time to outsource resources and knowledge as to how health promotion can be done in school. It is therefore recommended that the SMTs should serve as resources for the development of health promotion in schools.
- The Gauteng HPS framework was not clear as to how schools can promote health although the three components formed the basis of health promotion in schools. It is therefore recommended that SMTs should embrace the HPS framework that has

been designed as a framework for schools and use it to promote health of learners in school.

- It was found that although school health programmes promote healthy learning for learners, not all teachers would find interest to be involved as promoters of health in schools. The suggestions by teachers indicated that teachers need support from the SMT to avoid any confusion among the staff members in schools. It is recommended that the SMT should support and encourage all teachers in school to promote health of learners.

6.7.1.9 Teachers

- Teachers viewed school health programmes as an additional burden. Hence, they were reluctant to participate. The lack of understanding in terms of health promotion by teachers could be seen in the attitude of teachers towards health promotion activities. In Gauteng Province of South Africa, health promotion is in the hands of Life Orientation/Life Skills teachers. However, the screening of learners in school is more focused on physical health challenges that affect learning at school. Teachers were not aware that they should be able to screen barriers to learning, which interferes with learning in the classroom. It is recommended that teachers should fully participate in health promotion as promoters of health in schools by acquiring knowledge and skills related to health promotion.
- It was clear from the empirical research that the top-down approach affects how teachers can sustain health in schools. This was because teachers only wait for directives from the top officials in the department. It was found that teachers were not able to sustain the health promotion activities because they did not perceive themselves as promoters of health in schools even though they could see the benefits of it. It is recommended that teachers should sustain health promotion in schools by utilising the framework for teachers, which will guide them on the maintenance and sustenance of health programme in schools as well as the establishment of relationship with parents community and other stakeholders.
- The study was underpinned by Bronfenbrenner's ecosystemic theory, where all systems work together for the development of a learner, which then can be escalated in terms of understanding that the teacher works with the learner on a

daily basis such that they are able to observe challenges experienced by learners at home and even at school. The teachers' expectation that the top-down structures guide in the progress of health promotion in schools seemed to hinder the health promotion progress in schools because in all schools, teacher were waiting for the programme to continue. From the observations, teachers were promoting health even though at some point they were not aware. From the light of their perspective, it is recommended that teachers should be encouraged to promote health from their schools using the framework based on the bottom-up approach where they can guide the top structures on what is needed in their schools.

- Research findings indicated that because of lack of collaboration between the DoH as well as the DBE in both levels in the system, the roles and responsibilities of the departments could not clearly define the role of teachers and the roles of nurses when they visit schools. From the knowledge gained by teachers regarding health promotion in schools, it is recommended that teachers should collaborate with the school health nurses when they visit schools to ensure that they understand learners' barriers to learning. When school health nurses screen them, it can also help to get immediate feedback from the school health team.
- Throughout the study, from the literature review to empirical research teachers; apart from their role as teaching practitioners, they identified themselves as custodians of multiple roles. Hence, one of the themes indicates that their role is to promote learners health and well-being. At some point, they indicated their concerns in terms of administering deworming pills as part of school health programme. Such role is extended by the DoH to school. To ensure that teachers are certain about their roles, this study recommends that teachers should receive a proper training on how they can execute these roles without interfering with roles of other stakeholders.
- Health promotion in schools addresses health challenges that are barriers to learning in the classrooms. Apart from the health promotion activities such as nutrition, gardening and hygiene as well as the teaching of Life Orientation /Life Skills in the classroom, teachers could not be able to understand how they can differentiate curriculum to create a better learning experience for all. It is

recommended that teachers should know how to differentiate curriculum for all learners to benefit in learning in their classrooms.

- Schools cannot teach learners in isolation without parents and the community since education is a societal agenda. The struggles that schools face when they have to work with parents and the community are not insurmountable. Therefore, this study recommends that teachers should find strategies on how they can work with parents, community and all stakeholders in the school community.

6.7.1.10 Policy makers

- Teachers in schools could not interpret the policies, which underpin health promotion in schools, since they were more based on physical health. Although the ISHP was designed by the DoH and the DBE, the role of teachers as promoters of health was not clearly stated. It is recommended that policy makers should design clear policies that define the role of each department, which will also transcend to schools.
- The policies did not clearly indicate how schools in their capacity could interpret ways in which they could promote health. Hence, the health promotion activities implemented in the Gauteng schools were the same. It is recommended that policy makers should design policies, which can be easily interpreted by schools for better implementation in schools as well as to utilise the developed framework for teachers.

6.7.1.11 Stakeholders (Parents and the community)

- From the empirical research, it was clear that teachers were struggling on how they can collaborate and involve parents to promote the health of learners in schools. It is recommended that all stakeholders (the governmental departments, NGO's, parents and the community) should collaborate with the teachers to ensure learners' complete health in school. Workshops and seminars where all stakeholders could be empowered with the health promotion knowledge and skills should be organised by schools. Stakeholders will also need to understand that education is a societal agenda wherein they need to participate fully.
- Learners who are taught in schools come from the community. Teachers alone can find it hard to promote health without the involvement of parents since they are

taken as the primary educators of their learners. It is recommended that parents should volunteer their services in schools as part of health promotion.

6.7.2 Recommendations for further research

The study managed to bring about the conceptualisation of health promotion and HPS by teachers as well as the practical implications when they are involved. However, there is still a need for further research, which can enable and empower teachers to be more involved and accurate on their responsibility in the school level.

6.7.2.1 The approach to health promoting schools (HPS)

Studies have shown that HPS programmes are administered from national departments down to schools, a top-down approach. Most often, there is misconception of the concept in the process and probably teachers remain with the challenge of not being able to play their roles. However, if the programme was approached from bottom-up, probably there would be some practical implications experienced in schools.

6.7.2.2 How stakeholders can play their roles in schools

Schools are known as territories for teachers. However, when there are programmes that need implementation in schools, teachers are expected to play their role irrespective of their understanding, their training, and their roles in the programme. Therefore, to avoid confusion, other stakeholders' responsibilities need to be specifically outlined. The health concept is found within the DoH, and therefore how they go about promoting health in schools need to be clarified among the school staff members.

6.7.2.3 Collaboration between the departments

Because education is a societal matter, the collaboration between the departments needs to be clearly defined to avoid repetition of activities and unnecessary utilisation of resources as well as the element of accountability.

6.7.2.4 Better understanding of health promotion concept to all systems levels

The health promotion understanding of the concept is understood differently in all systems. Hence, there are challenges as to how the systems should be involved.

There should be a better understanding of the concept right from the policy makers (macro level); provincial and district official (meso level) to the schools (micro level).

6.7.2.5 Research on non LO/LS teachers

Research was done with the LO/LS teachers in the health promoting schools. It is recommended that further research can be done with teachers who are not teaching LO and LS.

6.7.2.6 Research in other Provinces of South Africa

This study was done in the Gauteng province. It is recommended that further research can be done in other provinces of South Africa.

6.8 REFLECTIONS ON THE STUDY

The study was my best research in the sense that from my education perspective, I was able to find out what teachers as teaching practitioners can do to promote health in schools. Most often, the health promotion/health promoting school study is about a single topic or activity in a school. A number of research studies conducted in schools were about HIV/AIDS, mental health, bullying, obesity, and teenage pregnancy or drug abuse in school. My main concern was how all teachers, besides the Life Orientation/Life Skills teachers can be involved in promoting health in schools. Research is done in and out of the school and the policy is not clear as to how teachers can promote health in schools.

Besides the literature from the developed and the developing countries, which I have reviewed, I could not find how teachers can be promoters of health in schools. HPS are explained and understood in terms of school health services. I almost fainted when I reached the first school and the principal asked this question. “Is HPS still existing? I thought it was over when JICA left”. However, I took courage to say I am here to learn from you what you have learnt from JICA. That sent a message to me to say there is more at stake. I spent many hours in schools observing the school environment, both socially and physically, observing how teachers interact with other staff members, with parents, with general workers as well as the learners in and outside the classroom.

From the interaction I had with teachers, that is where I got my “eureka” moment and a better understanding of what teachers can do to promote health in schools. The definition of health promotion and HPS are clear in terms of saying their main purpose is to empower people and to build capacity for people to take charge of their health. The designed framework is the exact tool for teachers to promote health in schools.

6.9 DISSEMINATION OF FINDINGS

After the study has been completed, the participating schools and all the key stakeholders will be invited in a meeting where the findings will be disseminated. In order to advance HPS in the province as well as the district, the research schools will be used as the cohort schools where the HPS framework, which has been developed for teachers, will be implemented. For the purpose of better understanding with regard to the role of the teacher as a promoter of health in schools, the study findings as per the ethics approval with the Gauteng DBE will be uploaded into their site.

6.10 FINAL CONCLUSION

The research process, which focused on the HPS and teachers in particular, enabled the researcher to understand what exactly could be the role of teachers in promoting the health of learners in schools. The framework, which has been developed, will then be used by the HPS to increase their understanding on the needs analysis of their school.

It takes all stakeholders within the Bronfenbrenner’s ecological framework to improve the health of learners in school as well as in the community. Above all, teachers are central to the success of any school that could venture to be a HPS. The HPS framework is useful to promote the health of children in school. However, the challenge could be when schools opt for health promotion where particular activities are addressed and not HPS where the WHO framework is used.

The developed framework has the potential to influence skills, knowledge and attitude of learners and to enforce positive behaviour when teachers are highly involved. It has to be understood that although the framework is developed for teachers, moreover, it can be used for a whole school development to influence the entire school staff;

including the principals, support staff in school and the general workers. This could have an influence in the school's physical and social environment as well as the school ethos where there could be structural changes in the school organisation since there would be more policy development and above all, the hidden curriculum can be made part of the school practice because there would be similar understanding of what HPS is.

Finally, a better understanding of HPS by teachers would not only have an influence on the learners, but it can have a potential to bring about better partnerships between schools and parents as well as the community where it evolves. In that way, the socio-economic barriers, which are experienced by learners, can be minimal. From the bottom-up approach by teachers in schools, the inter-sectoral collaboration between the DBE, the DoH and the DSD could be a success because teachers would have a better understanding that they need to work together and that they need to consult services from these departments in order to promote the health of learners.

HPS is a process that cannot be dealt with even within a specific number of years because in a number of communities in the Gauteng Province there are health challenges and health hazards, which emerge every now and then owing to overcrowding in the communities. To empower schools and communities to prevent and to fight the outbreak of any disease could see communities in control of their context.

Teachers' role requires them to be at schools serving in the midst of the community. The understanding that they should promote health requires them to be knowledgeable about the components of HPS. In terms of their role as promoters of health, they are the most agents who are able to influence learners who later on are able to influence their communities. Through teaching about health issues in and out of their classrooms (formal curriculum: teaching and learning); inviting community members who have experienced health challenges in their lives for workshops and seminars (community links), inviting health professionals such as nurses, doctors, therapist, psychologist as well as social workers to come and advice the teachers and to share health information with the community (school health services); designing their own school health policies which are guided by their school health analysis

(school health policy); maintaining the school environment by having vegetable gardens, herbs gardens and flowers gardens as well as to prevent littering in the school yard and the classrooms (physical environment of the school); maintaining positive relationship between other staff members and the learners (the school's social environment).

It is believed that schools are perfect settings where health issues affecting children can be addressed, since they are the best possible settings to promote health for all. That means health of learners, staff, parents and the community at large. The success of the HPS will not be possible if the schools are running it alone. However, the involvement in all levels and all stakeholders can see ordinary schools changing to be Health Promoting Schools. The support structure and services, which are used in the HPS are essential for the sustainability of health in schools.

7. REFERENCES

ABRAHAMS, E. & WIGTON, 1997. A Workshop on an Integrated Policy for School Health. Proceedings. Cape Town: Child Health Policy Institute.

ACKERMAN, A. 1997. Defining the Health Promoting School. In Colquhoun, D., Goltz, K. & Sheehan, M (eds.)., *The Health Promoting School: policy, programmes and practice in Australia*. (pp.1-26). Marrickville: Harcourt Brace & Company.

ADAMOWITSCH, M., GUGGLBERGER, L. & DÜR, W. 2014. Implementation practices in school health promotion: findings from an Austrian multiple-case study. *Health Promotion International*, *Advanced A*. doi:10.1093/heapro/dau018.

ADELMAN, H.S. & TAYLOR, L. 2002. *Addressing barriers to learning.* Department of Psychology. CLA. Los Angeles. *7*(3), 1-13.

ADELMAN, H.S. & TAYLOR, L. 2003. On sustainability of project innovations as systemic change. *Journal of Educational and Psychological Consultation*, *14,*1-25.

AGCAS. 2012. *Health promotion specialist* [Online]. Available: http://www.prospects.ac.uk/links/occupations.

AINSCOW, M. & SANDILL, A. 2010. Developing inclusive education systems: *International Journal of Inclusive Education*, *14*(4), 401-416.

ALDINGER, C., ZHANG, X.-W., LIU, L.-Q., GUO, J.-X., YU, S.H. & JONES, J. 2008. Strategies for implementing health-promoting schools in a province in China. *Promotion & Education*, *15*(1), 24–9.

ALLENSWORTH, D.D. 1993. Health education: State of the art. *Journal of School Health*, 63, 14-20.

ALLENSWORTH, D. D. & KOLBE, L. J. 2009. The comprehensive school health program: Exploring an expanded concept. *Journal of School Health*, *57*(10), 409-412.

ALLENSWORTH, D. 1995. The comprehensive school health programme: Essential elements. *Feeder paper to the WHO Expert Committee on Comprehensive School Health Education and Promotion*. Geneva.

ALVESON, M. 1996. Leadership studies: From procedure and abstraction to reflexivity and situation. *Leadership Quarterly, 7*(4), 455-485.

ANDERSON, A. 2005. Understanding school improvement and school effectiveness from a health promoting school perspective. *REICE. Revista Electrónica Iberoamericana Sobre Calidad, Eficacia Y Cambio En Educación*, *3*(1), 282–296.

ANDREWS, J. O., FELTON, G., WEVERS, M. E. & HEATH, J. 2004. Use of community health workers in research with ethic minority women. *Journal of Nursing Scholarship,* 36 (4), 358-365.

ANFARA, V. A., BROWN, K. M., & MANGIONE, T. L. 2002. Qualitative analysis on stage: Making the research process more public. *Educational Researcher*, *31*(7), 28–38.

APPLE, M. 2001. *Educating the 'Right' Way: markets, standards, God and inequality*. New York: Routledge & Falmer.

ASKELL-WILLIAMS, H. & CEFAI, C. 2014. Australian and Maltese teachers' perspectives about their capabilities for mental health promotion in school settings. *Teaching and Teacher Education, 40:61-72.*

ASMAL, K. & JAMES, W. 2002. *Spirit of the Nation: Reflections on South Africa's Educational Ethos.* South Africa: NAE/HSRC. Department of Education.

ATKINSON, R. L. & NITZKE, S. A. 2001. School based programmes on obesity: increase knowledge about nutrition but do not change eating habits by much. *British Medical Journal*, *323* (7320), 1018-1019.

AUDREY, S., HOLIDAY, J. & CAMPBELL, R. 2008. Commitment and compatibility: teachers' perspective on the implementation of an effective school based, peer led smoking intervention. *Health Education Journal*, *67* (2), 74-90.

AUSTRALIAN COUNCIL OF EDUCATIONAL RESEARCH. 2004. *Report on mind matters plus-the first year*. Camberwell: Author.

BABBIE, E. & MOUTON, J. 2001. *The practice of social research.* Cape Town: Oxford University Press.

BABBIE, E. & MOUTON, J. 2007. *The practice of social research*. Cape Town: Oxford University Press.

BABBIE, E. & MOUTON, J. 2011. *The practice of social research.* Cape Town: Oxford University Press.

BABCHUK, N. 1958. The role of the researcher as participant observer and participant-as observer in the field situation. *Human Organization,* XVII, 36-43.

BAILEY, K. D. 1994. *Methods of social research* (4th ed.). New York: Free Press.

BAILEY, C. A. 2007. *A guide to qualitative field research*. (2nd ed.). California: Sage Publication.

BARNEKOW, V., BUIJS, G., CLIFT, S., JENSEN, B. B., PAULUS, P., & RIVETT, D. 2006. *Health-promoting schools: A resource for developing indicators.* European Network of Health Promoting Schools. Copenhagen: WHO.

BARRET, J. R. 2007. The researcher as instrument: learning to conduct qualitative research through analysing and interpreting a choral rehearsal. *Music Education Research, 9* (3), 417-433.

BASAZA, R. & KAIJA, D. 2002. *The impact of HIV/AIDS on children: Lights and shadows in the "Successful Case" of Uganda*. Florence: UNICEF.

BATSIOU, S., BEBETSOS, E., PANTELI, P., & ANTONIOU, P. 2008. Attitudes and intention of Greek and Cypriot primary education teachers towards teaching pupils with special educational needs in mainstream schools. *International Journal of Inclusive Education*, *12*(2), 201-219.

BASTABLE, S.B., GRAMET, P., JACOBS, K. & SOPCZYK, D.L. 2011. *Health Professional as Educator*. Jones & Bartlett Learning: United States of America.

BAUER, K.W. & YANG, Y.W. 2004. How can we stay healthy when you're throwing all of this in front of us? Findings from focus groups and interviews in middle schools on environmental influences on nutrition and physical activity. *Health Education & Behaviour, 31(1), 34-46.*

BECKER, C.M., GLASCOFF, M.A. & FELTS, M.W. 2010. Salutogenesis 30 years later: Where do we go from here? *International Electronic Journal of Health Education. 13:25-32.*

BEIJARD, D., MEIJER. P. & VERLOOP, N. 2004. Reconsidering research on teachers professional identity". *Teaching and Teacher Education*, *20*(2), 107-128.

BENTLEY, T.G., EFFROS, R.M., PALAR, K. & KEELER, E.B. 2008. Waste in the U.S Health Care System: A conceptual Framework. *The Milbank Quarterly*, *86*(4), 629-659.

BERIC, B. & DZELETOVIC, A. 2003. Health promotion and the health education: Theory and practice. *Journal of Serbia & Montenegro, 60* (4), 455- 460.

BERRY, N. S., MURPHY, J., & COSER, L. 2014. Empowerment in the field of health promotion: recognizing challenges in working toward equity. *Global Health Promotion*, *21*(4), 35–43.

BEZUIDENHOUT, F. 2006. *A reader on selected social issues* (3rd ed.). Pretoria: Van Schaik.

BLOCH, G. 2009. *The Toxic Mix* (1st ed.). Cape Town: Tafelberg.

BLOCH, P., TOFT, U., REINBACH, H.C., CLAUSEN, L.T., MIKKELSEN, B.E., POULSEN, K. & JENSEN, B.B. 2014. *Revitalizing the setting* approach- supper settings for sustainable impact in community health promotion. *International Journal of Behavioural Nutrition and Physical Activity,*11:118.

BLOCH, G. 2007. The difficulties of systems change in education. *Paper prepared for HSRC Research Colloquium on Education and Poverty*, February 22, 2007, Irene Country Lodge.

BLOOR, M. & WOOD, F. 2006. *Keywords in Qualitative Methods*: A vocabulary of research concepts. London: SAGE publications.

BODEINHEIMER, T., LORIG, K., HOLMAN, H., & GRUMBACH, K. 2002. Patient self-management of chronic disease in primary care. *JAMA*, *288* (19), 2469- 2475.

BORNMAN, J. & ROSE, J. 2010. *Believe that all can achieve*. Pretoria: Van Schaik.

BOOTH, M.L. & SAMDAL, O. 1997. HPS in Australia: models and measurement. Australian and New Zealand Journal of public health. 21 (365-370).

BOOTZIN, A., BOWER, R., CROCKER, C & HALL, B. 1991. *Psychology today: an introduction.* Boston: McGraw Hill.

BRAY, W. 2000. *Human Rights in Education*. Pretoria: Centre for Education Law and Policy (CELP).

BRAUN, V. & CLARK. V. 2013. *Successful qualitative research*. London: Sage-Publishing Company.

BRELLOCHS, C. 1995. *Ingredients for success: Comprehensive school based health centres.* New York: School Health Policy Initiative.

BRIKCI, N. & GREEN, J. 2007. *A guide to using qualitative research methodology*. London: Médecins SANS Frontiers.

BROBECK, E., ODENCRANTS, S., BERGH, H., & HILDINGH, C. 2013. Health promotion practice and its implementation in Swedish health care. *International Nursing Review*, *60*, 374-380. [Accessed 10 June 2018].

BRONFENBRENNER, U. 1979. *The ecology of human development: Experiments by nature and design.* Cambridge: Harvard University Press.

BRONFENBRENNER, U. 1992. Ecological systems theory. In R. Vasta (ed.). *Six theories of child development: Revised formulations and current issues*. (pp.187-249) London, UK: Jessica Kingsley.

BRONFENBRENNER, U. 1994. Ecological models of human development. In Gauvain, M & Cole, M. (Eds.), *International Encyclopaedia*. (2nd ed.). Oxford: Elsevier.

BRONFENBRENNER, U. & MORRIS, P. A. 2006. The bio ecological model of human development. In W. Damon and R. M. *Learner Handbook of Child Psychology.* (pp.793-828). New York: John Wiley & Sons

BRUCE, E., KLEIN, R. & KELEHER, H. 2012. Parliamentary inquiry into HPS in Victoria: analysis of Stakeholders views. Journal of School Health, 82, PP 441-447.

BUCHARIES, D.G., ALVERNE, M. & FONTENELE CATRIB, A.M. 2013. Health promotion and schools: how to move forward. *Brazilian Journal in Health Promotion, 26*(3),306-310.

BUKATKO, D. & DAEHLER, M. 1998. *Child development: A thematic approach*. Boston: Houghton Mifflin.

BUNDY, D. 2011. *Rethinking School Health: A key Component of Education for All. The International Bank for Reconstruction and Development*. Washington DC: The World Bank.

BUSH, T. 2007. Educational leadership and management: Theory, policy, and practice. *South African Journal of Education*, *27*(3), 391–406.

BYRNE, J., ALMOND, P., GRACE, P. & MEMON, A. 2012. Health promotion in pre service teacher education. *Health Education, 112* (6), 525- 542.

CALDERON, J. L., BAKER, R. S. & WOLF, K. E. 2000. Focus groups: A qualitative method complementing quantitative research for studying culturally diverse groups. *Education for Health, 13* (1), 91-95.

CBO. 2013. State of the Art: Health Promoting Schools in Europe. [Online]: Available at: http://www.schools-for-health.eu/

CENTER FOR MENTAL HEALTH IN SCHOOLS. 2008. Working collaboratively: From School-Based Teams to School community Higher Education Connections. Los Angeles, CA. Author. [Online]: Available at http://smhp.psych.ucla.edu/pdfdocs/worktogether/worktogether.pdf (accessed 11 July 2017).

CHAMUSRI, S. 2008. What underpins success in a HPS in North Eastern Thailand? An unpublished thesis.

CHAN, C.M.S. & KITZMANN, K.M. 2010. Exploratory factor analysis: Health perceptions of Chinese early childhood educators in Hong Kong. *Health Promotion International, 25:* 412-424.

CHAN, C.M.S. 2007. The assessment of pre-school health curriculum. *Hong Kong Journal of Early Childhood, 6: 5-11.*

CHECK, J. & SCHUTT, R.K. 2012. *Research methods in education*. Thousand Oaks, CA. Sage Publications.

CHINN, P. & KRAMER, M.K. 2004. *Integrated knowledge development in nursing*. (6th ed.). USA, St. Louis: Elsevier-Mosby.

CLARKE, A. M., O'SULLIVAN, M. & BARRY, M. M. 2010. Context matters in programme implementation. *Health Education*, *110* (4), 273–293.

CLELLAND, T., CUSHMAN, P. & HAWKINS, J. 2013. Challenges of Parental Involvement Within a Health Promoting School Framework in New Zealand. *Education Research International*

CLIFFORD, N., FRENCH, S. & VALENTINE, G. 2010. *Key methods in geography,* London, SAGE Publications Inc.

COHALL, A.T., COHALL, R., DYE, B., DINI, S., VAUGHN, R.D. & COOTS, S.C. 2007. Overheard in the halls: what adolescents are saying, and what teachers are hearing, about health issues. *Journal of School Health,* 77 (7):344-350.

COHEN, L. & MORRISON, K. 2006. *Research methods in education*. New York: Routledge-Farmer.

COHEN, L., MANION, L. & MORRISON, K. 2007. *Research methods in education*. (6th edition). London: Routledge.

COLEMAN, G. 2001. *Issues in Education: View from the other side of the room*. Westport: Bergin & Garvey.

CONGER, J. 1998. Qualitative research as the cornerstone methodology for understanding leadership*. Leadership Quarterly, 9*(1): 107-121.

COOVADIA, H., JEWKES, R & BARRON, P. 2009. The health and health system of South Africa: Historical roots of current public health challenges. *Lancet* 374 (9692): 817-834.

COULSON, N. 1999. *Health Promotion South African Health Review*. Durban: Healthy System Trust.

CRESWELL, J.W. 1998. *Qualitative inquiry and research design: choosing among five traditions*. Thousand Oaks: SAGE Publications.

CRESWELL, J.W 2003. *Research design: Qualitative, quantitative, and mixed methods approaches*. 2nd ed. Thousand Oaks, CA: Sage.

CRESWELL, J.W. 2007. *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (2nd ed.). Thousand Oaks, CA: SAGE Publications Ltd.

CRESWELL, J.W. 2008. *Educational research: planning, conducting and evaluating quantitative and qualitative research*. Upper Saddle River: Pearson Prentice Hall.

CRESWELL, J.W. 2009. *Research design: Qualitative, quantitative, and mixed methods approaches* (4th ed.). Thousand Oaks, CA: Sage.

CRESWELL, J.W. 2010. Mapping the developing landscape of mixed methods research. In A. Tashakkori & C. Teddlie (Eds.). *Sage Handbook of mixed methods in social and behavioural research*. California: Sage.

CRESWELL, J.W. 2011. Mapping the developing landscape of mixed methods research. In Tashakkori, A. & Teddlie, C. (Eds), *SAGE handbook of mixed methods in social and behavioural research* (2nd ed). Thousand Oaks, CA: Sage.

CRESWELL, J. W. 2013. *Qualitative inquiry research design: Choosing among five approaches.* Thousand Oaks: SAGE Publications.

CRESWELL, J.W. 2014. *Educational research: Planning, Conducting and Evaluating Quantitative Research and Qualitative Research*. (4th ed). Thousand Oaks: Sage.

CRESWELL, J.W. & MILLER, D. 2000. Determining validity in qualitative research. *Theory and Practice*, *39*(3): 1221–130.

CRESWELL, J.W. & PLANO, C. V. L. 2011. *Designing and conducting mixed methods research* (2nd ed.). Thousand Oaks, CA: SAGE Publications.

CROOKES, P. & DAVIES, S. (Eds.). 1998. *Research into practice: Essential skills for reading and applying research.* London: Ballière Tindall.

CROTTY, M. 2003. *The foundations of social research*. London: Sage Publications.

CROSSWAITE, C., CURRIE, C. & YOUNG, I. 1996. The Network of Health Promoting Schools: development and evaluation in Scotland. *Health Education Journal*, 55 450-456.

CURRIE, C., ZANOTTI, C., MORGAN, A., CURRIE, D., DE LOOZE, M., ROBERTS, C., SAMDAL., SMITH, OTTO R.F. & BARNEKOW, V. 2012. *Social determinants of health and well-being among young people. Health behaviour in school-aged children (HBSC) study: International report from the 2009/2010 survey.* Copenhagen, WHO Regional Office for Europe.

CUSHMAN, P. & CLELLAND, T. 2012. Addressing health issues in New Zealand schools. *International Journal of Health Promotion and Education, 5*0:4, 159-168, DOI: 10.1080/14635240. 2012. 702504

CUSHMAN, P. 2008. Health promoting schools: a New Zealand perspective. *Pastoral Care in Education, 26*(4), 231–241.

DAVIDSON, F.F. 2007. Childhood obesity prevention and physical activity in schools. *Childhood Obesity Prevention*, 107(4).

DAVIES, B. 1994. *Poststructuralist theory and classroom practice.* Geelong: Deakin University.

DAVIES, M. & MACDOWALL, W. 2006. *Health promotion theory*. Maidenhead: Open University Press.

DAY, C. & GU, Q. 2010. *The new lives of teachers*. London: Taylor and Francis.

DE JONG, T. 2000. The role of the school psychologist in developing a health-promoting school some lessons from the South African context. *School Psychology International,* 21(4): 339-357.

DENMANN, S., MOON, A., PARSONS, C. & STEARS, D. 2002. *The Health Promoting School. Policy, Research and Practice.* Routledge Falmer: London and New York, NY.

DENZIN, N.K. & LINCOLN, Y.S. 1994. *Handbook of qualitative research*. Thousand Oaks, CA: Sage Publications.

DENZIN, N.K. & LINCOLN, YS (eds). 2000. *Handbook of qualitative research*. (2nd ed.). Thousand Oaks, CA: Sage.

DENZIN, N. K. & LINCOLN, Y. S. (Eds.). 2005. *The Sage handbook of qualitative research* (3rd ed.). Thousand Oaks, CA: Sage.

DEPARTMENT OF EDUCATION. 2000. *A South African curriculum for the 21st century: report of the review committee on Curriculum 2005*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2001. Education White Paper 6: Special education: Building an inclusive education and Training system. Pretoria: Government Printers.

DEPARTMENT OF EDUCATION. 2002a. *Draft guidelines for the implementation of inclusive education: District-Based Support Teams* (2nd Draft). Pretoria: Government Printers.

DEPARTMENT OF EDUCATION. 2002b. Revised National Curriculum Statement. Grades: R-9. Life Orientation. Cape Town: Former Set Printers.

DEPARTMENT OF EDUCATION. 2002c. *Drug Abuse Policy Framework*. Government Gazette, 24172. Pretoria: Government Printers.

DEPARTMENT OF EDUCATION. 2003. *National Curriculum Statement Grades 10-12 (General): Life Orientation*. Pretoria: Department of Education.

DEPARTMENT OF EDUCATION. 2004. National School Nutrition Programme(NSNP) Implementation, Monitoring and Reporting Manual. Unpublished.

DEPARTMENT OF EDUCATION. 2009. Schooling 2025 and Action plan to 2014: Call to Action: Mobilizing Citizens to Build a South African Education and Training System for the 21st Century. Pretoria: Government Printer..

DEPARTMENT OF EDUCATION. 2012. *Action Plan to 2014 – Towards the Realisation of Schooling 2025: Popular version*. Pretoria: Government Printers.

DEPARTMENT OF EDUCATION. 2014. *Policy on Screening, Identification, Assessment and Support.* Pretoria: Government Printer.

DEPARTMENT OF BASIC EDUCATION. 2010. *Education statistics in South Africa 2009.* Pretoria: Government Printer.

DEPARTMENT OF BASIC EDUCATION. 2011. *Action Plan to 2014 – Towards the Realisation of Schooling 2025.* Pretoria: Department of Basic Education.

DEPARTMENT OF BASIC EDUCATION. 2012. *Curriculum and Assessment Policy Statement. Foundation Phase Grade R-3*. Government: Pretoria.

DEPARTMENT OF BASIC EDUCATION. 2012. *Curriculum and Assessment Policy Statement. Foundation Phase Grade 7-9*. Government Printers: Pretoria.

DEPARTMENT OF HEALTH AND DEPARTMENT OF EDUCATION. 1997-1998. *Life skills and HIV/AIDS education program. Project report of the joint venture of the South African Departments of Health and Education*. Pretoria: Department of Education.

DEPARTMENT OF HEALTH, 2000b. *National guidelines for the development of health-promoting schools/sites in South Africa (Task Team Draft 4)*. Pretoria: Government Printer.

DEPARTMENT OF HEALTH. 2000a. *The Primary Health Care Service Package for South Africa- A set of norms and standards*. Pretoria: Government Printer.

DEPARTMENT OF HEALTH, 2003. *The National School Health Policy and Implementation Guidelines.* Pretoria: Government Printer.

DEPARTMENT OF HEALTH. 2006. *Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974.* Pretoria: Government Printer.

DEPARTMENT OF HEALTH. 2009 - *Strategic Plan 2009/10-2011/12*. Pretoria: Government Printer. [Online]: Available at: http://www.info.gov.za/view/DownloadFileAction?id=133115.

DEPARTMENT OF HEALTH, 2011. *School Health Policy and Implementation Guidelines*. Government Printers: Pretoria.

DEPARTMENT OF HEALTH. 2012. *National strategic plan on HIV, STI's, and TB Department of Health.* Pretoria: Government Printer.

DEPARTMENT OF HEALTH. 2015. *Mission and Vision* [Online]. Department of Health: Pretoria: Government Printer [Online]: Available at: http://www.health.gov.za/index.php/shortcodes/vision-mission [Date accessed 2 August 2018].

DEPARTMENT OF SOCIAL DEVELOPMENT. 2006. *National Drug Master Plan*. Pretoria: Government Printer.

DESCHESNESS, M., F. TRUDEAU, F. & KE´BE, M. 2010. Factors influencing the adoption of a Health Promoting School approach in the province of Quebec, Canada. *Health Education Research,* 25 (3): 438–450.

DESCHESNESS, M., MARTIN, C. & HILL, A.J. 2003. Comprehensive approaches to school health promotion: how to achieve broader implementation? *Health Promotion International,* 18(4):387-96.

DESCHESNESS, M. 2014. Schools' capacity to absorb a health school approach into their operations. *Health Education,* 114 (3): 219.

DE VOS, A.S. (ed). 2002. *Research at grass roots*. Pretoria: Van Schaik.

DE VOS, A. S., STRYDOM, H., FOUCHÈ, C. B. & DELPORT, C. S. L. 2005. *Research at grass root,* Pretoria: Van Schaik.

DE VOS, A.S., STRYDOM, H., FOUCHÈ. C.B. & DELPORT, C.S.L. 2011. *Research at grass roots: for the social sciences and human service professions*. (4th ed). Pretoria: Van Schaik.

DICICCO-BLOOM, B. & CRABTREE, B. F. 2006. The qualitative research interview. *Medical Education,* 40, 314-321.

DONALD, D., LAZARUS, S. & LOLWANA, P. 1997. *Educational Psychology in social context.* Cape Town: Oxford University Press.

DONALD, D., LAZARUS, S. & LOLWANA, P. 2002. *Educational Psychology in Social Context: Challenges of development, social issues and special needs in Southern Africa* (2nd ed.). Cape Town: Oxford University Press.

DONALD, D., LAZARUS, S., & LOLWANA, P. 2010. *Educational psychology in social context* (3rd ed.). Cape Town: Oxford University Press.

DONALD, D., DAWES, A. & LOUW, J. 2000. *Addressing childhood adversity*. Cape Town: David Philip.

DOWNIE, R. S., FYFE, C. & TANNAHILL. A. 1990. *Health Promotion Models and Values.* Oxford: Oxford Medical Publications.

DOORIS, M. 2009. Holistic and sustainable health improvement: the contribution of the settings based approach to health promotion. *Perspectives in Public Health*, 129 (29).

DUERDEN, M. & WITT, P. 2010. An ecological systems theory perspective on youth programming. *Journal of Park and Recreation Administration*, 28(2): 108- 120.

DURRHEIM, K. 2009. Research design. In M. Terre Blanche, K. Durrheim & D. Painter (Eds.). *Research in Practice: Applied Methods For The Social Sciences*. (pp. 33-59). Cape Town: UCT Press.

DU TOIT, P. & FORLIN, C. 2009. Cultural transformation for inclusion, what is needed. *School Psychology International*, 30 (6): 644-666.

EASTON, L. B. 2008. From professional development to professional learning. *Phi Delta Kappa*, 89 (10), 755-759.

EDELMAN, C. L. & MANDLE, C.L. 1990. *Health Promotion throughout the Lifespan* 2nd Edition. St Louis: The C.V. Mosby Company.

EDLIN, G. & GOLANTY, E. 2007. *Health and wellness*. 9th ed. Sudbury, MA: Jones and Bartlett.

ELOFF, I. & KGWETE, L. 2007. South African teachers' voices on support in inclusive education. [Online]: Available at: http://findarticles.com/p/articles/mi_qa3641/is_200701/ai_n19511566/pg_4/?tag=content;col1. Date accessed October 20, 2010.

ENGELBRECHT, P., OSWALD, M. & FORLIN, C. 2006. Promoting the implementation of inclusive education in primary schools in South Africa. *British Journal of Special Education*, 33(3): 121-129.

ENGELBRECHT, P. & GREEN, L. 2001. *Promoting learner development. Preventing and working with barriers to learning*. Pretoria: Van Schaik Publishers.

ENGELBRECHT, P. 2004. Changing roles for educational psychologists within inclusive schools in South Africa. *School Psychology International*, 25(1):20-29.

ENGELBRECHT, P., GREEN, L., NAICKER, S. & ENGELBRECHT, L. (Eds.) 2003. *Inclusive education in action in South Africa*. Pretoria: Van Schaik Publishers.

EISENMANN, J., GENTILE, D., WELK, G., CALLAHAN, R., STRICKLAND, S., &
WALSH, M. 2008. SWITCH: rationale, design, and implementation of a community, school, and family-based intervention to modify behaviours related to childhood obesity. *BMC Public Health.*

EISNER, E. W. 1991. *The enlightened eye: Qualitative inquiry and the enhancement of educational practice.* New York: Macmillan.

FATHI, B., ALLAHVERDIPOUR, H., SHAGHAGHI, A., KOUSHA, A. & JANNATI, A. 2014. Challenges in Developing Health Promoting Schools' Project: Application of Global Traits in Local Realm. *Health Promotion Perspectives*. 4(1): 9-17.

FINLAY, L. 2008. Introducing phenomenological research. Retrieved (10 October 2014). [Online]: Available at: http://www.lindafinlay.co.uk/phenomenology.htm

FINK, D. & STOLL, L. 1998. Educational change: easier said than done. In: Hargreaves, A., Lieberman, A., Fullan, M. & Hopkins, D. Eds. *International Handbook of Educational Change*. London: Kluwer Academic Publishers.

FLASCHBERGER, E. 2012. Initial teacher education for school health promotion in Austria: Does it support the implementation of the health-promoting school approach. *Health Education,* 113(3): 216-231.

FLISCHER, A.J. & REDDY, P. 1995. "Editorial. 'Towards health-promoting schools in South Africa'", *South African Medical Journal*, 85(7),629-630.

FOUCHÉ, C. 2002. Research strategies. In A. de Vos (Ed.), *Research at grass roots*

for social and human service professions (2nd ed.) (pp. 272-277). Pretoria: Van Schaik.

FRANTZ, J.M. *2015.* A peer-led approach to promoting health education in schools: The views of peers*. The South African Journal of Education, 35* (1):1-7.

FREDRICK, M. & CLIVE, K.S. 2002. *Emotional and Behavioural Problems: A Handbook for Understanding and Handling Students.* California: Corwin Press.

FREIRE, P. 1972. *Pedagogy of the oppressed*. Middlesex: Penguin.

FRENCH MINISTRY OF EDUCATION. 2001. Guidelines for school health policy. Journal no. 12 (12 January 2012).

FRENCH MINISTRY OF EDUCATION. 2011. Regional school health policy. Journal no.46 (15 December 2015).

FRENCH MINISTRY OF EDUCATION. 2014. Guidelines for the school year 2014. Journal no. 21 (22 May 2014).

FRY, A. 2010. *The effects of child poverty*. [Online]: Available at: http://www.essex.ac.uk/sociology/student_journals/ [Retrieved on 16 April 2017].

FULLAN, M. & HARGREAVES, A. 1992. Teacher Development and Educational Change. In M. FULLAN and A. HARGREAVES (Eds.). *Teacher development and Educational Change*. London: Falmer.

FULLAN, M. 1993. Why Teachers Must Become Change Agents. *Educational Leadership*, 50:1-13.

FULLAN, M. 2001. *Leading in a culture of change*. San Francisco, CA: Jossey Bass.

FULLAN, M. 2007. *The new meaning of educational change*. (4th ed.). New York: Teachers College Press.

GABRIEL, M., DOIRON, R., ARIAS DE SANCHEZ, G. & WARTMAN, C. 2010. The research in early child development framework. In R. Doiron & M. Gabriel (Eds.), *Research in early child development in Prince Edward Island: A research monograph* (pp. 11-17). Charlottetown, Prince Edward: Centre for Education Research, University of Prince Edward Island.

GERBER, R. 2008. *Outline of various research methodologies*. Unpublished class notes, Centre for Teaching, Learning and Integrated Media, NMMU: Port Elizabeth.

GIBSON, W. & BROWN, A. 2009. *Working with qualitative data*. Washington: Sage Publications.

GIBSON, W. 2010. Qualitative research as a method of inquiry in education. In D. Hartas (Ed.), *Educational research and inquiry: Qualitative and Quantitative approaches* (pp. 54-64). New York: Continuum International Publishing Group.

GLEDDIE, D. 2011. A journey into school health promotion: district implementation of the health promoting schools approach. *Health Promotion International,* 27(1): 82-89

GLESNE, C. 2006. *Becoming Qualitative Researchers: An Introduction.* (3rd edition). New York: Pearson Allbyn and Bacon.

GORDON, J. & TURNER, K. 2001. School Staff as exemplars- where is the potential? *Health Education*, 10(6): 283-291.

GRAY, G., YOUNG, I. & BARNEKOW, V. 2006. *Developing a health-promoting school: A practical resource for developing effective partnerships in school health, based on the experience of the European Network of Health Promoting Schools.* European Network of Health Promoting Schools. [Online]: Available at: http://www.euro.who.int/ENHPS.

GREEN, L.W. & KREUTER, M. 1991. Health Promotion Planning: an Educational and Environmental Approach. Mayfield Publishing Company, Mountain View.

GUBA, E.G. & LINCOLN, YS. 1994. *Competing paradigms in qualitative research*. Newbury Park, CA: Sage.

GUGGLBERGER, L. & DÜR, W. 2010. Capacity building in and for health promoting schools: Results from a Qualitative study. *Elsevier,* 101, 37-43.

GUGGLBERGER, L. 2011. *Phases of School Health Implementation in Scotland*. Vienna: LBIHPR.

GUGGLBERGER, L. & DÜR, W. 2011. Capacity building in and for health promoting schools: Results from a qualitative study. *Health Policy*, 101(1): 37–43. doi:10.1016/j.healthpol.2010.08.019

GUGGLBERGER, L. & INCHLEY, J. 2012. Phases of health promotion implementation into the Scottish school system. *Health Promotion International, 29,* 2 doi:10.1093/heapro/das061.

GUGGLBERGER, L. & INCHLEY, J. 2014. Phases of health promotion implementation into the Scottish school system. *Health Promotion International*, 29(2): 256–66.

HAIDER, S., AHMAD, J. & AHMED, M. 2018. Identifying barriers to implementation of health promoting schools in Pakistan: The use of qualitative content analysis and fuzzy analytic hierarchy process. *International Journal of Advanced and Applied Sciences*, 5(4): 56-66

HALES, D. 2009. *An invitation to health.* Belmont, CA: Wadsworth Cengage Learning.

HANCOCK, B. 1998. *Trent Focus for Research and Development in Primary Health Care: An Introduction to Qualitative Research.* Nottingham: Trent Focus Group.

HAN, S. & WEISS, B. 2005. Sustainability of teacher implementation of school based mental health programmes. *Journal of Abnormal Child Psychology*, 33, 665-679.

HARGREAVES, A. 1994. *Changing Teachers, Changing Times: teachers' work and culture in the postmodern age*. London: Cassell.

HARGREAVES, A. & FULLAN, M. 2012. *Professional Capital: Transforming teaching in every school.* Teacher College Press: Canada.

HARPER, T. & OLDENBURG, B. 2009. *Call for a National Charter for Health*. Issue Paper, February 2009.

HARTAS, D. 2010. Quantitative research as a method of inquiry in education. In D. Hartas (Ed.), *Educational research and inquiry: Qualitative and Quantitative approaches* (pp. 65-81). New York: Continuum International Publishing Group.

HATCH, J. A. 2002. *Doing qualitative research in education settings.* Albany: SUNY Press.

HATCH, J. A. 2002. *Doing qualitative research in education settings*. Albany: State University of New York Press.

HAWKINS, J. D., CATALANO, R., KOSTERMAN, R., ABBOT, R. D. & HILL, K. G. 1999. Preventing adolescent health-risk behaviour by strengthening protection during childhood. *Archives of Paediatrics' and Adolescent Medicine*, 153: 226. 234.

HAY, R.B. 2009. Inclusive Education: educators‟ perceptions of teaching learners with emotional, cognitive and physical barriers to learning. Unpublished Theses: University of Witwatersrand.

HEATON, T. B. 2014. Race differences in education attainment of youth aged 7-18 in post-apartheid South Africa: The role of family structure, recourses and school quality. *South African Review of Sociology,* 45 (1).

HENDERSON, A.T. & MAPP, K.L. 2002. A New Wave of Evidence: The Impact of School, Family, and Community Connections on Student Achievement. National Center for Family and Community Connections with Schools, Southwest Educational Development Laboratory. *International Journal of Educational Research,* 35:1-9.

HENNING, E., VAN RENSBURG, M. & SMITH, B. 2004. *Finding your way in qualitative research*. Pretoria: Van Schaik.

HENNING, E., VAN RENSBURG, W. & SMITH, B. 2005. Finding your way in qualitative research. Van Schaik Publishers.

HENNING, E., VAN RENSBURG, W. & SMITH, B. 2011. *Finding your way in qualitative research.* Pretoria: Van Schaik.

HERMAN, K.C., MERRELL, K.W., REINKE, W.M. & TUCKER, C.M. 2004. The role of the school psychology in preventing depression. *Psychology in the schools*. 41(7)763-775.

HERMAN, H., SAXENA, S. & MOODIE, R. (Eds). 2005. *Promoting mental health: concepts, emerging evidence, practice: report of the World Health Organization*. Geneva: World Health Organisation Press.

HEWARD, S., HUTCHINS, C. & KELEHER, H. 2007. Organisational change- key to capacity building and effective health promotion. *Health Promotion International*. 22 (2): 170-178.

HJELM, J.R. 2010. *The Dimensions of health: conceptual models*. Sudbury, MA: Jones and Bartlett.

HOYLE, T.B., SAMEK, B.B. & VALOIS, R.F. 2008. Building capacity for the continuous improvement of health promoting schools. *Journal of School Health*, 78(1): 1-8.

HOYLE, T. B., BARTEE, R. T. & ALLENSWORTH, D. D. 2010. Applying the process of health promotion in schools: a commentary *Journal of School Health*, 80(4): 163–166.

HOLLIDAY, A. 2002. Doing and writing qualitative research. London: Sage Publications. [Online]: Available at: http://www.humanrace.org/prelogin/content/help/PGHPS_final.pdf

HOEPFL, M. 1997. Choosing Qualitative Research: A Primer for Technology Education Researchers. *Journal of Technology Education*, 9(1): 1-10. Retrieved on July 15, 2011, from http://scholar.lib.vt.edu/ejournals/JTE/v9n1/.

HOSEK, S., HARPER, G., LEMOS, D. & MARTINEZ, J. 2008. An ecological model of stressors experienced by youth newly diagnosed with HIV. *Journal of HIV/AIDS Prevention in Children & Youth,* 9(2): 192-218.

HUGO, A. 2006. Overcoming barriers to learning through mediation. In M. Nieman & R Monyai (Eds.). *The Educator as mediator of learning* (pp. 43-71). Pretoria: Van Schaik.

INCHLEY, J., MULDOON, J. & CURRIE, C. 2007. Becoming a health promoting school: evaluating the process of effective implementation in Scotland. *Health Promotion International,* 22(1): 65-71.

INCHLEY, J., CURRIE, C. & YOUNG, I. 2000. Evaluating the health promoting school: a case study approach. *Health Education,* 100: 200-206

INTEGRATED SCHOOL HEALTH POLICY (ISHP). 2012. *National Department of Health and National Department of Basic Education:* Pretoria: Government Printer.

INTERNATIONAL UNION FOR HEALTH PROMOTION & EDUCATION (IUHPE). 2000. *The evidence of health promotion effectiveness*. Brussels: European Commission.

INTERNATIONAL UNION FOR HEALTH PROMOTION & EDUCATION (IUHPE). 2005. Health promotion in schools- a historical perspective. *Promotion & Education* XII, 3-4.

ISRAEL, G.D. & GALINDO-GONZALEZ, S. 2011*. Using focus group interviews for planning or evaluating extension programmes*. Florida Cooperative Extension Service, University of Florida.

JAPANESE INTERNATIONAL CO-OPERATION AGENCY (JICA). 2007. Annual Report 2007. [Online]: Available at: http://www.jica.go.jp/english/publications/reports/annual/2007/ [Date accessed 13 April 2014].

JENSEN, B.B. & SIMOVSKA, V. 2002. *Models of health promoting schools in Europe*. Copenhagen: European Commission.

JOHNSON, B. & LAZARUS, S. 2003. Building Health-Promoting and Inclusive Schools in South Africa: Community-based intervention in action. *Journal of Prevention and Intervention in the Community*, 25(1): 81-97.

JOHNSON, R.L., SENDALL, M.C. & MCCUAIG, L.A. 2014. Primary schools and the delivery of relationships and sexuality education: the experience of Queensland teachers. *Sex Education,* 14(4):359-374*.*

JOSSELSON, R., LIEBLICH, A. & MCADAMS, D. P. 2003. *Up close and personal: the teaching and learning of narrative research* [Online]. Washington, DC: American Psychological Association.

JOURDAN, D. 2011. Health education in schools. The challenges of teacher training. Saint-Denis: In pes, coll. Santé en action.

JOURDAN, D., SAMDAL, O., DIAGNE, F. & CARVALHO, G. S. 2008. The future of health promotion in schools goes through the strengthening of teacher training at a global level. *Promotion & Education*, 15(3): 36–38. doi:10.1177/1025382308095657

JOURDAN, D., STIRLING, J., MACNAMARA, P.M. & POMMIER, J. 2011. The influence of professional factors in determining primary school teachers' commitment to health promotion. *Health Promotion International*, 20 (3).

JOURDAN, D., MCNAMARA, P.M., SIMAR, C., GEARY, T. & POMMIER, J. 2010a. Factors influencing the contribution of staff to health education in schools. *Health Education Research*, 25 (4): 519-530. [Date accessed 13 August 2013] https://doi.org/10.1093/her/cyq012

JOURDAN, D*.,* POMMIER, J. & QUIDU, F. 2010b*.* Practices and representations of health education among primary school teachers*. Scandinavian Journal of Public Health,* (38): 86-94.

JOURDAN, D., SIMAR, C., DEASY, C., CARVALHO, G.S. & McNAMARA, P.M. 2016. School health promotion and teacher professional identity. *Health Education*, 116 (2): 106-122.

JUKES, M., SIMMONS, S. & BUNDY, D. 2008. Education and vulnerability: the role of schools in protecting young women and girls from HIV in Southern Africa. *AIDS*, 22 (4): 41-56.

KARSTENS, A.C. 2010. Towards an epistemological framework for a Life Orientation programme based on spirituality. PhD Thesis. North West University.

KELLY, K. 2006. From encounter to text: collecting data in qualitative research. In M. Terr Blanche, K. Durrheim, & D. Painter (Eds.). *Research in Practice: Applied Methods for Social Science Research* (2nd ed.). Cape Town: University of Cape Town Press.

KICKBUSCH, I. 1981. Involvement in health: A social concept of health education. *International Journal of Health Education*, Supplement to Vol XXIV, No 4, October –December, pp.3−13.

KICKBUSCH, I. 1986. Health Promotion: a global perspective. *Canadian Journal of Public Health*, 22(2): 321−326.

KICKBUSCH, I. 1989. Approaches to an ecological base for public health. *Health Promotion*, 4, 265−268.

KICKBUSCH, I. 2003. The Contribution of the World Health Organization to a New Public Health and Health Promotion. *American Journal of Public Health,* 93(3): 383-388.

KIDGER, J., GUNNELL, D., BIDDLE, L., CAMPBELL, R. & DONOVAN, J. 2010. Part-and-parcel of teaching? Secondary school staff's views on supporting student emotional health and well-being. *British Educational Research Journal,* 36(6):919–935.

KIRBY, D.B., LARIS, B. A. & ROLLERI, L. A. 2007. Sex and HIV education programmes: Their Impact on Sexual behaviours of young people throughout the world. *Journal of Adolescent Health,* 40(3): 206-217.

KIRK, D. 2006. The obesity crisis and school physical education. *Sport, Education and Society,* 11(2): 121-133.

KONU, A. & RIMPELÄ, M. 2002. Well-being in schools: a conceptual model. *Health Promotion International*, (17)1:79-87.

KREMSER, W. 2011. Phases of school health promotion implementation through the lens of complexity theory: Lessons learnt from an Austrian case study. *Health Promotion International*, 26(2): 136–47.

KITZINGER, J. 1995. Qualitative research: introducing focus groups. *British Medical Journal,* 311 (7000): 299-302.

KWAN, S.Y.L., PETERSEN, P.E., PINE, C.M. & BORUTTA, A. 2005. Health-promoting schools: An opportunity for oral health promotion. *Bulletin of the World Health Organization*, 83(9):677-685.

KWATUBANA, S. & KHESWA, J. 2014. Integrated approach to health promotion: The South African schools' role. *Mediterranean Journal of Social Sciences*, 5 (20).

KWATUBANA, S. 2014. School community participation and School Health Promotion: Challenges and opportunities. *Mediterranean Journal of Social Sciences*, 5 (27).

KWATUBANA, S. 2018. Harmonising the Efforts of School Nurses and Teachers in Health Promotion in Schools. *Africa Education Review*, DOI:10.1080/18146627.2016.1251294

LANDBROOK, M. 2009*. Challenges experienced by educators in the implementation of inclusive education in primary schools in South Africa*. Unpublished M.Ed dissertation. Pretoria: University of South Africa.

LANDSBERG, E. 2011. *Addressing barriers to learning: A South African Perspective.* [2nd ed.], Pretoria: Van Schaik Publishers.

LANDSBERG, E; KRUGER, D. & NEL, N. 2005. *Addressing barriers to learning: A South African Perspective*. [1st ed.], Pretoria: Van Schaik.

LANDSBERG, E., KRUGER, D. & SWART, E. 2011. *Addressing barriers to learning: a South African perspective.* Van Schaik: Pretoria.

LANGFORD, R., BONELL, C., JONES, H. & CAMPHBELL, R. 2015. Obesity prevention and the Health Promoting Schools framework: essential components and barriers to success. *International Journal of Behavioural Nutrition and Physical Activity*, 12 (15).

LARSEN, T. & SAMDAL, O. 2008. Facilitating the implementation and sustainability of second step. *Scandinavian Journal of Educational Research*, 52(2): 187–204.

LAUERMANN, F.V. 2013. Teacher responsibility: Its meaning, measure, and education implications. PhD. University of Michigan.

LAWSON, P.J. & FLOCKE, S.A. 2009. Teachable moments for health behaviour change: A concept analysis. *Patient Education and Counselling,* 76: 25-39.

LAZARUS, S., DAVIDOFF, S., & DANIELS, B. 2000. Developing health promoting and inclusive schools within an integrated framework for understanding and developing schools. *Paper presented at the National Health Promoting Schools Task Team Meeting, 15 September 2000, and at the National Conference on Learner Support and Development*, 26 September 2000, in Cape Town, South Africa.

LAZARUS, S. 2006. Indigenous approach to health promotion: Challenges for education support in South Africa. *South African Journal of Psychology,* 36 (3): 521-546.

LEAHY, D., BURROWS, L., MCCUAIG, L., WRIGHT, J. & PENNEY, D. 2016*. School Health Education in Changing Times. Curriculum, Pedagogies and Partnerships.* London: Routledge.

LEAN, D.S. & COLUCCI, V.A. 2010. *Barriers to learning: The case for integrated mental health services in schools.* Toronto: Rowman & Littlefield Education.

LEE, A., CHENG, F.F.K., FUNG, Y. & ST LEGER, L. 2006. Evidence based policy and practice: Can Health Promoting Schools contribute to the better health and well-being of young people? The Hong Kong Experience. *Journal of Epidemiology and Community Health,* 60 (6): *530-536.*

LEE, A. 2009. Health-Promoting Schools evidence for a holistic approach to promoting health and improving health literacy. *Applied Health Economic Health Policy,* 7 (1): 11-17

LEE, A., TSANG, K., LEE, S., TO, C. & TO, C.O. 2001. Challenges in the development of Health Promoting Schools: A review of Hong Kong innovations and initiatives. *Health Education*, 10(2): 83-89.

LEEDER, S.R. 1997. Health promoting environments: the role of public policy. *Australian and New Zealand Journal of Public*, 21: (413-414).

LEEDY, P.D. & Ormrod, J.E. 2001. *Practical research: planning and design.* (7th ed.). New Jersey: Merrill Prentice Hall.

LEEDY, P.D. & OMROD, J.E. 2005. *Practical research: Planning and design*. (8th ed.). Upper Saddle River: Merrill Prentice Hall.

LEEDY, P. D. & ORMROD, J. E. 2004. *Practical research: Planning and design*. (8th ed.). Upper Saddle River, NJ: Merrill Prentice Hall.

LEEDY, P. D. & ORMROD, J. E. 2010. *Practical research: Planning and design*, Upper Saddle River.

LEIBSON, C.L., KATUSIC, S.K., BARBARESI, W.J., RANSOM, J., & O'BRIEN, P.C. 2001. Use and costs of medical care for children and adolescents with and without attention-deficit/hyperactivity disorder. *Journal of the American Medical Association, 285,* 60–66.

LEURS, M.T.W., BESSEMS, K., SCHAALMA, H.P. & De VRIES, H. 2007. Focus points for school health promotion improvements in Dutch primary schools. *Health Education Research,* 22(1): 58-69.

LEMMER, E. 1992. Qualitative research methods in education. *South African Journal of Education,* 12(3): 292-296.

LE ROUX, V. 2017. A profile of the health promoter in schools in the North-West Province. M.Ed Dissertation. North-West University.

LICHTMAN, M. 2010. *Qualitative research in education: A user's guide*. Thousand Oaks, California: SAGE.

LINCOLN, Y.S. & GUBA, E.G. 1985. *Naturalistic Inquiry*. Newbury Park, CA: Sage Publications.

LINDSAY, G. 2007. Education psychology and the effectiveness of inclusive education/mainstreaming. *British Journal of Educational Psychology*, 77(1): 1-24.

LONG-SHAN, X., BAO-JUN, P., JIN XIANG, L., LI-PING, C., SEN-HAI, Y. & JONES, J. 2000. Creating health promoting schools in rural China: A project started from deworming. *Health Promotion International*, 15(3): 197-206.

LYNAGH, M., PERKINS, J. & SCHOFIELD, M. 2002. An evidence-based approach to health promoting schools. *Journal of school health,* 72 (7), 300-301.

MACMILLAN EDUCATION. 2007. Macmillan English Dictionary for Advanced Learners. London: Bloomsbury.

MACNAB, I. 2009. Collaborative consultation: Psychologists and teachers working together. In P. Hick, R. Kershner, & T. Farrel (Eds.), *Psychology for inclusive education* (pp. 139-149). New York: Routledge.

MACNAB, A.J., KANGASAKI, A., MBABALI, M., ZAVUGA, R., RADZIMINSKI, N., BUDDEN, H. & GAGNON, F. 2010. Brighter smiles Africa. Translation of Canadian community-based health promoting school program to Uganda. *Education for Health*, 23 (2), 1-8.

MACNAB, A.J. & KANGASAKI, A. 2012. Many voices, one song: A model for an oral health programme as a first step in establishing a health promoting school. *Health Promotion International*, 27(1): 63-73.

MACNAB, A.J. 2013. The Stellenbosch consensus statement on HPS. IUHPE*, Global Health Promotion,* 20(1): 78- 81.

MACNAB, A.J., GAGNON, F. & STEWART, D.E. 2014. HPS: Consensus, strategies and potential. *Health Education*, 114(3):170-185.

MACNAB, A. J. 2014. Health promoting schools: Initiatives in Africa. *Health Education,* 114 (1).

MACNAB, A.J., GAGNON, F.A. & STEWART, D. 2014. Health promoting schools: consensus, strategies and potential. *Health Education,*114 (3):170-185.

MACNAB, A.J., STEWART, D. & GAGNON, F.A. 2014. HPS initiatives in Africa. *Health Education*,114, (4): 246-259.

MAHLO, F.D. 2012. Experiences of Learning Support Teachers in the Foundation Phase with reference to the implementation of Inclusive Education in Gauteng. D Ed Thesis. University of South Africa: Pretoria.

MAREE, K. 2010. *First steps in research*. Pretoria: Van Schaik Publishers.

MAREE, K. 2011. *First steps in research,* Hatfield, Pretoria: Van Schaik Publishers.

MAREE, J.G. 2012. *Complete your thesis or dissertation successfully: Practical guidelines.* Cape Town: Juta.

MARKHAM, W. & AVEYARD, P. 2003. A new theory of health promoting schools based on human functioning, school organisation and pedagogic practice. *Social Science & Medicine,* 56(6): 1209–1220.

MARKS, R. 2009. "Schools and health education. What works, what is needed and why?" *Health Education,* 109(1):4-8.

MARSHARK, M. & HAUSER, P. 2013. H*ow deaf children learn: What parents and teachers need to know?* New York: Oxford University Press.

MARSHALL, B., SHEEHAN, M., NORTHFIELD, J., MAHER, S., CARLISLE, R. & ST. LEGER, L.H. 2000. School-based health promotion across Australia. *Journal of School Health,* 70 (6): 251-252

MARSHALL, C. & ROSSMAN, G.I. 1994. *Designing a qualitative research*. Newbury Park, CA: Sage.

MARSHALL, M. 1996. Sampling for qualitative research. *Family Practice*, 13 (6): 522-525.

MASHAU, T.I. 2011. The role of parents in health promoting schools. MED. Dissertation. Potchefstroom: North-West University.

MARX, E., WOOLEY, S.F. & NORTHROP, D. 1998. *Health is Academic: A guide to coordinated school health programmes*. New York: Teachers College Press, Columbia University.

MBANYA, J.C.N., MOTALA, A.A., SOBNGWI, E., ASSAH, F.K. & ENORU, S.T. 2010. Diabetes in Sub-Saharan. *Lancet*, 375 (9733): 2254-2256.

McDONALD, H. & ZIGLIO, E. 1994. European schools in a changing environment: health promoting opportunities not to be lost. In Chu, C.M. & Simpson, R. (eds.). *Ecological Public Health: from Vision to Practice*. Griffith University, Brisbane.

McENVOY, A. & WELKER, R. 2000. Antisocial behaviour, academic failure and school climate: a critical review. *Journal of Emotional and Behavioural Disorders*, 8 (130-140).

MCMILLAN, J.H. & SCHUMACHER, S. 2010. *Research in education: Evidence-based inquiry*. (7th ed.). New York: Pearson.

McQUEEN, D.V & JONES, C.M. 2007. *Global Perspective on Health Promotion Effectiveness.*(pp.107-124). New York: International Union for Health Promotion and Education. Springer.

MCRAE, D. 1988. *Teachers, Schools and Change*. Richmond: Heinemann Educational Australia.

MEIER, C. & LEMMER, G. 2015. What do parents really want? Parents' perceptions of the children's schooling. *South African Journal of Education*, 32(2).

MERRIAM, S.B.1998. *Qualitative research and case study application in education*. San Francisco: Jossey-Bass.

MERRIAM, S. B. 2009. *Qualitative research: A guide to design and implementation*. San Francisco: Jossey Bass.

MERTENS, D.M. 1998. *Research methods in education and psychology: Integrating diversity with quantitative and qualitative approaches*. Thousand Oaks, CA: Sage.

MERTENS, D. M. 2009. *Transformative Research and Evaluation*. New York: The Guilford Press.

MEWEZINO, A. 2010. Improving schools by improving parental involvement. Unpublished M Ed dissertation. Dayton: University of Dayton.

MIGLIORETTI, M., VELASCO, V., CELATA, C. & VECCHIO, L. 2012. Teachers' ideas about health: Implications for health promotion at school. *Health Education Journal,* 0(0): 1-13.

MITCHELL, M. & JOLLEY, J. 2010. *Research design explained* (7th ed.). Belmont, California: Wadsworth.

MITTELMARK, M.B., KICKBUSCH, I. & ROOTMAN. I. 2007. *The encyclopaedia of Public Health*. Oxford: Elsevier.

MOHAMED, S. 2015. Factors influencing the implementation of health promoting schools: A multiple case study of three secondary schools in a resource limited community in Cape Town. PhD Thesis: University of the Western Cape.

MOHAMMADI, N.K., ROWLING, L. & NUTBEAM, D. 2010. Acknowledging educational perspectives on HPS. *Health Education,* 110(4): 240-251.

MOHLABI, D., VAN ASWEGEN, E. & MOKOENA, J. 2010. Barriers to the successful implementation of school health services in the Mpumalanga and Gauteng Provinces. *South Africa Family Practice*, 52 (3): 249–254.

MOOLLA, N., LAZARUS, S. & REDDY, P. 2007. Challenges of inter-sectoral collaboration in education support services in South Africa. *South African Journal of Education*.

MORGAN, D.L. 1997. *Focus groups as qualitative research.* (2nd ed). Thousand Oaks: Sage.

MORMOT, M. 2005. Social determinants of health inequities. *Lancet,* 365 (9464), 1099-1104.

MORSE, J.M. & NIEHAUS, L. 2009. *Mixed Method design. Principles and procedures.* California: Walnut Creek.

MORSE, J.M. & RICHARD. L. 2002. *Read me first for a user's guidance to qualitative methods.* California: Sage.

MORTON, R. & LLOYD, J. 1994. *The Health Promoting Primary School.* London: David Fulton Publishers.

MOUTON, J. 2001. *How to succeed in your Master's and Doctoral Studies: A South African Guide and Resource Book.* Pretoria: Van Schaik Publishers.

MOTLATLA, R. 2007. *The National Guidelines for the Development of the Health Promoting Schools in South Africa Draft 3*. Pretoria: Government Printers.

MTHIYANE, S.E. 2013. Dynamics of school based violence: Exploring school governing bodies in addressing violence in post conflict South African schools. Thesis. University of KwaZulu-Natal.

MUKOMA, W. & FLISHER, A.J. 2004. Evaluations of health promoting schools review of nine studies. *Health Promotion International,* 19(3): 257- 368.

NAIDOO, J. & WILLS, J. 2009. *Public health and health promotion: Developing practice.* London: Bailliere Tindall.

NAIDOO, J. & WILLS, J. 2010a. *Developing practice for public health and health promotion.* Bailliere: Edinburgh.

NAIDOO, J. & WILLS, J. 2010b. *Foundations for health promotion*. Baillière Tindall Elsevier.

NATIONAL ASSOCIATION OF SCHOOL NURSES. 2002. *School Health Nursing Services Role in Health Care: Role of the School Nurse*. Silver Spring: National Association of School Nurses.

NATIONAL DEPARTMENT OF HEALTH. 2003. *The National School Health Policy and Implementation Guidelines.* Pretoria: Government Printers.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL. 1996. *Draft report on the school as a setting in improving young people's health.* Canberra: AGPS.

NATIONAL PROGRAMME OF ACTION STEERING COMMITTEE. 1996. National Plan of Action for Children in South Africa.

NEL, M., ENGELBRECHT, P., NEL, M.M. & TLALE, L.D.N. 2013. South African Teachers views of collaboration within an Inclusive Education system. *International Journal of Inclusive Education*, 18(9): 903-917.

NEL, N., NEL, M. & HUGO, A. 2013*. Learner support in a diverse classroom. A guide for Foundation, Intermediate and Senior Phase teachers of language and Mathematics.* Pretoria: Van Schaik Publishers.

NEW ZEALAND HEALTH PROMOTING SCHOOLS NATIONAL STRATEGIC FRAMEWORK, 2011. Ministry of Health. Cognition of Education. New Zealand.

NEUMAN, W. L. 2010. *Social Research Methods: Quantitative and Qualitative Methods*. Allyn & Bacon, Incorporated.

NEUMAN, W. L. 2011. *Social research methods. Qualitative and quantitative approaches*. Boston. Allyn and Bacon.

NEWMANN, F.M., KING, M.B. & RIGDON, M. 1997, Accountability and School Performance: implications from restructuring schools. *Harvard Educational Review*, 67(1): 41−74.

NIC GABHAINN, S., O'HIGGINS, S. & BARRY, M. 2010. The implementation of social, personal and health education in Irish schools. *Health Education,* 110(6): 452 – 470.

NIEMANN, M.M. & MONYAI, R.B. 2012. *The educator as a mediator of learning*. 8th impression. Van Schaik: Pretoria.

NIEUWENHUIS, J. 2007. *Analysing qualitative data.* In Creswell, J.W., Ebersöhn, L., ELOFF, I., FERREIRA, R., IVANKOVA, N.V., JANSEN, J.D. NIEUWENHUIS, J.,PIETERSON, V.L., PLANO, C.V.L. & VAN DER WESTHUIZEN, C. *First Steps in Research.* Pretoria: Van Schaik Publishers.

NIEUWENHUIS, J. 2010a. Qualitative research designs and data gathering techniques. In K. Maree (Ed.). *First Steps in Research*. Hatfield: Van Schaik Publishers.

NIEUWENHUIS, J. 2010b. Introducing qualitative research. In K. Maree (Ed.). *First Steps in Research*. (pp.47-68). Hatfield: Van Schaik Publishers.

NORDIN, L.L. 2016. Implementing the health promoting school in Denmark: a case study. *Health Education*, 116 (1): 86-103.

NORTHFIELD, J., ST LEGER, L., MARSHALL, B., SHEEHAN, M., MAHER, S., & CARLISLE, R. 1998. *School based health promotion across Australia (Background Briefing Report No.1)*. Sydney: Commonwealth Department of Health and Family Services and the Australian Health Promoting Schools Association.

NTAGUNGIRA, E.K. 2014. Building a Health-Promoting Schools Conceptual Framework Model as a Strategy to Address Barriers to Learning and to Promote Healthy Development of School-Aged Children in Rwanda. Thesis. University of Western Cape.

NTSANWISI, L. 2007. The identification of barriers to learning by Grade 3 teachers in the Ritavi district of Limpopo Province. Unpublished M. Ed dissertation. Limpopo: University of Limpopo.

NUTBEAM, D. 1992. The health promoting school: closing the gap between theory and practice*. Health promotion International,* 7(3): 151- 153*.*

NUTBEAM, D. 1998. Evaluating health promotion-progress, problems and solutions. *Health Promotion International*, 13(1): 27-44.

NYAMWAYA, D. 2003. Health promotion in Africa: Strategies, players, challenges and prospects. *Health Promotion International,* 18 (2).

ODORA-HOPPERS, C. A. 2001. Indigenous knowledge systems: An invisible resource in literacy in education. Article based on a paper presented at '*The Role of Adult Education in Sustainable Development' Conference*, *2001*.

OKEKE, C & VAN WYK, M. 2015. Educational research. An African approach. Oxford University Press.

ONCHWARI, G., ONCHWARI, J. & KEENGWE, J. 2008. Teaching the immigrant child: Application of child development theories. *Early Childhood Education Journal,* 36(3): 267-273.

OXFORD ADVANCED LEARNER'S DICTIONARY. 2000. 6th Ed. London: Oxford University Press.

PARSONS, C. & STEARS, D. 2002. Evaluating health-promoting schools: Steps to success. *Health Education*, 102(1): 7-15.

PARSONS, C., STEARS, D. & THOMAS, C. 1996. The health promoting school in Europe: conceptualising and change. *Health Education Journal*, 55: (311-321).

PATTON, M.Q. 2002. *Qualitative Research and Evaluation Methods.* (3rd ed.). London: Sage Publications.

PEARSONS, J.R. 2002. Health Promotion in one New Zealand Primary School. A case study-Unpublished doctoral dissertation. Victoria University: Wellington.

PEU, MD; NAPOLES, L; WENHOLD, F; MOSTERT-WENTZEL, K. & SEANE, N. 2010. Health education training needs of educators at Makapanstad schools in the North West Province. *Curationis*, 33 (1): 33-41.

PEU, D., MATABOGE, S., LADZANI, R., WESSELS, L., MOSTERT, W. & SEANE, N. 2015. Perceptions of educators regarding the implementation of the health promotion programme manuals for children in schools in Makapanstad, South Africa. *Curationis,* 38(2).

PERSSON, L. & HARALDSSON, K. 2010. Health promotion in Swedish schools: managers' views. *Health Promotion International. doi:10.1093/heapro/dat073.*

PETERS, L.W.H., KOK, G. & TEN DAM, G.T.M. 2009. Effective elements of school health promotion across behavioural domains: A systemic review of review. *BMC Public Health. 9: 182.*

PETERSON, F.L., COOPER, R.J. & LAIRD, J.M. 2001. Enhancing teacher health literacy in school health promotion: a vision for the new millennium. *Journal of School Health.* 71(4): 138-144.

PIETERSE, G. 2010. Establishing a framework for an integrated, holistic community based education support structure. D.Ed thesis. Port Elizabeth: Nelson Mandela Metropolitan University.

PILLAY, K. 2000. Schools-based crime prevention with specific reference to the prevention of drug abuse. *Acta Criminologica*, 13(1): 72-79.

POLAND, B., KRUPA. G. & MCCALL, D. 2009. Settings for health promotion: an analytic framework to guide intervention design and implementation. *Health Promotion Practice,* 10(4): 505-516.

POWER, C. 2006. Education for the future: an international perspective. *Educational Research Policy Practice, 5,* 165-174. [Date accessed July 7 2010].

PREISER, R. 2014. External stakeholders and HPS: complexity and practice in South Africa. *Health Education,* 114 (4).

PREISER, R., STRUTHERS, P., MOHAMED, S. CAMERON, N. & LAWRENCE, E. 2014. Eternal stakeholders and health promoting schools: Complexity and practice in South Africa. *Health Education*, 114(4): 260-270.

PRICE, M. 1986. Health care as an instrument of apartheid policy in South Africa. *Health Policy and Planning*, 1(2):158-170.

PRIDMORE, P. 2000. Children's participation in development for school health. *British Association of International and Comparative Education*, 30(1),103-111.

QUIRKE, M.B.C. 2015. An evaluation of the effect of a health promoting school approach, *The Healthy Schools Programme*, on the psychological health and well-being of primary school-aged children. Unpublished doctoral thesis, Maynooth University: Ireland.

RASMUSSEN, V. B. & RIVETT, D. 2000. The European Network of Health Promoting Schools: an alliance of health, education and democracy. *Health Education,* 100 (2).

RASMUSSEN, V. B. 2005. The European Network of Health Promoting Schools – from Iceland to Kyrgyzstan. *Promotion & Education,* 12 (3): 169-172.

RENWICK, K. 2006. HPS – the right way. Unpublished doctoral dissertation, Victoria University: Melbourne, Australia.

REPORT 2007. [Online]: Available at: http://www.jica.go.jp/english/publications/reports/annual/2007/ Date of access: 10 Nov 2014.

RICHARDSON, J. W. 2007. Building bridges between school-based health clinics and schools. *The Journal of School Health*, 77(7): 337–43. doi:10.1111/j.1746-1561.2007.00217.x

RICHTER, L. 2004. The impact of HIV/AIDS on the development of children. In Pharoah, R. (Ed.), *A generation at risk: HIV/AIDS, vulnerable children and security on Southern Africa.* Pretoria: Institute of Security Studies.

ROSAS, S., CASE, J. & THOLSTRUP, L. 2009. A retrospective examination of the relationship between implementation quality of the coordinated school health programme model and school-level academic indicators over time. *The Journal of School Health,* 79(3): 108.

ROSS, A. 2010. Nutrition and its effect on academic performances. How can our schools improve? Dissertation. Northern Michigan University.

ROUX, J. 2013. Life Orientation in the health promoting schools. Thesis. Potchefstroom: North-West University.

ROOTH, E. 2005. An investigation of the status and practice of Life Orientation in South African schools in two provinces. Unpublished PhD Thesis, University of Western Cape: Cape Town.

ROWLING, L. 1996. The adaptability of the health promoting schools concept: A case study from Australia. *Health Education Research*, 11(4): 519–26.

ROWLING, L. & JEFFREYS, V. 2000. Challenges in monitoring the development of HPS, *Health Education*, 100, 117-23.

ROWLING, L. 2003. School mental health promotion research: Pushing the boundaries of research paradigms. *Australian E-Journal for the Advancement of Mental Health*, 2(2).

ROWLING, L. & JEFFREYS, V. 2006. Capturing complexity: Integrating health and education research to inform health promoting schools policy and practice. *Health Education Research,* 21(5): 705-718.

ROWLING, L. & SAMDAL, O. 2011. Filling the black box of implementation for health promoting schools. *Health Education*, 111(5): 347–366.

ROWLING, L. & JEFFERYS, V. 2000. Challenges in the development and monitoring of Health Promoting Schools. *Health Education 100,* 117-123

RUBIN, H.J. & RUBIN, I.S. 1995. *Qualitative interviewing: The art of hearing data*. Thousand Oaks, CA: Sage.

RULE, P. & JOHN, V. 2011. *Your guide to case study research* (1st ed.). Pretoria: Van Schaik Publishers.

SAMDAL, O. & ROWLING, L. 2011. Theoretical and empirical base for implementation components of health promoting schools. *Health Education*, 111(5): 367-390.

SAMDAL, O. 2008. School health promotion. In H. Heggenhougen (Ed.) *The Encyclopaedia of Public Health*, 5, 653-61.

SAMDAL, O. & ROWLING, L. 2013. *The implementation of Health Promoting Schools. Exploring theories of what, why and how*. London: Routledge.

SAMDAL, O., NUTBEAM, D., WOLD, B. & KANNAS, L. 1998. Achieving health and educational goals through schools. A study of the importance of the school climate and the students' satisfaction with school. *Health Education Research*,13, 383-397.

SAMDAL, O., VIIG, N.G. & WOLD, B. 2010. Health promotion integrated into school policy and practice: experiences of implementation in the Norwegian network of health promoting schools. *Journal of Child and Adolescent Psychology,* 1(2): 43- 72.

SAVENYE, W. & ROBINSON, R. 2004. Qualitative research issues and methods: An introduction for educational technologists. In D. Jonassen (Ed.), *Handbook of research on educational communications and technology* (2nd ed.), (pp. 1045-1071). New Jersey: Lawrence Erlbaum.

SAWAYA, M.M. 2006. Malnutrition and poor academic performances: critical contributions. *Estudos Avançados*, 20(58): 133-146.

SCHAGEN, S., BLENKINSOP, S., SCHAGEN, I., SCOTT, E., EGGERS, M., WARWICK, I., CHASE, E. & AGGLETON, P. 2005. Evaluating the impact of the National Healthy School Standard: using national datasets. *Health Education Research*, 20 (6): 688-696.

SCHMIDT, M. & DATNOW, A. 2005. Teachers' sense making about comprehensive school reform: The influence of emotions. *Teaching and Teacher Education*, 21 (2005): 949-965.

SCHOOLS FOR HEALTH IN EUROPE (SHE). 2013. "Acting for better schools, leading to better lives". [Online]: Available at: www.schoolsforhealth.eu (Date accessed 20 July 2014).

SHENTON, A.K. 2004. Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information,* 22(2):63-75.

SHEPARD, J., DEWHIRST, S., PICKETT, K., BYRNE, J., SPELLER, V., GRACE, M., ALMOND, P., HARTWELL, D. & RODERICK, P. 2013. Factors facilitating and constraining the delivery of effective teacher training to promote health and well-being in schools. a survey of current practice and systematic review. *Public Health Research,* 1(2).

SHUNG-KING, M. 2014. *2003-2009 Review Report. Implementing the National School Health Policy in South Africa*. Oxford University: UK.

SHUNG-KING, M. 2012. Why child health policies in post-apartheid South Africa had not performed as intended. The Case of the School Health Policy. DPhil thesis. Oxford University: UK.

SHUNG-KING, M., ORGILL, M. & SLEMMING, W. 2014. School health in South Africa: reflections on the past and prospects for the future. *South African Health Review* 2013/14: 59-72.

SHUNG-*KING, M. 2013.* From 'stepchild of primary healthcare' to priority programme: Lessons for the implementation of the National Integrated School Health Policy in South Africa*. South Africa Medical Journal,* 103 (12): 895-898.

SILVERMAN, D. 2005. *Doing qualitative research: A practical handbook*. London, Thousand Oaks, New Delhi: Sage Publications.

SIMAR, C., JOURDAN, D., PIZON, F. & BARNOIN. F. 2007. Teachers' professional positioning in relation to a health education program. Communication at the 2007 World Conference of IUHPE, Vancouver: Canada.

SIMOVSKA, V. 2004. Student participation – simulation or reality? A vignette from the Macedonian network of health promoting schools. *Health Education*, *104*(3), 163–173.

SIMOVSKA, V. 2005. CHAPTER 9. Participation and learning about health, p177. In Cliff, S. & Jensen, B.B. 2005. *The Health Promoting Schools: International Advances in Theory, Evaluation and Practice*. Danish University of Education Press.

SIMOVSKA, V. 2012. Case study of a participatory health promotion intervention in school. *Democracy & Education*, 20, 1–10.

SIMOVSKA, V. 2012. What do health-promoting schools promote? Processes and outcomes in school health promotion. *Health Education*, 112(2): 84-88.

SIMOVSKA, V. & MCNAMARA, P. (eds). 2015. *Schools for Health and Sustainability: Theory, Research and Practice.* Springer Science+Business Media B.V., Dordrecht.

SINGH, P., MBOKODI, S. & MSILA, V. 2004. Black parental involvement in education. *South African Journal of Education*, 24(4): 301-307.

SIZANANG CENTRE FOR RESEARCH & DEVELOPMENT. 2006. Baseline study

for project: Enhancing the health and well-being of disadvantaged communities in Gauteng through the health promoting school concept. Pretoria.

SMITH, J.A., FLOWERS, P. & LARKIN, M. 2009. *Interpretative phenomenological analysis: Theory, method and research*. Los Angeles: Sage.

SMITH, W & PHILPOT, R. 2011. Beginning & graduating student-teachers' beliefs about physical education: A case study. *Asia-Pacific Journal of Health, Sport and Physical Education*.

SOUTH AFRICA. 1996. *South African Schools Act no* 84 of 1996. Pretoria: Government Printer.

SOUTH AFRICA. 1997. *National Department of Health. Health promoting schools. Report on Provincial Health Promoting Schools Networks*. Pretoria: Government Printers.

SOUTH AFRICA. 2001. National Department of Health. Youth and adolescent health policy. Pretoria: Government Printers.

SOUTH AFRICA. 2011. *National Strategic Plan on HIV, STIs and TB: 2012-2016*. Pretoria: Government Printers.

SPELLER, V., BYRNE, J., DEWHIRST, S., ALMOND, P., MOHEBATI, L., NORMAN, M., POLACK, S., MEMON, A., GRACE, M., MARGETTS, B. & RODERICK, P. 2010. Developing trainee school teachers' expertise as health promoters. *Health Education,* 110 (6):490-507.

SPELLER, V., BYRNE, J., DEWHIRST, S., ALMOND, P., MOHEBATI, L., NORMAN, M., POLACK. S., MEMON, A., GRACE, M., MARGETTS, B. & RODERICK. 2012. Health promotion in pre-service teacher education: Effects of a pilot inter-professional curriculum change. *Health Education*, 112 (6): 525-542.

SPILT, J.L., KOOMEN, H.M.Y. & THIJS, J.T. 2011. Teacher well-being: The importance of teacher –student relationships. *Educational Psychology Review*, 20(1): 457-477.

STACKS, M. 2005. Using ecological framework for understanding externalizing behaviour in early childhood. *Early Childhood Education Journal,* 32(4): 269-278.

STEWART, D.E. 2014. Resilience: An entry point for African health promoting schools? *Health Education*, 114(3): 197-207.

STEWART-BROWN, S. 2005. Health promotion in schools: Report for the Health Evidence Network. Geneva: WHO.

STEWART-BROWN, S. 2006. What is the evidence on school health promotion in improving health or preventing disease and, specifically, what is the effectiveness of the health promoting school's approach? WHO Regional Office for Europe: Health Evidence Network report: [Online]: Available at: http://www.euro.who.int/document/e88185.pdf.

ST LEGER, L. 1998. Australian teacher's understandings of the health promoting school concept and the implications for the development of school health. *Health Promotion International,* 13(3): 223-235*.*

ST LEGER, L. 1999. Health promotion indicators, coming out of maze with a purpose. *Health Promotion International*, 14(3): 193-195.

ST LEGER, L. 2000. Reducing the barriers to the expansion of health-promoting schools by focusing on teachers. *Health Education,* 100, 81-87*.*

ST LEGER, L. 2001. Schools, health literacy and public health: possibilities and challenges. *Health Promotion International*, 16. 197-205.

ST LEGER, L. 2004. What's the place of schools in promoting health? Are we too optimistic? *Health Promotion International,* 19(4): 405-408.

ST LEGER, L. 2006. Improving the quality of school health evaluations. *Health Education*, 106 (4), 261-264, https://doi.org/10.1108/09654280610673445

ST. LEGER, L. & NUTBEAM, D. 2000. Research into HPS. *Journal of School Health,* 70 (6).

ST LEGER, L., YOUNG, I., BLANCHARD, C. & PERRY, M. 2010*. Promoting* Health *in Schools. From Evidence to Action.* IUHPE, Saint Denis Cedex.

STOFILE, S. & GREEN, L. 2007. Inclusive education in South Africa. In P. Engelbrecht & L. Green (Eds.), *Responding to the challenges of inclusive education in Southern Africa.* Pretoria: Van Schaik.

STORBECK, C. 2009. Educating the deaf and hard of hearing learner. In L. Landsberg, D. Kruger & N. Nel (Eds.) *Addressing barriers to learning: A South African Perspective.* 7th ed. Pretoria: Van Schaik.

STRYDOM, H. 2002. Ethical aspects of research in the social sciences and human services professions. In A.S. de Vos, H. Strydom, C.B. FOUCHÈ & C.S.L. Delport (eds). *Research at Grassroots: a primer for the social sciences and human service professions* (pp.62-76). Pretoria: Van Schaik Publishers.

STRYDOM, H. & DELPORT, C.S.L. 2010. Information collection: Document study and secondary analysis. In A.S. De Vos, H. Strydom, C.B. FOUCHÈ & C.S.L.

Delport. (Eds.). *Research at grass roots: for the social sciences and human service professions* (3rd Ed.). Pretoria: Van Schaik Publishers.

STRYDOM, V.Z. 2011. The support needs of Life Orientation teachers in the further education and training band. Dissertation. Stellenbosch University.

SWART, E., ENGELBRECHT, P., ELOFF, I., PETTIPHER, R. & OSWALD, M. 2004. Developing inclusive school communities: Voices of parents of children with disabilities. *Education as Change*, 8(1): 80–108.

SWICK, K. & WILLIAMS, R. 2006. An analysis of Bronfenbrenner's bio-ecological perspective for early childhood educators: Implications for working with families experiencing stress. *Early Childhood Education Journal,* 33(5): 371- 378.

SUHRCKE, M. & de PAZ NIEVES, C. 2011. *The Impact of Health and Health Behaviours on Educational Outcomes in High-Income Countries: A review of Evidence,* WHO, Regional Office for Europe, Copenhagen.

SWART, D. & REDDY, P. 1999. Establishing network for health-promoting schools in South Africa. *Journal of School Health* 69 (2):47-54.

SWART, R.E. & PETTIPHER, O.R. 2005. Framework for understanding inclusion, In Landsberg, E; Kruger, D. & Nel, N. (eds.). *Addressing barriers to learning*. Pretoria: Van Schaik: 3-21.

SWART, R.E. & PETTIPHER, O.R.1999. Barriers teachers experience in implementing inclusion in South Africa. *Paper presented at the International Association for Special Education Conference* held in Sydney, Australia, July.

SWARTZ, S. 2007. The moral ecology of South Africa's township youth. Unpublished doctorate thesis, University of Cambridge: United Kingdom.

SYMONS, C., CINCELLI, B., JAMES, T.C. & GROFF, P. 1997. Bridging student health risks and academic achievement through comprehensive school health programmes. *Journal of School Health*, 67, 220-227.

TANG, K.C., NUTBEAM, D., ALDINGER, C., St LEGER, L., BUNDY, D. & HOFFMANN, A. 2008. Schools for health, education and development: a call for action. *Health Promotion International, dano37.*

TAYLOR, N., QUINN, F., LITTLEDYKE, M. & COLL, R. 2012. *Health education in context: An international perspective on health education in schools and local communities, sense*. Rotterdam: Netherlands.

TERBURGH, L. 2015. Health promotion in schools: perceptions of the health promotion. Dissertation: North-West University.

TERRE BLANCHE, M., DURRHEIM, K. & PAINTER, D. 2006. *Research in Practice: Applied methods for the social sciences*. (2nd Ed.). Cape Town: University of Cape Town press.

THE CHILDREN'S ACT (Act No. 38 of 2005). 2005. Government of the Republic of South Africa. Pretoria: Government Printers.

THE CONSTITUTION OF THE REPUBLIC OF SOUTH AFRICA. ACT OF 108 OF 1996. Republic of South Africa. Pretoria: Government Printers.

THE HEALTHY SCHOOLS PROGRAMME IN SOUTH AFRICA: INTERSECTORAL CASE STUDY. 2013. WHO Regional Office for Africa.

THE INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION (IUHPE). Promoting health in schools: From evidence to action. 2009. [Online]: Available at http://www.iuhpe.org/?page=516. [Date accessed 3 August 2014].

TJOMSLAND, H. E., LARSEN, T. M. B., VIIG, N. G. & WOLD, B. 2009. A fourteen-year follow-up study of health promoting schools in Norway: Principals perceptions of conditions influencing sustainability. *Open Educational Journal*, 2, 54-64.

TJOMSLAND, H. E. 2010. Sustaining comprehensive physical activity practice in elementary school: a case study applying mixed methods. *Teachers and Teaching: Theory and Practice,*16(1): 73-95.

TJOMSLAND, H. E., IVERSEN, A. C. & WOLD, B. 2009. The Norwegian Network of Health Promoting Schools: A three-year follow-up study of teachers' motivation, participation and perceived *outcomes. Scandinavian Journal of Educational Research,* 53(1): 89-102.

THOMAS, C. 2007. *Sociologies of disability and illness: Contested ideas in disability studies and medical sociology*. New York: Palgrave Macmillan.

TOMLINSON, C.A. 2001. *How to differentiate instruction in mixed ability classrooms*. 2nd ed. Alexandria: Association for Supervision and Curriculum Development.

TONES, K. & TILFORD, S. 1994. *Health education. Effectiveness, efficiency and equity.* London: Chapman and Hall.

TONES, K. & TILFORD, S. 2001. *Health promotion. Effectiveness, efficiency and equity* (2nd ed.). London: Chapman & Hall.

TONES, K. 2005. Health Promotion in Schools: The radical imperative. In Cliff, S. & Jensen, B.B. 2005. *The Health Promoting Schools: International Advances in Theory, Evaluation and Practice*. Danish University of Education Press.

TRACY, S. J. 2010. Qualitative quality: eight “Big-Tent” criteria for excellent qualitative research. *Qualitative Inquiry,* 16:837. 1077800410383121.

TUDGE, J., MOKROVA, I., HATFIELD, B. & KARNIK, R. 2009. Uses and misuses of Bronfenbrenner’s bio-ecological theory of human development. *Journal of Family Theory and Review*, 1(4): 198-210.

TZENALIS, A. & SOTIRIADOU, C. 2010. Health promotion as multi-professional and multi-disciplinary work. *International Journal of Caring Sciences,* 3 (2).

UNESCO. 1998. Health-Promoting Schools: Promoting the World Health Organization’s concept of health. *UNESCO International Science, Technology & Environmental Education Newsletter,* 23 (2).

UNITED NATIONS EDUCATIONAL, SCIENTIFIC AND CULTURAL ORGANIZATION. 2003. *Overcoming Exclusion through Inclusive Approaches in Education: a Challenge, a vision*. Conceptual Paper, Spain, Paris: UNESCO.

UNESCO. 2010. *Education for All global monitoring report 2010:* Reaching the marginalized. Paris. [Online]: Available at: <http://www.unesco.org> [Accessed October 2010].

UNICEF, 2002.The state of the World’s Children 2002. [Online]: Available at: http://www.unicef.org/sowc02briefl.htm. [Date accessed 8 August 2014].

UNICEF. 2008. *The state of the world’s children 2009*. New York: United Nations Children’s Fund.

UNICEF. 2004. Life Skills. [Online]: Available at: http://www.unicef.org/lifeskills/index_hiv_aids.html

UNIVERSITY OF SOUTH AFRICA. DEPARTMENT OF EDUCATIONAL STUDIES. 2003. *Inclusive education: a guide for parents, caregivers and communities: Study Letter OSN421-Q/109/2003*. Pretoria.

UNIVERSITY OF WESTERN CAPE. 2006. Health Promoting Schools Creating a decade of Health Promoting Schools Strengthening Whole School Development, Executive Summary Report on the National Conference on Health Promoting Schools held at the University of Western Cape, Bellville, Western Cape: South Africa (14-16 September 2006), http://www.healthpromotingschools.co.za/document/conf_06_ex_sum.pdf

VAN DER BERG, S. 2008. *Poverty and education*. Paris: The International Institute for Educational Planning.

VAN DEVENTER, K. J. 2008. Perceptions of Life Orientation teachers regarding the implementation of the learning area in Grade 8 & 9: A survey in selected Western Cape high schools. *South African Journal for Research in Sport, Physical Education and Recreation*, 30 (2): 131-146.

VAN HOUT, M. C., FOLEY, M., McCORMACK, A. & TARDIFF, E. 2012. Teachers' perspectives on their role in school based alcohol and cannabis prevention. *International Journal of Health Promotion and Education,* 50(6), 328-341.

VAN HOUT, M. & CONNOR, S. 2008. A qualitative study of Irish teachers' perspective of student substance use. *Journal of Alcohol and Drug Education,* 52(1): 80-91.

VAN MAANEN, J. 1983. *Qualitative methodology*. London: SAGE.

VAN NIEKERK, E. & PRINS, A. (eds.). 2001. *Counselling in South Africa: A youth Perspective.* Sandown: Heinemann Publishers.

VAN WYK, N. 2010. Theories, policies and practices of parent involvement in education. In E. Lemmer, & N. Van Wyk (Eds.). *Themes in South African Education*. Cape Town: Pearson Education South Africa Publishers.

VIIG, N.*G.* & WOLD, B. 2005. Facilitating teachers' Participation in School-based Health Promotion- A Qualitative Study. *Scandinavian Journal of Educational Research,* 49(1), 83-109.

VIIG, N. G., TJOMSLAND, H. E. & WOLD, B. 2010. Program and school characteristics related to teacher participation in school health promotion. *The Open Education Journal*, *3*(1874), 10– 20.

VILJOEN, C., KIRSTEN, J.G.C., HAGLUND, B. & TILLGREN, P. 2005. Towards the development of indicators for health promoting schools. In Clift, S. & Jensen, B.B. (Eds). *The Health Promoting Schools: International advances in the Theory, Evaluation and Practice*. Denmark: Danish University of Education Press.

WHITMAN, C. & ALDINGER, C. 2009. *Case studies in global school health promotion*. New York: Springer.

VYGOTSKY, L. 1931. The collective as a factor in the development of the abnormal child. In RW Rieber & AS Carton (Eds). *The collected works of LS Vygotsky.* New York: Springer, pp. 191-209.

WAGGIE, F., LAATTOE, N. & FILIES, G.C. 2013. Moving from conversation to commitment: optimising school-based health promotion in the Western Cape, South Africa. *African Journal of Health Professions Education,* 5(1):26-29.

WALKER, J. & EVERS, C. 1999. Research in Education: Epistemology issues. In J. Keeves & G. Lakomski (Eds.), *Issues in educational research*. New York: Elsevier Science.

WARREN, J.M., HENRY, C.J.K., LIGHTOWLER, H.J., BRADSHOW, S.M. & PERWAIZ, S. 2003. Evaluation of a pilot school programme aimed at the prevention of obesity in children. *Health Promotion International*, 18(4): 287-296.

WATERMAN, H. 1998. Embracing ambiguities and valuing ourselves: issues of validity in action research. *Journal of Advanced Nursing,* 28: 101-105.

WATERS, S. K., CROSS, D. S., & RUNIONS, K. 2009. Social and ecological structures supporting adolescent connectedness to school: a theoretical model. *Journal of School Health*, 79(11): 516–524.

WEARE, K. 2000. *Promoting mental, emotional and social health: A whole school approach.* New York: Routledge.

WEARE, K. & GRAY, G. 2003. *What Works in Developing Children's Emotional and Social Competence and Well-being? Research Report No 456*. University of Southampton: Crown Printers. Retrieved December 4, 2009, [Online]: Available at: www.dcsf.gov.uk/research/data/uploadfiles/RR456.pdf

WEARMOUTH, J., EDWARDS, G. & RICHMOND, R. 2000. Teachers' professional development to support inclusive practices. *Professional development in Education*, 26(1): 49-61.

WENT, S. 1992. *A healthy start- Holistic approaches to health promotion in school communities*. Melbourne: Monash University.

WEST, M., AINSCOW, M. & JACQUI, S. 2005. Sustaining improvement in schools in challenging circumstances: a case study of successful practice. *School Leaders Managers,* 25(1): 77-93.

WEVERS, N.E.J. 2012. The management of learners who experience barriers to learning in mainstream primary schools in the Eastern Cape. Doctoral studies: Nelson Mandela Metropolitan University.

WILLIAMS, H. A. & LAWSON, M. J. 2013. Teachers' knowledge and confidence for promoting positive mental health in primary school communities. *Asia-pacific Journal of Teacher Education,* 41 (2): 126-143.

WHO/AFRO. 2007. A Special Health Promotion Project: The HPS Initiative, Brazzaville, WHO AFRO. [Online] Available at: 2007www.afro.who.int/healthpromotion/project.html

WORLD BANK. 1993. *World Development Report 1993. Investing in Health*. Oxford: Oxford University Press.

WORLD BANK. 2011. *Rwanda education country status report towards quality enhancement and achievement of Universal Nine Year Basic Education, an education system in transition, a nation in transition*. Washington DC.

WORLD HEALTH ORGANISATION. 1958. *The first ten years of the World Health Organisation.* New York: WHO.

WORLD HEALTH ORGANISATION. 1948. Official records of the World Health Organisation, no.2 *Proceedings and final acts of the international health conference held in New York from 19 June to 22 July 1946.* New York: United Nations WHO Interim Commission.

WORLD HEALTH ORGANISATION. 1984. *Concepts and principles in health promotion.* Copenhagen: World Health Organization.

WORLD HEALTH ORGANISATION. 1986. *Ottawa Charter for Health Promotion.* Adopted at an International Conference on Health Promotion – The Move Towards a New Public Health (co-sponsored by the Canadian Public Health Association, Health and Welfare Canada and the World Health Organization); 17– 21 November. Geneva: World Health Organization.

WORLD HEALTH ORGANISATION. 1987. Regional office for Europe.

WORLD HEALTH ORGANISATION. 1988. Healthy public policy. *Adelaide recommendations on healthy public policy.* South Australia: Adelaide: World Health Organization.

WORLD HEALTH ORGANIZATION. 1991. Sundsvall Statement on Supportive Environments for Health. *Third International Conference on Health Promotion*, Sundsvall, Sweden, 9-15 June 1991.

WORLD HEALTH ORGANISATION. 1993. *The health of young people: A challenge and promise.* Geneva: Author.

WORLD HEALTH ORGANISATION. 1995. The world health report 1995 - bridging the gaps. [Online]: Available at: http://www.who.int/whr/1995/en/ [Date accessed 16 June 2014].

WORLD HEALTH ORGANISATION (WHO). 1996. *Regional guidelines: development of health-promoting schools- a framework for action*. Geneva: WHO.

WORLD HEALTH ORGANISATION. 1997. *The Jakarta Declaration on leading health promotion into the 21st Century*. Geneva: World Health Organisation.

WORLD HEALTH ORGANISATION. 1998. WHO global school health initiative: Helping schools to become 'health-promoting schools'. [Online]: Available at: http://www.who.int/inf- fs/en/fact092.htm [Date accessed. 12 January 2015].

WORLD HEALTH ORGANIZATION (WHO). 1999. *Programming for adolescent health and development: Report of a WHO/UNFPA/UNICEF. Study group on programming for adolescent health*. WHO Technical Report Series, 886.

WORLD HEALTH ORGANISATION. 2000. Location: Creating health-promoting schools. DoH Promotion/NCD Prevention and Surveillance, WHO/NMH/HPS/00.4.

WORLD HEALTH ORGANISATION. *World Health Report. 2002: Reducing risks, Promoting Health Life.* Geneva: WHO, 2002.

WORLD HEALTH ORGANISATION. 2005. Promoting mental health as an public health priority. *Promoting mental health*. Geneva: WHO.

WORLD HEALTH ORGANISATION. 2006. *Constitution of the World Health Organisation. Basic documents.* 45th edition. Supplement, October 2006. Geneva: WHO.

WORLD HEALTH ORGANISATION. 2008. *Global programme on health promotion effectiveness.* Geneva: World Health Organization.

WORLD HEALTH ORGANISATION. 2009. *Milestones in Health Promotion. Statements from Global Conferences.* Geneva: WHO.

WORLD HEALTH ORGANISATION. 2013. *Health in all policies*. Finland: WHO.

WORLD HEALTH ORGANISATION. 2015. *World Health Organization* [Online]. Available at: http://study.com/academy/lesson/what-is-the-world-health-organization-definition-history-purpose.html [Date accessed. 2 August 2018]

WULF, M. 1993. Is your school suffering from sick building syndrome? *PTA Today*, 19, 12-13.

WYN, J., CAHILL, H., HOLDSWORTH, R., ROWLING, L. & CARSON, S. 2000. Mind Matters, a whole school approach promoting mental health and well-being. *Australian and New Zealand Journal of Psychiatry*, 34(4): 594–601.

YORKE, L.C. 2008. Promotion of inclusive education by the learning support teacher concerning foundation phase numeracy and literacy in Gauteng independent schools. MEd dissertation, University of South Africa, Pretoria.

YOUNG, I. & CURRIE, C. 2009. The HBSC study in Scotland: can the study influence policy and practice in schools? *International Journal of Public Health*, 54 (271-277).

YOUNG, I., ST LEGER, L. & BUIJS, G. 2013. School health promotion: Evidence for effective action. Background paper SHE Factsheet 2.

YOUR DICTIONARY. 2013. http://www.yourdictionary.com/implication.

ZIGLIO, E., HAGARD, S. & GRIFFITHS, J. 2000. Health promotion development in Europe: achievements and challenges. *Health Promotion International*, 15 (143- 154).

8. APPENDICES

APPENDIX A: PERMISSION LETTER TO THE GDE

P.O. Box 12439
Hatfield
Pretoria
0028

Office of the Chief Director
Information and knowledge management
GDE

PERMISSION TO CONDUCT RESEARCH STUDY AT HEALTH PROMOTING PRIMARY SCHOOL

Dear Sir/Madam

I hereby request permission to conduct research at health promoting primary schools in Gauteng. I am presently registered for a PhD (Learner Support) with the North-West University (Potchefstroom Campus) under the supervision of Dr CT Viljoen, tel 018 299 4767/082 440 7482. The research is about “The role of the teacher as a promoter of health in schools: conceptualisation and practical implications”.

The objectives of the study are:

- to understand how do teachers perceive health and health promotion in schools;
- to investigate how teachers in their pedagogical practice, promote health in schools, and;
- to develop a possible framework that can be presented for teachers as promoters of health in the schools.

A qualitative design will be used in conducting the research and the methods for data collection will be in the form of interviews, observation, and documents pertaining to the role of teachers will be collected and analysed.

Participants in the study will be Life Orientation/Life Skills teachers. They will be interviewed by the researcher in English and this will take not more than one hour after normal teaching time. Interviews will be audio taped with the consent of the participants. Interviews will be transcribed, stored for seven years at the North-West University archives and after which they will be destroyed. Data will be used to develop a framework on how teachers can be involved in the promotion of health in schools. A copy of the transcription will be returned to the participants to ensure that no misunderstandings occurred.

Be assured that the principles of confidentiality, anonymity and privacy will be adhered to.

Thanking you in advance.

Yours truly

Mrs Mashau TI

mashati@unisa.ac.za

APPENDIX B: LETTER FROM GDE

GAUTENG PROVINCE
Department: Education
REPUBLIC OF SOUTH AFRICA

8/4/4/1/2

GDE RESEARCH APPROVAL LETTER

Date:	19 April 2017
Validity of Research Approval:	06 February 2017 – 29 September 2017 2017/70
Name of Researcher:	Mashau T.I
Address of Researcher:	P.O Box 12439
	Hatfield
	Pretoria, 0028
Telephone Number:	012 343 0192 083 613 8086
Email address:	mashati@unisa.ac.za
Research Topic:	The role of the teacher as a promoter of health in schools: Conceptualisation and practical implications.
Number and type of schools:	Six Primary Schools
District/s/HO	Tshwane North, Tshwane South and Tshwane 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.

19/04/2017

1

Making education a societal priority

Office of the Director: Education Research and Knowledge Management
7th Floor, 17 Simmonds Street, Johannesburg, 2001
Tel: (011) 355 0488
Email: Faith.Tshabalala@gauteng.gov.za
Website: www.education.gpg.gov.za

APPENDIX C: PERMISSION LETTER FROM THE DISTRICT

GAUTENG PROVINCE

Enquiries: MP NTSHANGASE
Tel: 012 543 1203
Reference: 22/16/1

TO	:	MRS TI MASHAU
FROM	:	MS SL MOLOBI DISTRICT DIRECTOR: TSHWANE NORTH
DATE	:	19 MAY 2017
SUBJECT	:	PERMISSION GRANTED TO CONDUCT RESEARCH

Dear Sir

It is our pleasure to inform you that the District Office grants you permission to conduct research at **Khensani Primary School** on the topic: **"The role of the teacher as promoter of health in schools: conceptualisation and practical implications".**

You may conduct the research from **06 February to 29 September 2017** and only **after contact time** to protect teaching and learning activities. The principal must be consulted about an appropriate time to conduct the research.

You are personally responsible for providing and utilizing your own research resources. Participants' names must not appear in the research report and all appropriate ethical measures must be implemented to safeguard them.

Tshwane North District expects you to submit, upon completion, a summary of your research findings as stipulated in **Clause No. 12 of the GDE Research Approval Letter.**

The District appreciates your contribution towards the enhancement of education in the province and anticipates your success with your research project.

Regards

MS SL MOLOBI
DISTRICT DIRECTOR: TSHWANE NORTH

DISTRICT: TSHWANE NORTH
Tel: (012) 543 1479, Cell: 083 539 3868, Fax: 086 771 8165, Email: Shirley.Molobi@gauteng.gov.za
Wonderboom Junction Mall, 1st Floor, Corner Lavender & Lawrence Weir, Road,
Wonderboom, 0000, Private Bag X946, Pretoria, 0001
www.callcentre.gpg.gov.za | Call Centre: 0800 605 175

APPENDIX D: NORTH-WEST UNIVERSITY ETHICS APPROVAL

NORTH-WEST UNIVERSITY
YUNIBESITI YA BOKONE-BOPHIRIMA
NOORDWES-UNIVERSITEIT

Private Bag X6001, Potchefstroom,
South Africa, 2520

Tel: (018) 299-4900
Faks: (018) 299-4910
Web: http://www.nwu.ac.za

Institutional Research Ethics Regulatory Committee
Tel: +27 18 299 4849
Email : Ethics@nwu.ac.za

ETHICS APPROVAL CERTIFICATE OF STUDY

Based on approval by the **Ethics Committee of the Faculty of Education Sciences (ESREC) on 04/12/2017** after being reviewed at the meeting held on **25/05/2017**, the North-West University Institutional Research Ethics Regulatory Committee (NWU-IRERC) hereby **approves** your study as indicated below. This implies that the NWU-IRERC grants its permission that, provided the special conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

Study title: The role of the teacher as a promoter of health in schools: conceptualisation and practical implications

Study Leader/Supervisor: Dr C Viljoen
Student: TI Mashau

Ethics number: N W U - 0 0 1 8 3 - 1 6 - A 2
(Institution | Study Number | Year | Status)

Status: S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation

Application Type:
Commencement date: 2017-05-01 **Expiry date**: 2017-12-31 **Risk:** Minimal

Special conditions of the approval (if applicable):

- Translation of the informed consent document to the languages applicable to the study participants should be submitted to the ESREC (if applicable).
- Any research at governmental or private institutions, permission must still be obtained from relevant authorities and provided to the ESREC. Ethics approval is required BEFORE approval can be obtained from these authorities.

General conditions:

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- *The study leader (principle investigator) must report in the prescribed format to the NWU-IRERC via ESREC:*
  - *annually (or as otherwise requested) on the progress of the study, and upon completion of the project*
  - *without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.*
  - *Annually a number of projects may be randomly selected for an external audit.*
- *The approval applies strictly to the proposal as stipulated in the application form. Would any changes to the proposal be deemed necessary during the course of the study, the study leader must apply for approval of these changes at the ESREC. Would there be deviated from the study proposal without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.*
- *The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-IRERC via ESREC and new approval received before or on the expiry date.*
- *In the interest of ethical responsibility the NWU-IRERC and ESREC retains the right to:*
  - *request access to any information or data at any time during the course or after completion of the study;*
  - *to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process.*
  - *withdraw or postpone approval if:*
    - *any unethical principles or practices of the project are revealed or suspected,*
    - *it becomes apparent that any relevant information was withheld from the ESREC or that information has been false or misrepresented,*
    - *the required annual report and reporting of adverse events was not done timely and accurately,*
    - *new institutional rules, national legislation or international conventions deem it necessary.*
- *ESREC can be contacted for further information or any report templates via Erna.Greyling@nwu.ac.za or 018 299 4656*

The IRERC would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the IRERC or ESREC for any further enquiries or requests for assistance.

Yours sincerely

Prof Refilwe Phaswana-Mafuya
Chair NWU Institutional Research Ethics Regulatory Committee (RERC)

APPENDIX E: EXAMPLE OF FOCUS GROUP INTERVIEW QUESTIONS

1. How would you describe the role of the school in society?
2. What would you say is the role of the teacher in the classroom/school?
3. What are your views on health and the promotion of health in schools?
4. What are your views on the health promoting school as such?
5. In your opinion, how do you think teachers can promote health in school?
6. As a Life Orientation/Life Skills teacher, how do you promote health in your pedagogical practice?
7. Are there any barriers, which hinder you from promoting health in the classroom/school? What are they?
8. In what ways do you counteract/overcome these barriers in the promotion of health in the classroom/school?
9. Is there anything that you would like to add on in terms of the promotion of health in the classroom/school?

APPENDIX F: EXAMPLE OF OBSERVATION SCHEDULE

Name of the school:……..

Time: (Period number):…….

Subject: Life Orientation/Life Skills

Teacher:……

Observation checklist:

The following list of questions will guide/inform the observations during engagements with the teachers. The main aim with these questions is to obtain a well-informed perspective of the teacher acting as a promoter of health.

1. Is the teacher aware of the various health and health promoting policies, guidelines, documents and standards (staff health and well-being, induction of new teachers, health and safety, sickness and absence, stress management, injury prevention, waste management, pollution, immunisation, etc.) set and available to them? To what extend do these documents impact on the teaching of the teacher?
2. Is the teacher aware of any vision, mission statements and planning/strategies of the school in terms of health promotion? What are the priorities in the school in terms of the promotion of health? What type of action is being taken?
3. Is the teacher aware of any priorities that need to be dealt with in this classroom/school?
4. Is the teacher knowledgeable in terms of what to be done in terms of health promotion, why it should be done, by whom and what a positive outcome could be?
5. Is the teacher knowledgeable in terms of what to do if there is a negative outcome in terms of health promotion?
6. Is the teacher aware of the knowledge, skills, attitudes and behaviour among the students?
7. Is the teacher aware of the values at play in promoting health in the classroom/school?
8. Is the teacher aware of the general/specific educational needs of the learners/school?
9. Is the teacher aware of the health inequities that may exist in the community?
10. Is the teacher aware of the environment (physical, social, and cultural) of the school?

11. Is the teacher aware of the knowledge, skills, attitudes and behaviour in the community?
12. Is the teacher knowledgeable about possible health and social services available to the students/school and how to access them?
13. Is the teacher aware of the role that he/she can play in terms of health promotion in the classroom/school/community?
14. Is the teacher aware of any communication structures within the school where specific health issues can be addressed?
15. Is the teacher aware of specific health promoting activities at present in the school (health eating, nutrition, physical activity, smoke free, mental health (drug and alcohol, sexual health, injury prevention, communicable diseases, etc.)?
16. Is the teacher aware of any links/relationships that exist between the school and the community and what these links/relationships mean in terms of health promotion?
17. Is the teacher aware of the importance of participation between the various role players when it comes to health promotion in the classroom/school?
18. Is the teacher knowledgeable in terms of the possible strengths within the school/community that might have a positive impact of health promotion?
19. Is the teacher aware of those aspects that need improvement in his/her classroom/school?
20. According to the teacher, what could be described as a health promoting relationship with colleagues, students, parents and the community?
21. According to you as a teacher how would you gather information about the health and well-being of your students and how does this influence your teaching practice?
22. Are you aware of any groups that might exist that can help and support you as a teacher promoting health in your classroom/school?
23. How would you rate your impact as a promoter of health in the classroom/school and why do you say so?
24. How do the teachers gather and share promising health promoting practices in the classroom/school?
25. Is the teacher aware of the fact that health promotion is a cross curricular activity and that it should permeate the whole curriculum and be focused on the identified needs of the students?

26. Is the teacher aware of the SIAS policy document and how it is supposed to be used in assisting the learners with special needs and/or learning support in the classroom/school?
27. Is the teacher aware of the role of the School based support team (SBST) and the District based support team (DBST) and what they can/should offer in terms of support?
28. Is the teacher aware of the importance of the leadership role that the principal/management can/should play in guiding/supporting health promoting activities in the school?
29. Can the teacher reflects on his/her own teaching practices in terms of health promotion in the classroom/school?
30. In terms of administration (preparation, resources, files, etc.) how is the teacher organising his/her approach within the context of promoting health in the classroom/school?
31. What does the teacher experience as possible barriers in the promotion of health in his/her classroom/school?

APPENDIX G: DOCUMENTS RECEIVED FROM SCHOOLS

- Baseline study for the project: “enhancing the health and well-being of Disadvantaged Communities in Gauteng through the HPS concept, 2006;
- Education White Paper 6: Building an inclusive education and training system, 2001;
- Policy on Screening, Identification, Assessment and Support, 2014;
- ISHP (ISHP), 2012
- How to… for implementers of HPS, 2011.
- The National Policy on HIV/AIDS for learners and teachers, 1999
- National School Nutrition Program, 2004;
- Basic School Gardening: Teachers Manual, 2009;
- Basic School Gardening: Learners Activity book. Foundation phase, 2009;
- Basic School Gardening: Learners Activity book. Intermediate phase, 2009;
- Basic School Gardening: Learners Activity book. Senior Phase, 2009; and
- HPS project mid-term evaluation. Final report. March. 2010

APPENDIX H: LANGUAGE CLEARANCE AND EDITING CERTIFICATE

EDITING AND PROOFREADING CERTIFICATE

7542 Galangal Street

Lotus Gardens

Pretoria

0008

31 October 2018

TO WHOM IT MAY CONCERN

This certificate serves to confirm that I have edited and proofread Ms T Mashau's doctoral thesis entitled, "**The role of the teacher as a promoter of health in schools: conceptualisation and practical implications.**"

I found the work easy and intriguing to read. Much of my editing basically dealt with obstructionist technical aspects of language, which could have otherwise compromised smooth reading as well as the sense of the information being conveyed. I hope that the work will be found to be of an acceptable standard. I am a member of Professional Editors' Guild.

Hereunder are my particulars:

Jack Chokwe (Mr)

Contact numbers: 072 214 5489

jackchokwe@gmail.com

Professional EDITORS Guild

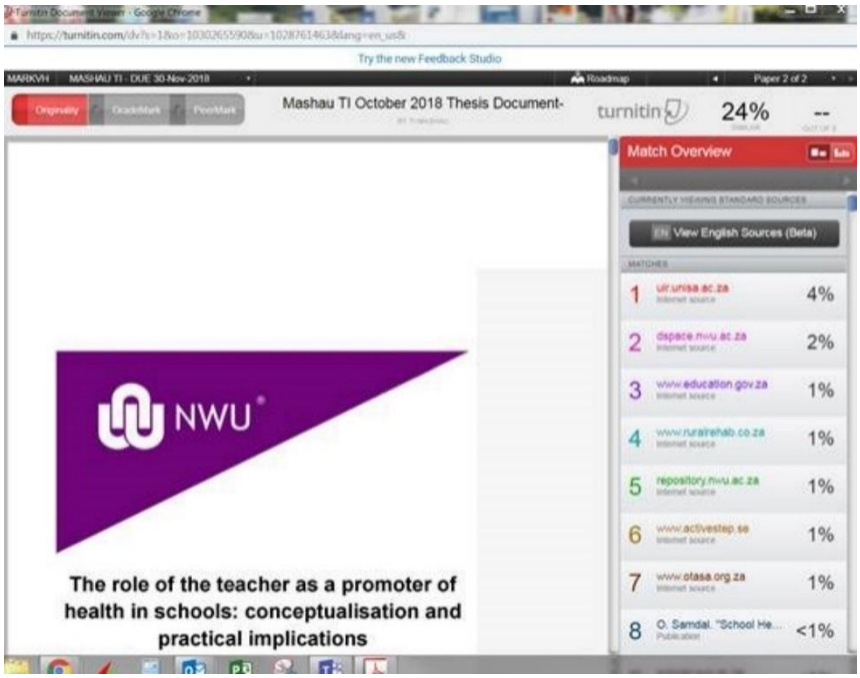


Open Rubric

APPENDIX I: TURNITIN REPORT

Dropbox link:

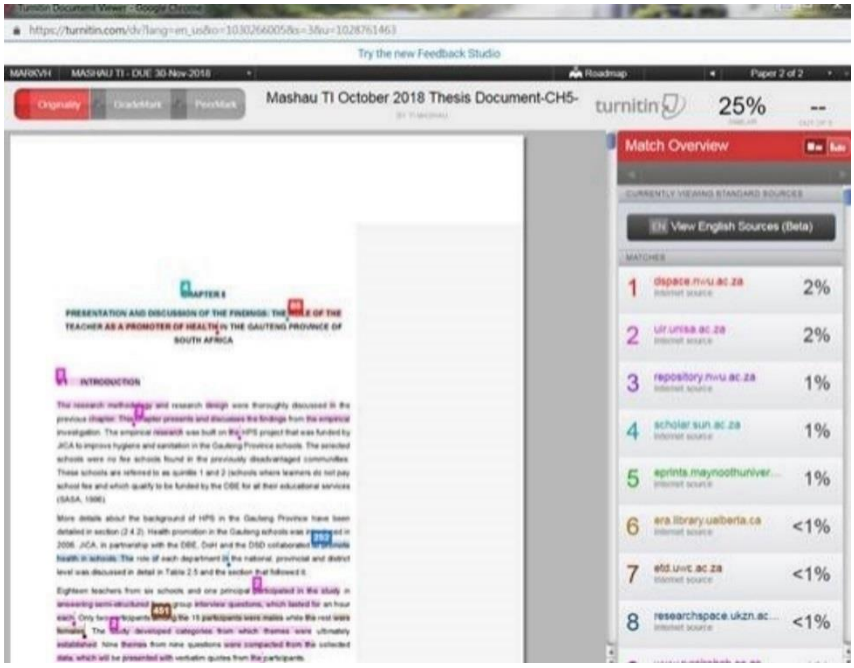
https://www.dropbox.com/s/bfjx7b4owj4q2tq/Mashau%20TI%20October%202018%20Thesis%20Document-START-CH4-TURNITIN-24%25.pdf?dl=0



Part 2: Ch 5 – end screenshot below:

Dropbox link:

https://www.dropbox.com/s/sdle7qbe83bmvkz/Mashau%20TI%20October%202018%20Thesis%20Document-CH5-END-TURNITIN-25%25.pdf?dl=0


Try the new Feedback Studio
Mashau TI October 2018 Thesis Document-CH5-
turnitin
25%
Match Overview
View English Sources (Beta)
1 dspace.nwu.ac.za 2%
2 ur.unisa.ac.za 2%
3 repository.nwu.ac.za 1%
4 scholar.sun.ac.za 1%
5 eprints.maynoothuniver... 1%
6 era.library.ualberta.ca <1%
7 etd.uwc.ac.za <1%
8 researchspace.ukzn.ac... <1%